

## **MEDICAL STAFF POLICIES & PROCEDURES**

**Applicability:** Community Hospital Anderson, Community Hospital East, Community Heart and Vascular Hospital (A Department of Community Hospital East), Community Fairbanks Recovery Center, Community Howard Regional Health, Community Hospital North, Community Hospital South

# **ALLIED HEALTH PRACTITIONER POLICY**

# Table of Contents

Page

1.	<b>PURPOSE</b> .....	4
2.	<b>DEFINITIONS</b> .....	4
	<b>A. Advanced Practice Nurse</b> .....	4
	<b>B. Adverse Recommendation or Action</b> .....	4
	<b>C. Allied Health Practitioners</b> .....	4
	<b>D. Board Certification</b> .....	4
	<b>E. Bylaws</b> .....	4
	<b>F. Clinical Assistants</b> .....	4
	<b>G. Clinical Psychologist</b> .....	5
	<b>H. Collaborating Physician</b> .....	5
	<b>I. Direct Economic Competition</b> .....	5
	<b>J. Governing Body</b> .....	5
	<b>K. Hospital</b> .....	5
	<b>L. Medical Staff</b> .....	5
	<b>M. Medical Executive Committee</b> .....	5
	<b>N. Physician Assistant</b> .....	5
	<b>O. Sponsoring Physician</b> .....	5
3.	<b>CLINICAL PRIVILEGES</b> .....	6
4.	<b>COLLABORATION, LIMITATIONS AND RESPONSIBILITIES</b> .....	6
	<b>A. Collaboration</b> .....	6
	<b>B. Limitations</b> .....	6
5.	<b>AUTOMATIC SUSPENSIONS</b> .....	6
6.	<b>ACTING ON REPORTED CONCERNS</b> .....	7
	<b>A. Collegial Intervention</b> .....	7
	<b>B. Grounds for Initiating Investigation</b> .....	7
	<b>C. Initiation</b> .....	7
	<b>D. Procedure</b> .....	7
	<b>E. Completion of Investigation</b> .....	8
	<b>F. Committee Action</b> .....	8
	<b>G. Grounds for Suspension</b> .....	9
7.	<b>HEARING AND APPEAL PROCEDURE</b> .....	10
	<b>A. Actions Giving Rise to Hearing</b> .....	10

B.	Exhaustion of Remedies .....	10
C.	Expedited Hearing Rights .....	10
D.	Request for Review .....	10
E.	Hearing Committee.....	10
F.	No Discovery.....	10
G.	Hearing .....	11
H.	Hearing Committee Report and Recommendation.....	11
8.	APPEAL.....	12
A.	Appeal to the Governing Body .....	12
B.	One Hearing/Appeal .....	12
C.	Reports .....	12

## **MEDICAL STAFF ALLIED HEALTH PRACTITIONER POLICY ("Policy")**

### **1. PURPOSE**

The purposes of this Medical Staff policy are (1) to establish a method by which an eligible Allied Health Practitioner may seek and be granted clinical privileges; (2) to establish a method by which each Medical Staff will oversee the quality of care provided by the Allied Health Practitioner granted clinical privileges; and (3) establish a review process by which the Allied Health Practitioner may challenge certain actions or recommendations limiting clinical privileges granted.

### **2. DEFINITIONS**

**A. Advanced Practice Nurse.** Advanced Practice Nurse means an advanced practice registered nurse practitioner, clinical nurse specialist certified nurse-midwife, or certified registered nurse anesthetist who currently holds a valid license to practice nursing in the State of Indiana and has matriculated from a graduate program offered by an accredited college or university which prepares registered nurses to practice.

**B. Adverse Recommendation or Action.** Adverse Recommendation or Action means any review action as defined by the Health Care Quality Improvement Act (HCQIA) that if approved by the Governing Body of the Hospital, will Adversely Affect the clinical privileges of a Privileged Practitioner for a period of greater than thirty (30) days.

**C. Allied Health Practitioners.** Allied Health Practitioners are licensed or certified health care practitioners (other than physicians, oral surgeons, podiatrists or dentists) who are eligible to seek and be granted clinical privileges as approved by each Community Health Network Hospital's Medical Staff and Governing Body as an Allied Health Practitioner. Those eligible to seek clinical privileges as an Allied Health Practitioner are set forth below:

- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Physician Assistants
- Registered Radiology Assistant

**D. Board Certification.** Board Certification means the board certification approved by the Medical Executive Committee, as ratified by the Governing Body of the hospital at which the Allied Health Practitioner is seeking or maintains clinical privileges.

**E. Bylaws.** Bylaws for the purposes of this Policy, means the medical staff bylaws, rules and regulations, policies and procedures of the medical staff of the hospital at which the Allied Health Practitioner is seeking or maintains clinical privileges.

**F. Clinical Assistants.** Clinical Assistants are licensed or certified health care practitioners (other than physicians, oral surgeons, podiatrists, dentists, nurse practitioners, clinical nurse specialists, certified nurse-midwives, certified registered nurse anesthetists, physician assistants, or clinical psychologists) who are employed by a Member to clinically assist the Member in the Hospital setting and who practice within the scope of care as approved by each Hospital's Medical Staff and Governing Body. Clinical Assistants are not eligible to seek clinical privileges. Those practitioners eligible to be a Clinical Assistant are set forth below:

- Scrub Nurses
- Certified Surgical Technicians
- Rounding Nurse
- Rounding Nurse First Assist

**G. Clinical Psychologist.** Clinical Psychologist means an individual who has earned a doctorate degree in psychology from an accredited educational institution, who is licensed by the State of Indiana, and who has least two (2) years of clinical experience in an organized health care setting supervised by a licensed clinical psychologist with one year of that supervision being post doctorate degree, and has an endorsement as a Health Service Provider in Psychology (HSPP) by the appropriate Indiana board or must acquire such HSPP endorsement within two (2) years of initial appointment to Allied Health Professional Staff.

**H. Collaborating Physician.** Collaborating Physician means a physician who, either because required by law or voluntarily, has agreed to collaborate with an Allied Health Practitioner, and who has clinical privileges in the same specialty at the same Hospital.

**I. Direct Economic Competition.** Direct Economic Competition for the purposes of this Policy means that the Allied Health Practitioner selected to serve on the Hearing Committee practices at the Hospital in the same specialty, with the same privileges as the Affected Practitioner. Direct economic competition does not mean another Allied Health Practitioner employed by or under contract with the same group practice, including but not limited to situations where the employer is Community Health Network.

**J. Governing Body.** Governing Body means Hospital's board of directors or delegated committee.

**K. Hospital.** Hospital means the hospital at which the Allied Health Practitioner is seeking or maintains clinical privileges.

**L. Medical Staff.** Medical Staff means the medical staff of the hospital at which the Allied Health Practitioner is seeking or maintains clinical privileges.

**M. Medical Executive Committee.** Medical Executive Committee means the executive committee of the medical staff of the hospital at which the Allied Health Practitioner is seeking or maintains clinical privileges. For the purposes of this Policy, it also includes the Medical Executive Committee's subcommittees that may routinely conduct quality reviews/peer review activities on behalf of the Medical Executive Committee.

**N. Physician Assistant.** Physician Assistant means an individual who currently holds a valid physician assistant license in the State of Indiana, maintains certification by the National Commission on Certification of Physician Assistants, and has a dependent collaborate practice agreement with a physician Member.

The definitions contained in the applicable Medical Staff Bylaws apply to this Policy. There are numerous Community Health Network hospitals and each Hospital's medical staff has its own Medical Staff Bylaws.

**O. Sponsoring Physician.** Sponsoring Physician means a physician who has agreed to be responsible for the appropriate supervision of the professional and clinical activities of an Allied Health

Practitioner.

### **3. CLINICAL PRIVILEGES**

Allied Health Practitioners permitted to provide patient care services in the Hospital shall have delineated clinical privileges in accordance with the Medical Staff Credentialing Policy and the Medical Staff Bylaws of each Hospital.

### **4. COLLABORATION, LIMITATIONS AND RESPONSIBILITIES**

**A. Collaboration.** The exercise of clinical privileges requires the AHP to have a designated Physician Sponsor or Collaborating Physician as defined in this Policy unless provided otherwise by the Medical Staff Bylaws. All clinical privileges are performed in accordance with any applicable collaborating written agreement and policies and protocols developed and approved by the relevant Department/Section, the Medical Executive Committee, and the Governing Body, or its designee. Those Allied Health Practitioners required by law to have a written collaborative agreement for prescriptive authority or otherwise, must also have a provision in the agreement designating a back-up physician with appropriate Medical Staff membership and privileges when the collaborating physician is unavailable.

If clinical privileges are granted to an applicant, the applicant will be assigned to a Medical Staff Department/Section. The Allied Health Practitioner is subject to the Medical Staff policies and regulations of that Department/Section and to the authority of the President of the Medical Staff and assigned Department/Section. The quality and efficiency of the care provided by Allied Health Practitioner within any such Department/Section shall be monitored and reviewed by the collaborating physician and the medical staff quality review processes such as focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE).

**B. Limitations.** Allied Health Practitioners are not eligible to become members of the Medical Staff and therefore do not pay dues to the Medical Staff. Allied Health Practitioners are not eligible to admit patients. Allied Health Practitioners are not governed by the procedures defined in the Fair Hearing Plan/Corrective Action Section of the Medical Staff Bylaws. However, Allied Health Practitioners are governed by a similar process contained in this Policy. Allied Health Practitioners may not admit or discharge patients.

### **5. AUTOMATIC SUSPENSIONS**

Automatic suspensions or limitations on clinical privileges and voluntary resignations/relinquishments of clinical privileges for administrative reasons relating to failure to meet Threshold Eligibility requirements found in the Medical Staff Bylaws and applicable clinical privilege forms become effective immediately by operation of this Policy. Automatic actions are not considered "Adverse Recommendations or Actions" as defined in Article 1 because they are not based on a peer review committee determination of competence or unprofessional conduct. Therefore, automatic suspensions or limitations do not give rise to any hearing or appeal procedures.

Grounds for an automatic suspension of clinical privileges are the same as set forth in the Medical Staff Bylaws. In addition to those grounds, an Allied Health Practitioner's clinical privileges will be automatically suspended when (1) a collaborative agreement required by law is terminated; or (2) employment with CHNw or group practice is terminated resulting in the loss of professional liability coverage and required collaborative or supervisory agreements. An Allied Health Practitioner terminated from CHNw employment or their group practice, who is otherwise eligible for clinical privileges, may reapply. If an Allied Health Practitioner's collaborating physician's clinical privileges are restricted or suspended, the Allied Health Practitioner's prescriptive authority and/or supervised clinical

privileges will also be similarly automatically restricted or suspended. The Allied Health Practitioner must notify the Medical Staff Office of any change in the Allied Health Practitioner's collaborating physician agreement and provide documentation indicating details of the change.

## 6. ACTING ON REPORTED CONCERNS

**A. Collegial Intervention.** When concerns about professional conduct or performance are raised, the Medical Staff leadership will work collegially with the Allied Health Practitioner to address the concerns expeditiously as long as patient safety is not jeopardized. Collegial interventions will be documented. The Department/Section Chair and, if applicable, the Community Physician Network ("CPN") peer review committee representative, will receive notification of the collegial intervention. The collaborating physician may be required to participate. The medical staff leadership may collaborate with the collaborative or sponsoring physician. When collegial intervention is not successful, or insufficient to protect the well-being of patients, staff or the orderly administration of the Hospital, additional corrective peer review activities may be commenced.

**B. Grounds for Initiating Investigation.** A preliminary review or collegial intervention may be initiated when reliable information indicates the Allied Health Practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be: detrimental to patient safety or to the delivery of quality patient care within the Hospital;

- (1) unethical or illegal;
- (2) contrary to the Medical Staff Bylaws, associated procedures, Hospital or Medical Staff Policies and/or any Rules and Regulations or to the delineation of clinical privileges;
- (3) harassing or intimidating to Hospital employees, Medical Staff colleagues, patients or their families;
- (4) disruptive of Hospital or Medical Staff operations;
- (5) below applicable professional standards for competency or standards established by the Medical Staff; or
- (6) harmful to the reputation of the Hospital and/or Medical Staff

The purpose of an preliminary review is to gather information related to the concern so that the appropriate Peer Review Committee can make a recommendation as warranted by the facts.

**C. Initiation.** Concerns about an AHP may be presented to the designated Department/Section Chair, Medical Staff President, Hospital Administrator, Network Executive or their designee, or any member of the MEC for preliminary review to determine whether further investigation is warranted. An investigation can be initiated upon the agreement of two of the foregoing individuals with notice to the Medical Staff President or Chair of a Medical Staff Peer Review Committee. A request for an investigation must be substantiated by reference to the specific activities, concerns, or conduct alleged to warrant the investigation. Unless grounds for suspension as set forth in this Policy exist and are acted upon, the findings of the initial review must be presented to the MEC for a determination of the need for further action. If further action is determined necessary, the Medical Executive Committee will provide notice to the Allied Health Practitioner, and if applicable, the collaborating Physician, and/or the CPN peer review committee representative. The Medical Executive Committee may query other appropriate peer review committees, including the CPN peer review committee to gather additional information. When the Allied Health Practitioner is employed by Community Health Network, the human resources department also may be queried to gather additional information.

**D. Procedure.** If the Medical Executive Committee concludes further action is warranted, it will direct the actions to be taken and may do so by delegation to a designated subcommittee or other

medical staff committee and may enlist the assistance of the applicable sponsoring or collaborating Physician. The Medical Executive Committee or the Credentials Committee may ask the Hospital to undertake external peer review if it believes such a step is warranted to conclude its investigation.

Any further actions will be initiated within ten (10) days following the date the Medical Executive Committee determined that further action is warranted, in an effort to provide a resolution or recommendation by the next MEC meeting. A written report of the findings and any recommendations will be submitted to the Medical Executive Committee as soon as practicable if the Medical Executive Committee delegates a subcommittee to conduct the investigation or action. If the Medical Executive Committee conducts the investigation, the findings and recommendation may be noted in the committee's minutes and a separate document is unnecessary. The investigating committee or its designee shall interview the AHP and may, but is not obligated to, conduct interviews with persons knowledgeable about the Allied Health Practitioner under review. The committee may delegate the interviewing task to the "personnel of the peer review committee" as defined in the Indiana peer review statute. The Allied Health Practitioner and as applicable, the collaborating physician and CPN Peer review representative will be notified of the investigation before the written report is completed and will be given an opportunity to provide information.

An investigation is not a hearing and the procedural rules with respect to hearings or appeals do not apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances to protect any patient, staff, and the Hospital.

**E. Completion of Investigation.** The Medical Executive Committee shall strive to conclude an investigation within thirty (30) days of a referral for an investigation. Where the committee believes it is necessary, an investigation can be extended for an additional thirty (30) day period or longer. The Medical Executive Committee will determine if the results of the investigation are sufficient to make a determination and whether corrective action should be recommended. When it makes this decision, the Medical Executive Committee will indicate in its minutes that the investigation is completed and so notify the Allied Health Practitioner and the collaborating physician involved and, if applicable, the CPN peer review committee representative.

**F. Committee Action.** As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action that may include, without limitation:

- (1) Determining no further action is warranted based on available information. The request for investigation and the concern will be maintained in the Allied Health Practitioner's medical staff quality assurance file in a peer review protected manner, and compared to future reported events that may indicate a pattern that warrants further review.
- (2) Deferring action if it believes more information is needed. However, such deferral should not be longer than 120 days from the initial recommendation for an investigation.
- (3) Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected Allied Health Practitioner may make a written response, which shall be placed in the Allied Health Practitioner's Medical Staff peer review file.
- (4) Recommending special limitation upon continued exercise of clinical privileges.
- (5) Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.
- (6) Recommending limitation of any prerogatives directly related to the AHP's delivery of patient care.
- (7) Taking other actions deemed appropriate under the circumstances.

If the recommendation is an adverse recommendation or action that restricts or suspends clinical privileges for a period over thirty days, it will give rise to hearing rights. The following recommendations are not adverse recommendations or actions:

- (1) the issuance of a letter of guidance, warning, or reprimand;
- (2) automatic suspension or limitation as provided above;
- (3) the restriction or suspension of clinical privileges for a period of less than fourteen (14) days while an Investigation is pending;
- (4) the denial of a request for a leave of absence or for an extension of a leave of absence;
- (5) determination by the Hospital that an initial or renewed application is untimely or incomplete;
- (6) assignment to a particular clinical Service/Department/Section;
- (7) imposition of a proctoring or monitoring requirement where such does not include a restriction on clinical privileges;
- (8) failure to process a request for clinical privileges when the Applicant does not meet the threshold eligibility requirements to seek a particular clinical privilege;
- (9) imposing focused peer review including external peer review or focused professional practice evaluation or a formal Investigation;
- (10) the requirement to appear for a special meeting;
- (11) the termination or limitation of Temporary Privileges;
- (12) any ineligibility to exercise or request clinical privileges because of an exclusive agreement for those services;
- (13) termination of any contract with or employment by the Hospital;
- (14) any non-Adverse Recommendation voluntarily accepted by the AHP as a result of collegial intervention;
- (15) any requirement to complete an educational assessment;
- (16) any requirement to undergo a mental, behavioral, or physical evaluation to determine fitness for practice;
- (17) clinical privilege term less than 24 months;
- (18) refusal of the Governing Body to reinstate clinical privileges following a leave of absence;
- (19) actions taken by the licensing agency or any other governmental agency or regulatory body.

**G. Grounds for Suspension.** The clinical privileges of an Allied Health Practitioner may be summarily suspended upon the agreement of two of the following persons: the President of the Medical Staff, the Department/Section Chair, and the Hospital Administrator, Network Executive or their designees. Upon the agreement of no less than two (2) of the above listed authorized individuals, one of which must be a privileged provider, all or any portion of the clinical privileges of Allied Health Practitioner will be suspended whenever there is a reasonable possibility that failure to do so may pose danger to the health and/or safety of any individual or to the orderly operations of the Hospital. This suspension will take place immediately. The affected Allied Health Practitioner and their collaborating physician and as applicable the CPN peer review representative will be promptly informed. The imposition of the suspension will be reviewed by the Medical Executive Committee as soon as practicable, but in no more than fourteen (14) days.

Whenever an Allied Health Practitioner has been suspended for more than fourteen (14) days or when the Medical Executive Committee makes a recommendation to extend the suspension beyond fourteen (14) days, the Allied Health Practitioner will be entitled to request a hearing as described in Article 12 of this Policy.

## 7. HEARING AND APPEAL PROCEDURE

**A. Actions Giving Rise to Hearing.** Any recommendation to deny an initial complete application or reapplication of an Allied Health Practitioner will trigger the same notice and opportunity to be heard provisions set forth in this Article. The clinical privileges may be limited or restricted by the Board upon the recommendation of the Medical Executive Committee. The Allied Health Practitioner will receive a written notice of proposed action and the allegations supporting the proposed action within ten (10) days of the MEC recommendation. The AHP will have ten (10) days from the date that the notice is delivered in person or by secure electronic delivery via email to request a hearing. The Collaborating Physician and, if applicable, the CPN peer review committee representative will be copied on the notice.

When an eligible Allied Health Practitioner (hereinafter "Affected Practitioner") receives notice of a proposed Adverse Action made by the Medical Executive Committee that, if ratified by decision of the Board, will adversely affect the exercise of clinical privileges for more than thirty (30) days, the Affected Practitioner will be entitled to one (1) hearing as provided herein. If the recommendation of the Medical Executive Committee following such hearing is still adverse to the Affected Practitioner, then the Affected Practitioner will be entitled to one (1) written appellate review prior to the Board making a final decision on the matter.

**B. Exhaustion of Remedies.** The procedures and remedies provided in this Policy must be exhausted before resorting to any legal action.

**C. Expedited Hearing Rights.** A hearing for an Affected Practitioner who is under suspension shall be held as soon as arrangements may reasonably be made, if the Affected Practitioner requests in writing such an expedited hearing date and waives the usual deadlines as stated below in favor of an expedited process.

**D. Request for Review.** Within ten (10) days of receiving notice of the proposed Adverse Action, the Affected Practitioner may request a hearing before the hearing committee appointed by the President of the Medical Staff. If a hearing is not requested in ten (10) days, the Medical Executive Committee recommendation will be forwarded to the Governing Body.

**E. Hearing Committee.** The hearing committee shall consist of a minimum three (3) providers from the AHP staff and Medical Staff of the Hospital, utilizing the following criteria unless a broader selection is required. The panel will be selected from practitioners with clinical privileges at the same Hospital and with the same license as the Affected Practitioner and members of the Medical Staff that have experience in collaborating with AHPs. The Hearing Committee shall have no members (i) who actively participated in initiating or investigating the underlying matter at issue or who were responsible for making the proposal giving rise to the hearing unless it is otherwise impossible to select a representative group, or (ii) who are in Direct Economic Competition as defined in Article 2 of this Policy with the Affected Practitioner for whom the hearing has been scheduled. The Affected Practitioner may waive this requirement thereby allowing another Allied Health Practitioner considered to be in direct economic competition with the Affected Practitioner to serve on the hearing committee. If not waived by the Affected Practitioner, the President of the Medical Staff may appoint other qualified practitioners.

**F. No Discovery.** There shall be no right to discovery. In advance of the hearing, the Affected Practitioner will be provided a copy of any materials considered by the Medical Executive Committee in support of its proposed Adverse Action to prepare for the hearing. These materials remain confidential and peer review privileged. The Affected Practitioner is prohibited from using the materials outside of the hearing and appeal.

**G. Hearing.** At the hearing, the Affected Practitioner shall have an opportunity to present evidence or rebut the concerns leading to the recommendation of denial, limitation, restriction, or suspension.

- (1) **Personal Appearance Requirement.** The personal presence of the Affected Practitioner is mandatory. An Affected Practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived their rights and to have accepted the Adverse Recommendation and the same shall thereupon become and remain in effect until action by the Governing Body.
- (2) **Continuance.** Postponement of the hearing beyond the time set forth in this Policy shall be made only with the approval of the Hearing Committee if good cause is shown in the sole discretion of the Hearing Committee.
- (3) **Representation.** The Affected Practitioner may be accompanied by and represented at the hearing by an Allied Health Practitioner licensed in Indiana and in good standing at the Hospital or by an attorney licensed to practice in Indiana at their own expense.
- (4) **No Rule of Evidence.** The hearing shall not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in any civil or criminal action. The Affected Practitioner and Medical Executive Committee may present documents, including affidavits, and have others provide testimony.
- (5) **Standard Burden of Proof.** In cases challenging the proposed Adverse Action of the Medical Executive Committee, the Medical Executive Committee shall have the burden of initially producing evidence in support of the proposed Adverse Action. The Affected Practitioner bears the ultimate burden of proving, by a clear and convincing evidence that the proposed Adverse Action should be rejected.
- (6) In cases challenging denial or limitation of requested clinical privileges, the Affected Practitioner shall bear the burden to initially produce evidence and bear the ultimate burden of persuading the Hearing Committee.
- (7) In all cases, at the Hearing and any Appeal, the Affected Practitioner shall be required to prove, by a preponderance of the evidence presented, that the reasons for the proposed Adverse Action were (1) lacking foundation in fact or (2) that the recommended action or decision was arbitrary or unreasonable.

**H. Hearing Committee Report and Recommendation.** Upon hearing the evidence, the Hearing Committee may recommend to the Medical Executive Committee that the proposed Adverse Recommendation be approved, modified or denied. Within ten (10) days of the hearing, the Hearing Committee shall make a written report and recommendation. This report and recommendation shall be forwarded to the Medical Executive Committee. A copy of the Hearing Committee's report and recommendation shall also be sent to the Affected Practitioner. The report may recommend confirmation, modification, or rejection of the original Adverse Recommendation. At its next regularly scheduled meeting, the Medical Executive Committee shall make a recommendation. If the Medical Executive Committee recommendation continues to be an Adverse Recommendation, the Allied Health Practitioner will have ten (10) days to request an appeal to the Governing Body. Written notice of the action taken shall be sent to the Affected Practitioner. The recommendation will not be acted upon by the Quality of Care Committee or forwarded to the Board for final action until the Affected Practitioner has exercised or been deemed to have waived their right to an appeal.

If an appeal is not requested, in the timeframes set herein, the Medical Executive Committee recommendation will be forwarded to the Quality of Care Council of the Board.

## **8. APPEAL**

**A. Appeal to the Governing Body.** If an appeal is requested, the Administrator of the Hospital or their designee will set a reasonable date for the Allied Health Practitioner to submit their written appeal, which shall be no earlier than thirty (30) days from the receipt of the Medical Executive Committee's formal recommendation. The Medical Executive Committee will be provided an opportunity to respond in writing to the Allied Health Practitioner's written appeal submission. The Board or its designee will consider the written submissions of both parties and make its final determination. Any action by the Board shall become effectively immediately. The Allied Health Practitioner will be notified of the final action by the Hospital President or their designee.

**B. One Hearing/Appeal.** Notwithstanding any other provision of this Policy, no Affected Practitioner shall be entitled to more than one hearing and one appellate review on any matter.

**C. Reports.** The Hospital or its authorized representative shall report to the appropriate licensing authority all final Adverse Actions taken by the Governing Body in compliance with the Indiana law. Upon the recommendation of the MEC to the Governing Body, the Hospital may make a report to the National Practitioner Data Bank.