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 2.7: Duration of Initial Provisional Appointment

All initial appointments to the medical staff (regardless of the category of the staff to which the appointment is made) and all initial clinical privileges shall be provisional for a period of twenty-four (24) months from the date of the appointment (. During the term of this provisional appointment, the individual receiving the provisional appointment shall be evaluated by the service director of the service in which the individual has clinical privileges and by the relevant committees of the medical staff and the hospital as to the individual's clinical competence and general behavior and conduct in the hospital. Focused Professional Practice Evaluation (FPPE) shall be considered by the Credentials Committee in determining appropriate continuation of medical staff membership. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment set forth in Article 8 of this Plan.

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 Advanced Practice Professionals (APP)

Section 7.1: Advanced Practice Professionals (APP's)

Selection Procedure

1) To the extent the Governing Body determines to permit such APP'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 APP 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 APP 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 APP 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 APP 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 APP 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) APP'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 APP 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) APP'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 APP'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 APP either to act or to issue instructions outside the physical presence of the supervising medical staff member shall require the APP's supervisor validate, either at the time or later, the instructions of the APP. Any act or instruction of the APP shall be delayed until such time as the hospital employee can be certain that the act is clearly within the scope of the APP's activities as permitted by the Governing Body.
4) The number of APP'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 APP's to provide evidence of professional liability insurance covering him in amounts required by the Governing Body. An APP shall act in the hospital only while such coverage is in effect.

Section 7.2: Allied Health Professionals

Nursing staff, technicians, and medical assistants who are employed by medical staff members or their medical group may function in the hospital but may perform duties, tasks, and procedures normally allowed by employed staff of the hospital under similar circumstances. They are not members of the medical staff and are not credentialed by the Credentials Committee but shall function under the rules, guidelines and policies established by the hospital for similar staff employed by the hospital. As they are not credentialed or privileged through the medical staff bylaw process, there is no right of fair hearing or appeal. Should they no longer be employed by the medical staff member or his medical group, they are no longer allowed to function in the hospital.

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

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.

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.

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.

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 APP'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.