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MEDICAL STAFF POLICIES & PROCEDURES

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

MEDICAL STAFF CREDENTIALING POLICY

MEDICAL STAFF CREDENTIALS POLICY

TABLE OF CONTENTS

MEDICAL STAFF CREDENTIALS POLICY

CLINICAL PRIVILEGES

MEDICAL STAFF CREDENTIALS POLICY

PURPOSE: The purpose of this Policy is to set forth the criteria for assessing applications for appointment and reappointment to the Medical Staff and evaluating privilege requests. This Policy only applies to eligible healthcare professionals seeking membership and or clinical privileges to the Medical Staff. This Policy is incorporated in the Medical Staff Bylaws as stated therein.

APPLICABLITY: This policy shall individually and separately apply to each of the following Medical Staffs: Community Hospital Anderson, Community Hospital East, Community Fairbanks Recovery Center, Community Heart and Vascular, Community Hospital North, Community Hospital south and Community Howard Regional Health.

DEFINED TERMS

"Accreditation Body" means any organization which (1) awards an accreditation or certification to or sought by the Hospital to obtain reimbursement or improve quality; or (2) provides quality oversight programs to the Hospital.

"Allied Health Practitioner" means any Advance Practice Nurse, Physician Assistant, or Clinical Psychologist granted clinical privileges by the Governing Body and collectively are referred to as "Allied Health Practitioner Staff."

"Applicant" means a practitioner seeking Membership to the Medical Staff and/or clinical privileges and includes members and Privileged Practitioners.

"Application" means the form developed by Medical Executive Committee and all supporting documentation required to apply for Medical Staff Membership and/or clinical privileges.

"Bylaws" means the Medical Staff Bylaws of Community Health Network, Inc. doing business individually and separately as Community Hospital Anderson, Community Hospital East, Community Fairbanks Recovery Center, Community Howard Regional Health, Community Hospital North, and Community Hospital South.

"Credentialing Representative" is any individual assisting the Medical Executive Committee, Medical Staff Quality Committee, or the Credentials Committee of the Medical Staff in credentialing and other Peer Review processes. Such individual is Personnel of the Peer Review Committee.

"Disaster" means an emergency that due to its complexities, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

"Governing Body" means the board of directors of Community Health Network, Inc. or delegated Governing Body committee.

"Medical Executive Committee" means the committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Bylaws and Policies.

MEDICAL STAFF CREDENTIALS POLICY

"Member" means a Physician, Oral Surgeon, Dentist or Podiatrist who has been granted Membership on the Medical Staff of the Hospital pursuant to the terms of these Bylaws and Policies.

"Network" means Community Health Network, Inc.

"Network Executive" means a senior leader within the Network with administrative responsibilities to the Hospital and Medical Staff.

"Oral Surgeon" means an individual with a D.D.S. or D.M.D., who currently holds a valid license to practice dentistry in the State Indiana, and who has successfully completed an Approved Residency Program in Oral and Maxillofacial Surgery.

"Physician" means an individual who currently holds a valid license to practice medicine or osteopathic medicine in the State of Indiana.

"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 is supervised by a physician Member.

"Podiatrist" means an individual who currently holds a valid license to practice podiatric medicine in the State of Indiana.

"Qualified Provider" means a practitioner who has sufficient professional liability insurance because the practitioner either (1) meets the requirements of the Indiana Medical Malpractice Statute including paying the surcharge; or (2) has insurance coverage under the Federal Tort Claim Act.

1. **CONFIDENTIALTY**

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

   a) To another authorized individual and for the purpose of conducting professional review activity;
   b) As authorized by a policy; or
   c) As authorized, in writing, by the CMO or by legal counsel to the Hospital

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

MEDICAL STAFF CREDENTIALS POLICY

2. NATURE

Membership is a privilege which shall be granted by the Governing Body only after an Applicant demonstrates that the qualifications for membership have been met and the responsibilities of membership as set forth have been accepted. Membership shall confer only such prerogatives as have been established in these Bylaws.

3. CONFLICT OF INTEREST

In any instance where any Medical Staff officer, department chair or vice chair, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving another Medical Staff Member that comes before such individual or Medical Staff committee, or in any instance where any such Member or committee member brought the complaint against the Member, such individual or committee member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time though the individual or committee member may be asked and may answer any questions concerning the matter before leaving. As a matter of procedure, the committee chair designated to make such a review should inquire, prior to any discussion of the matter, whether any committee member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any committee member may be called to the attention of the chair by any committee member with knowledge of the matter.

A department chair shall have a duty to delegate review of an application for appointment, reappointment, or clinical privileges or questions that may arise to the department vice chair or another member of the department if the chair has a conflict of interest with the Member under review or could be reasonably perceived to be biased.

In any instance where a Member of the Medical Staff has or reasonably could be perceived to have a contractual relationship which creates a conflict of interest in the delivery of quality patient care, that issue may be reviewed by the Medical Staff Quality Committee for recommendation and clarification. If unresolved at that level, the issue should be directed to the Governing Body for resolution upon recommendation of the Medical Executive Committee.

All members of the Medical Executive Committee, Department Chairs and Vice Chairs, and all nominees for Medical Staff officer position are required to execute the Hospital's Corporate Conflict of Interest Statement annually.

4. CATEGORIES OF MEMBERSHIP

Categories of Membership on the Medical Staff will be determined by the Governing Body based on the recommendations of the Credentials Committee and the Medical Executive Committee. Categories of Membership are defined in Article 3 of the Medical Staff Bylaws.

5. THRESHOLD ELIGIBILITY CRITERIA

Before appointment and continuously thereafter including at reappointment, the Applicant must demonstrate each of the following criteria:

a) current, unrestricted valid license to practice medicine, dentistry, or podiatric medicine in Indiana.
b) never had a license to practice revoked or suspended by any state licensing agency.
c) where applicable to their practice, a current unrestricted state and federal controlled substance registration.
d) availability on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of their practice patients admitted to the Hospital and (ii) respond to emergency department patients during those times when they are on call for the emergency department in a prompt, efficient, and conscientious manner as defined by the applicable department and approved by the Medical Executive Committee and Governing Body. "Appropriate coverage" means coverage by another Member with appropriate specialty-specific privileges as determined by the Credentials Committee.
e) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage as determined by the applicable department or Credentials Committee with other Members for those times when the Applicant will be unavailable.
f) Qualified Provider. The Governing Body may approve an initial Applicant or Privileged Practitioner upon becoming a Qualified Provider with sufficient evidence from the professional malpractice carrier that the surcharge will be paid and policy effective prior to the commencement of any services in the Hospital.
g) no convictions of, or plea of guilty or no contest to, any fraud or abuse related to Medicare, Medicaid, or other federal or state governmental or private third-party payer, nor history of any civil monetary penalties.
h) no convictions of, or plea of guilty or no contest to any felony, or any misdemeanor relating to controlled substances, moral turpitude, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence.
i) no current or history of exclusion, preclusion, or debarment from participation in Medicare, Medicaid, or other federal or state governmental health care programs.
j) no current or history of medical staff appointment or clinical privileges denied, revoked, or terminated by any Healthcare Entity or health plan for reasons related to clinical competence or professional conduct.
k) no history of resignation from medical staff appointment or relinquishment of clinical privileges during an investigation or in exchange for not conducting such an investigation.
l) recent clinical activity in their primary area of practice in an acute care setting or residency program during the last two years.
m) Agree to satisfy any current or future eligibility requirements for the clinical privileges sought.
n) if applying for clinical privileges in an area covered by an exclusive contract, meet the specific requirements set forth in such contract.
o) compliance with all applicable training and educational protocols that may be adopted by the Network and Medical Executive Committee, including those involving electronic medical records, computerized physician order entry, the privacy and security of protected health information, infection control, and culture of safety.
p) agree to utilize the Network’s electronic mail system for the receipt of notifications and notices under these Bylaws, and to monitor the emails on an ongoing basis for

announcements from the Network, Hospital, and Medical Executive Committee. If using a personal email system, agree to utilize the Network's encrypted email services by signing into the Network and setting up a password to communicate information under the Bylaws or to share protected health information.

q) compliance with any health screening requirements such as tuberculosis testing, mandatory vaccines, and infectious agent exposures.

r) successful completion of an Approved Residency Program as set forth in the applicable clinical privilege forms. The Approved Residency Program requirement shall not apply to any Member who was continuously appointed prior to May 1, 2023. Such Member shall be grandfathered and shall be governed by the Approved Residency Program requirement, if any, in effect at the time of their initial appointment.

s) Board Eligible, Board Certified, or maintenance of Board Certification, whichever is applicable. The requirements pertaining to Board Eligible, Board Certification, or maintenance of Board Certification shall not apply to any Member who was continuously appointed prior to May 1, 2023. Such Member shall be grandfathered and shall be governed by the Board Eligible, Board Certification, and maintenance of Board Certification requirements, if any, in effect at the time of their initial appointment.

    a. The initial board certification must be by a specialty board of the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) and/or American Board of Foot Ankle Surgery (ABFAS). Upon the expiration of the ABMS or AOA Certification, Certification by the National Board of Physicians and Surgeons (NBPAS) is acceptable
    b. If the applicant is an active candidate in the board certification process at the time of initial appointment, the physician must become board certified in the primary specialty within the five (5) years or in the appropriate number of years according to the specialty board requirements.

6. EXCEPTIONS AND WAIVER REQUESTS.

Only the Governing Body may waive a Threshold Eligibility Criteria for membership or clinical privileges or both upon recommendation of the Medical Executive Committee. Any Applicant who does not satisfy one or more of the Threshold Eligibility Criteria may request a waiver. A Member who, between credentialing cycles, and for administrative or other reasons not related to professional competence or professional conduct may also request a waiver. Such request must be submitted to the Medical Staff Office to be resolved prior to processing of the reapplication for membership and clinical privileges, or prior to the lifting of an automatic suspension. The Medical Executive Committee will consider the request and make a recommendation to the Governing Body for its decision prior to processing the reapplication. The waiver will be approved or denied by the Governing Body within a reasonable timeframe not to exceed sixty (60) days.

7. EFFECT OF OTHER AFFILIATIONS.

No person shall be entitled to membership or to be granted clinical privileges merely because of:

a) Employment by Community Health Network or its subsidiaries or has a contract with the Hospital.
b) Is or is not a member or employee of any physician group.
c) Is licensed to practice a profession in this or any other State.
d) Is a membership in any professional organization.
e) Has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility.
f) No practitioner, including those in a medical administrative position, shall provide services to patients of the Hospital unless clinical privileges have been granted in accordance with the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures.

8. **FACTORS FOR EVALUATION.**

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

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

9. **NON-DISCRIMINATION.**

No aspect of medical staff membership or clinical privileges shall be denied based on sex, race, age, creed, color, national origin, sexual orientation, or any disability that does not adversely jeopardize patient safety.

10. **DELEGATION OF FUNCTIONS.**

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

manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. The delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee is a record of the committee that is ultimately responsible for review in a particular matter.

b. When a Medical Staff leader is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

11. AUTHORIZATION TO SHARE INFORMATION AMONG CHNw HEALTH ENTITIES.

The induvial specifically authorizes Community Health Network entities (as defined above) to share with another credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct, and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual. The sharing of any information or documentation pursuant to this Section does not waive any privilege, and all such disclosures shall be made with the understanding that the receiving entity will only use information and documentation for peer review purposes.

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

12. HOSPITAL EMPLOYEES.

a. Any member of the Medical Staff or Allied Health Staff who is employed by Community Health Network or a Community Health Network-affiliated group is bound by all the same conditions and requirements in this Policy that apply to members who are not employed by Community Health Network or a Community Health Network-affiliated group.

b. If a concern about an employed member's clinical competence, conduct or behavior arises, the concern may be reviewed and addressed in accordance with this or any Medical Staff policy, in which event a report will be provided to the Peer Review Committee of Community Health Network. his provision does not preclude Community Health Network or Community Health Network-affiliated groups from addressing an issue in accordance with its employment policies/manuals or in accordance with terms of any applicable employment contract.

13. ALLIED HEALTH PRACTITIONERS.

a. Any Allied Health Practitioner seeking permission to practice at the Hospital as a Licensed Independent Practitioners, or an Advanced Practice Provider shall be subject to the terms and conditions outlined in this Policy.

b. This Policy does not apply to Allied Health Practitioners who function as Clinical Assistants. A request for a scope of practice submitted by a Clinical Assistant will be processed by Human Resources. Whenever a question or concern is raised about the care or conduct of a Clinical Assistant, Human Resources will have the discretion to determine the action, if any, needed to address and resolve such question or concern. If the question or concern about a Clinical Assistant originates from the Medical Staff, a report shall be provided to the MEC upon resolution of the issue.

14. **ADVANCED TRAINEES.**

Advanced Trainees are either non-employed residents and fellows (visiting residents and fellows) or employed residents and fellows under the Network's Office and Administration of Graduate Medical Education (GME Office). Advanced Trainees will not be required to request specific clinical privileges, unless required by an Accreditation Body. Advanced Trainees must carry out any clinical care in accordance with the written educational protocols developed by the GME Office and approved by Graduate Medical Education Committee of the Network (GMEC) and their respective training programs. All employed residents and fellows will operate under the GME handbook, GMEC policies and procedures, and Network and program processes. Visiting residents and fellows must enter the Network through approval by the GME Office with specific documentation for curriculum, training, and supervision by an approved program of either the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, the Council on Podiatric Medicine Education, or the Network. The Network GME Office issues the requirements for oversight of Advanced Trainees, the types of orders they may write, when such orders must be countersigned, and by whom through protocols. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to Advanced Trainees. Advanced Trainees are not members of the Medical Staff.

RIGHTS AND RESPONSIBLITIES

15. **RESPONSIBILITIES.**

Unless provided otherwise in these Bylaws, these responsibilities apply to Members assigned to the Active Staff or Courtesy Staff.

a) Each Member shall provide patients with the quality of care that meets the professional standards of the Medical Staff.
b) Each Member shall provide continuous coverage for patients and appropriate coverage during periods of absence.
c) Each Member shall participate in emergency department and inpatient emergency coverage determined by the Member's assigned department and approved by the Medical Executive Committee.
d) Each Member shall prepare and complete medical records in a timely manner. A physical examination and medical history must be conducted and documented within 24 hours after admission, when applicable. When a history and physical examination performed within 30 days prior to an admission exists, it must be

updated within 24 hours of admission after assessing the patient by noting any changes in the patient's condition.

e) Each Member shall use reasonable means to secure authorization to perform autopsies in cases of unusual deaths and complete death certificates as applicable.
f) Each Member shall discharge in a responsible and cooperative manner assignments as imposed by virtue of Medical Staff membership, including committee assignments.
g) Each Member shall work cooperatively with others so as not to undermine the culture of quality improvement and safety.
h) Each Member shall participate in continuing education programs as determined by the Medical Staff and to comply with applicable training and education protocols that may be adopted by the MEC or by the Board.
i) Each Member shall refuse to engage in improper inducement for patient referrals.
j) Each Member shall appear for personal interviews whenever requested by a Medical Staff committee.
k) Each Member shall respond in a timely manner to performance improvement activities of the Medical Staff.
l) Each Member shall utilize the limited resources of the Hospital in an efficient manner.
m) Each Member shall provide data related to indications and outcomes, as required by any Accreditation Body upon request by the Hospital as a condition of the continued ability to exercise clinical privileges.
n) Each Member shall conduct themselves to reflect favorably on the Medical Staff. Physician Members shall follow the principles of ethics adopted by the American Medical Association and the certifying board referenced in the applicable core privilege form. Non-Physician Members shall follow the principles of ethics of the certifying board referenced in the applicable core privilege form.
o) Each Member shall abide by the Medical Staff Bylaws, Policies, Rights and Expectations Acknowledgement, and applicable Hospital and Network policies.
p) Each Member shall abide by all applicable federal, state, and local law and Accreditation Body regulations.
q) Each Member shall report to the Chief Medical Officer, Medical Staff President or their designee, as soon as possible, but in all cases within 10 days of any change of information provided on the individual application form with or without request, including but not limited to:
    a. Any and all complaints regarding, or changes in, licensure status or DEA certificate,
    b. Adverse changes in professional liability insurance coverage,
    c. Changes in the Members status (appointment, privileges, and/or any scope of practice) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
    d. Any arrest, charge, indictment, conviction, or a plea of guilty or no contest related to a felony or misdemeanor charge relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence,
    e. Exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

f. Any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment or permission to practice because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the individual's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Medical Staff's health policy),
g. any referral to a state board health-related program, and • any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the Medical Staff's health policy).

r) Each Member shall immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and the Hospital Administrator) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders (or the Medical Staff Leader and the Hospital Administrator) and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders.
s) Each Member shall agree to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts as may be requested.
t) Each Member shall discharge such other Medical Staff obligations as may be established from time to time by the Governing Body.

16. **RIGHTS.**

Unless provided otherwise in these Bylaws, these rights or prerogatives only apply to Members assigned to the Active Staff or Courtesy Staff.

a) Members are entitled to provide services in a culture that embraces quality improvement and safety.
b) Members are entitled to be notified of the performance standards and expectations, how those will be measured, and periodic feedback on personal performance.
c) Unless necessary to protect patient safety or prevent disruption to the operation of the Hospital, the Member will be notified after a formal investigation is initiated by the Medical Executive Committee on any matter of performance or conduct which could result in proposed Adverse Action.
d) Members subject to a proposed Adverse Action have the right to a hearing and appeal, unless excluded or waived under these Bylaws.
e) Members are entitled to be present at any Medical Staff committee meeting except during portions involving Peer Review.
f) Members are entitled to meet with the Medical Executive Committee on matters relevant to the responsibilities of the Medical Executive Committee or whenever unable to resolve a matter of concern after discussion with the appropriate department or committee chair.
g) Members are entitled to be informed of Medical Staff information and developments. Changes to Policies will be distributed in a timely manner. Proposed

bylaw amendments will be sent electronically thirty (30) days in advance of the meeting at which the vote is taken.

h) Each Member shall be allowed an opportunity to review their credentials or quality file related to the Member's personal practice as set forth in these Bylaws and Policies.
i) Matters undertaken in the performance of Medical Staff duties discussed in committee deemed to be confidential and otherwise privileged shall remain confidential.
j) Any Member eligible to vote has the right to initiate a recall vote of any Medical Staff officer, any member of the Medical Executive Committee, or applicable department chair in accordance with the recall provisions provided in these Bylaws.
k) Any Active Staff Member may call for a department meeting or general medical staff meeting in accordance with the meeting provisions provided in these Bylaws.

17. **EXCLUSIONS.**

These rights do not pertain to Peer Review activities involving an individual Member. Recourse for such matters is provided to the individual Member as described herein.

GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

18. **APPOINTMENT TERMS.**

Initial appointments and reappointments to the Medical Staff shall be for a period not to exceed three (3) years. Initial and subsequent authorization of clinical privileges shall be for a period not to exceed three (3) years during which time the Member may be subject to focused or ongoing professional practice evaluation. Appointments and reappointments of Applicants over the age of seventy (70) years of age shall be for a period of not more than one (1) year.

19. **APPOINTMENT AND REAPPOINTMENT.**

Appointments to the Medical Staff shall be made by the Governing Body upon the recommendations of the applicable department chair, the Credentials Committee, and the Medical Executive Committee.

20. **APPLICATION FORM.**

The initial Application form shall be developed by the Credentials Committee and Medical Executive Committee and ratified by the Governing Body. The form shall require detailed information which shall include, but not be limited to:

a. Requirements for the various Membership categories,
b. The requested membership category,
c. peer references who have had extensive experience in observing and working with the Applicant in the last year and who can provide adequate reference information concerning the Applicant's professional competence, professional conduct, and ethical character,
d. Clinical privileges, if applicable.

21. **INITIAL APPLICATION FEE.**

A non-refundable fee, in an amount established by the Medical Executive Committee and ratified by the Governing Body, shall be received from the Applicant at the time of an initial Application. An Application submitted without the fee will not be processed.

22. **EFFECT OF APPLICATION**.

By applying for appointment, reappointment, or clinical privileges, each Applicant:

a. Agrees to appear for personal interviews at any reasonable time as requested by a Credentialing Representative;
b. Authorizes Credentialing Representatives to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on the Applicant's credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the conditions that it be kept confidential;
c. Authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations, and other documents in their possession, bearing on his or her credentials to any Credentialing Representative, and consents to the inspection and procurement of such information, records, and other documents by the Credentialing Representative;
d. Authorizes the Credentialing Representatives to release information about such individual to other health care entities 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, reappointment, or clinical privileges;
e. Authorizes the Network or Hospital to maintain information concerning the Applicant's age, training, board certification, licensure, and other privileged or confidential information in a centralized physician data base for the purpose of making aggregate physician information available for use by the hospitals within the Network;
f. Authorizes the Network or Hospital for peer review purposes to release information, including otherwise privileged or confidential information, including but not limited to quality assurance information, obtained from or about the Applicant to peer review committees of the affiliated hospitals and facilities within the Network, including Community Physicians Network when the Applicant is or will be a Network employee;
g. Releases from any liability all persons for their acts performed in connection with investigating and evaluating the Applicant;
h. Releases from any liability to the fullest extent permitted by law, all individuals and organizations who provide information, including otherwise privileged or confidential information, regarding the Applicant to the Network or its affiliated hospitals concerning the Applicant's credentials including performance of patient care and complaints related to competence and behavior unless such information is false and the third party providing the information knew it was false;
i. Authorizes a criminal background check;

j. Consents to the disclosure to other hospitals, and licensing boards and other similar organizations any information including otherwise privileged or confidential information regarding the Applicant's competence, professional or ethical standing that the Network or Hospital may have and releases Network and Hospital from liability for so doing, to the fullest extent permitted by law;
k. Pledges to provide for continuous quality care for the Applicant's patients;
l. Agrees to comply with the Network's Responsibility and Compliance Program, and applicable Codes of Conduct of the Medical Staff, Hospital, and Network;
m. Agrees that the Network's affiliated hospitals and other facilities, through their peer review structures, may share information, including otherwise privileged or confidential information, concerning the Applicant's ongoing eligibility for membership and clinical privileges. Such information may include interpersonal and communication skills; professionalism including character and ethics; the ability to continuously learn, improve, and work harmoniously with others; the evaluation of patient care rendered including the accuracy of diagnosis, the propriety, appropriateness, quality or necessity of care rendered; utilization of services, procedures, and facilities in the treatment of patients; incident reports, complaints, or concerns about the Applicant; any performance improvement activities such as external reviews, focused professional practice evaluation, and ongoing professional practice evaluation; and fitness for duty evaluations;
n. Acknowledges that the Applicant (a) has received and read the Bylaws and Policies of the Medical Staff; (b) agrees to be bound by the terms thereof if the Applicant is granted membership and/or clinical privileges; and (c) agrees to be bound by the terms thereof without regard as to whether or not the Applicant is granted membership and/or clinical privileges in all matters relating to consideration of this Application;
o. Agrees that the foregoing provisions are in addition to any agreements, understandings, waivers, authorizations, or releases provided by law or contained in any application or request forms.

23. BURDEN OF PRODUCING INFORMATION AND RESOLVING REASONABLE DOUBT.

a. In connection with any Application, the Applicant shall have the burden of producing information for adequate evaluation of the Applicant's qualifications and suitability for the requested membership category and clinical privileges, including resolving any reasonable doubts about these matters and satisfying requests for information. The Applicant's failure to sustain this burden shall be deemed a termination of the Application process after thirty (30) days without a satisfactory response.
b. An application shall be considered complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees have been paid.
c. An application shall be considered incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after

the individual has been notified of the need of information, the application *shall be considered incomplete and deemed voluntarily withdrawn. An incomplete application will not be processed.*

d. The burden of producing may also include submission to a health status assessment at the Applicant's expense if deemed appropriate and in accordance with Medical Staff Wellness, Fitness, and Impairment Policy. Health status assessments for initial Applicants will only be performed after a conditional offer of clinical privileges has been made.

24. **MISSTATEMENTS AND OMISSIONS.**

a. The application shall sign the Application and verify that all answers and provided information are true and accurate. The Applicant shall acknowledge that if it is discovered, at any time, that false information was submitted or material information was omitted, the Application shall be subject to immediate termination.
b. If the appointment has been granted prior to the discovery of a misstatement or omission, appointment and/or clinical privileges may be deemed to be automatically relinquished.
c. No action taken pursuant to this section shall entitle the applicant or member the right to a hearing or appeal.

APPOINTMENT PROCESS

25. **APPLICATION.**

a) Each application for appointment and reappointment to the Medical Staff shall be submitted electronically on the prescribed Application form.
b) Applicants shall be sent documentation outlining the Threshold Eligibility Criteria for appointment, the applicable criteria for membership and clinical privileges.

26. **INITIAL APPLICATION PROCESS.**

a. The Applicant shall return the signed application, all required documents, and application fees, must be returned within 14 days after receipt of the application.
b. The application will be reviewed by Credentialing Representative to determine if all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Incomplete applications will not be processed. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their application will not be processed. A determination of ineligibility does not entitle the applicant to hearing and appeal rights outlined in the Medical Staff Bylaws and is not reportable to any state agency or the National Practitioner Data Bank.
c. If the information cannot be verified, the Applicant will be notified, and no further action will occur regarding the Application until outstanding verifications are received.
d. The Credentialing Representative shall oversee the process of gathering and verifying relevant information and confirming that all references and other information deemed pertinent have been received. Evidence of the applicant’s

character, professional competence, qualifications, behavior, and ethical standing shall be examined.

e. After collecting all verifications, the Application along with all supporting materials will be submitted to the applicable department/section chair in which the Applicant seeks membership and/or clinical privileges for evaluation, or to an available department chair if no privileges are requested, for evaluation of the Applicant's credentials for membership. Any inconsistent information discovered during the verification process will be flagged for the applicable department chair and Credentials Committee.

27. **DEPARTMENT OR SECTION CHAIR REVIEW.**

a. The applicable department or section chair shall evaluate the Application within a reasonable time and prepare a report regarding whether the applicant has satisfied all the qualification for appointment and clinical privileges, if applicable, requested.
b. After review, the department or section chair shall submit a report of the evaluation of application for presentation to the Credentials Committee, the MEC and the Board, and report any inconsistent information identified and whether it has been addressed and how it was resolved.
c. The applicable department or section chair may designate another Member of the department to assist in the review set forth in this provision.

28. **CREDENTIALS COMMITTEE REVIEW.**

a. At the next regular Credentials Committee meeting following receipt of the applicable department or section chair's recommendation, the Credentials Committee shall consider the report prepared by the department or section chair and shall make a recommendation to the MEC.
b. The Credentials Committee may use the expertise of the department or section chair, or any member of the Department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
c. If any reasonable doubts concerning the Applicant's qualifications exist, the Application shall be deemed incomplete and a decision on the Application tabled until the Applicant has been given a reasonable opportunity to resolve such doubts or withdraw the Application. Whenever the Application is incomplete, the Application will be deemed automatically withdrawn if it remains incomplete after thirty (30) days.
d. When all reasonable doubts have been resolved by the Applicant, the Credentials Committee shall make a recommendation to the MEC regarding membership, and if applicable, clinical privileges, and when warranted any conditions to those recommendations.
e. The Credentials Committee will forward its recommendations concerning the Applicant to the MEC.

29. **MEDICAL EXECUTIVE COMMITTEE REVIEW.**

a. At the next regular Medical Executive Committee meeting following receipt of the Credentials Committee's recommendation, the MEC shall review the recommendations, discuss any unresolved reasonable doubt or inconsistent

information, and determine whether any additional information is needed to make an informed recommendation on the Applicant.

b. If any reasonable doubt by the MEC exists concerning the Applicant's qualifications, the Application shall be deemed incomplete and a decision on the Application tabled until the Applicant has been given an opportunity to resolve such doubt or withdraw the Application. The MEC may refer an Application back to the Credentials Committee if it reasonably believes the Application is incomplete. Whenever the Application is incomplete, the Application will be deemed automatically withdrawn if it remains incomplete after thirty (30) days.
c. The MEC shall make a recommendation to the Board only when all reasonable doubts have been resolved by the Applicant in the time frame set forth herein.
d. The recommendation to the Board will address membership category, department assignment, and, if applicable, clinical privileges, and whenever warranted any conditions to those recommendations.
e. When the recommendation of the Medical Executive Committee is a proposed Adverse Action, the Applicant shall be notified in accordance with the Medical Staff Bylaws. No proposed Adverse Action shall be forwarded to the Governing Body for action until the Applicant has exercised, waived or has been deemed to have waived the Applicant's right to a hearing and appeal as provided in these Medical Staff Bylaws.

30. **GOVERNING BODY REVIEW.**

a. When there has been no delegation to the Board Committee, upon receipt of a recommendation for appointment and/or clinical privileges, the Board may:
    a. Appoint the applicant and grant clinical privileges as recommended; or
    b. Refer the matter back to the Credentials Committee or MEC or to another source inside of outside of the Hospital for additional research of information; or
    c. Reject or modify the recommendation.
b. If the Board determines to reject a favorable recommendation, it should first discuss the matter with the chair of the Credentials Committee and the chair of the MEC. If the Board's determination remains unfavorable to the applicant, the Administrator shall send notification that the applicant that the applicant is entitled to a hearing.
c. Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges will be disseminated to appropriate individuals as required and reported to appropriate entities.
d. When the Governing Body's decision is final, the Governing Body shall send a notice of such decision to the Applicant, the Medical Executive Committee, Credentials Committee, and applicable chairs through the Administrator and make any reports as required by law.

31. **DELEGATION TO THE BOARD COMMITTEE.**

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

MEDICAL STAFF CREDENTIALS POLICY

32. ELIGIBILITY FOR REAPPOINTMENT.

a. All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member shall have, as applicable:
b. Completed all medical records, as applicable.
c. Completed all continuing education requirements or participate in maintenance of certification (MOC) or ongoing continuous certification (OCC), as applicable.
    a. Physician Members not participating in MOC or OCC must provide documentation of fifty (50) hours of Category I CME in the prior two (2) years.
    b. Allied Health Practitioners are required to maintain Board Certification as a condition of meeting continuing education requirements.
d. Satisfied all Medical Staff and Allied Health responsibilities, including payment of any dues, fines, and assessments.
e. Continued to meet all qualifications and criteria for appointment and the clinical privileges requested.
f. For those applying for privileges, have sufficient patient contacts to enable the assessment of current clinical judgment and competency for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of the confidential quality profile from the primary hospital or surgery center) before the application shall be considered complete and processed further.
g. If the applicant has had fewer than ten (10) patient encounters in the previous appointment period, they may be required to complete a current Intent to Practice Form with their reappointment application (contracted service specialties may be exempt from this requirement). The completed Intent to Practice Form will be forwarded to the Department Chair and Credentials Committee form review. The review and decision-making process is outlined in this manual.

33. REAPPOINTMENT APPLICATION PROCESS.

a. The process for evaluating reappointment Applications is the same process used on initial Applications. Additional information may be gathered from other peer review committees and evaluated by the application department or section chair, Credentials Committee and MEC before making their recommendation to the Board.
b. An application for reappointment shall be furnished to members at least four (4) months prior to the expiration of the current appointment term. The reappointment application shall be returned at least ninety (90) days in advance of the appointment term expiration.
c. If for any reason the term of the appointment shall expire prior to final action on the application, the MEC may recommend that the Governing Board reappoint the Member with any conditions necessary for a period no greater than sixty (60) days. The MEC may, at its discretion, recommend more frequent reappointment intervals.
d. Failure to return a completed application ninety (90) days prior to the expiration of the reappointment term may be subject to a reappointment processing fee. In

addition, failure to submit a complete application ninety (90) days prior to the expiration of the reappointment term may result in automatic expiration of appointment and clinical privileges at the end of the current term of appointment.

e. Former Medical Staff applicants in good standing, whose privileges expired within the past six months, may request a reappointment application rather than going through an initial appointment process.

34. **CONDITIONAL REAPPOINTMENT.**

a. Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records or payment of fines, proctoring, completion of CME requirements). Such conditions do not entitle an individual to request the procedural rights set forth in the Medical Staff Bylaws.
b. Reappointments may be recommended for periods of less than three (3) years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than three (3) years does not, in and of itself, entitle an individual to the procedural rights set forth in the Medical Staff Bylaws.
c. In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than three (3) years may be granted pending the completion of that process.

35. **POTENTIAL ADVERSE RECOMMENDATION.**

a. If the Credentials Committee or MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
b. Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
c. At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the Credentials Committee's and/or MEC's recommendation.
d. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

36. **REAPPLICATION AFTER DENIAL.**

Any Applicant on initial Application denied Membership based on a falsification of information or a material omission in the Application shall be prohibited from applying for membership and clinical privileges for four (4) years. An initial Applicant who has

otherwise been denied membership and clinical privileges on the Medical Staff by the Governing Body may not make further Application for membership for a period of two (2) years from the date of the Final Adverse Action. An Application for membership or request for clinical privileges received after that two (2) year period must include evidence demonstrating that grounds for the denial have been addressed. A Member who has been denied a request for additional clinical privileges shall not be eligible to request those additional clinical privileges until the Member can demonstrate additional training, education, and experience to support the request as set forth in the clinical privilege form and as deemed appropriate by the Credentials Committee and Medical Executive Committee with input from the appropriate applicable department chair. In all instances listed above, if such an Application is accepted as complete and the recommendation of the Medical Executive Committee is a proposed Adverse Action, the Applicant shall have hearing and appeal rights.

CLINICAL PRIVILEGES

37. DELINEATION OF CLINICAL PRIVILEGES.

The Governing Body shall grant clinical privileges upon the recommendations of the applicable department chair, the Credentials Committee, and the Medical Executive Committee. Clinical Privileges are hospital specific. Any Privileged Practitioner providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges granted by the Governing Body. Such delineation shall confer on the Privileged Practitioner only such clinical privileges as specifically requested on the Application form and authorized by the Governing Body. All recommendations for appointment to Active and Courtesy Staff category must specifically recommend the clinical privileges to be granted, including any qualifying probationary condition relating to the exercise of the clinical privileges.

38. EVALUATION OF CLINICAL PRIVILEGES REQUESTS.

Determination of clinical privileges shall be based upon the Threshold Eligibility Criteria used in evaluating Applicant's credentials for Medical Staff appointment, and the criteria set forth in the applicable clinical privilege forms. Clinical privilege determinations may also be based on pertinent information concerning the Applicant's clinical performance at other Healthcare Entities. The process for evaluating requests for clinical privileges is the same as for appointment. Following receipt of the applicable department chair's recommendation, the Credentials Committee shall consider such recommendation. The Credentials Committee will make its recommendation to the Medical Executive Committee for consideration. The recommendation of the Medical Executive Committee concerning the clinical privileges request will be forwarded to the Governing Body with the recommendation of the Credentials Committee and applicable department chair. The steps described in the appointment process in Section 6.2.5. will be followed and associated details may be found in the Policies and the applicable clinical privilege forms.

39. ADDITIONAL CLINICAL PRIVILEGES REQUESTS.

Any Member may make a written request for modification of clinical privileges at any time. Documentation of training and/or experience must support the request and the process for

evaluation of clinical privileges request shall be followed. Such request may be subject to proctoring.

40. **CLINICAL PRIVILEGES FOR NEW PROCEDURES.**

Request for clinical privileges to perform a new procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (new procedure) shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria has been developed to request those clinical privileges.

The individual seeking to perform the new procedure shall submit a request to the Credentials Committee addressing the following:

a. Minimum education, training, and experience necessary to perform the new procedure safely and competently.
b. Clinical indications for when the new procedure is appropriate.
c. Whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients.
d. Whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available.
e. Whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
f. Whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to perform the new procedure safely and effectively.

The Credentials Committee shall review the report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure shall be offered to the community.

If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct with experts, as necessary, and develop recommendations regarding:

a. Minimum education, training, and experience necessary to perform the procedure or service.
b. The clinical indications for when the procedure or service is appropriate.
c. The extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privilege is granted; and
d. The manner in which the procedure or service would be reviewed as part of the hospitals professional practice evaluation process.

The Credentials Committee shall forward its recommendation to the MEC, which shall review the matter and forward its recommendation to the Governing Body for final action.

The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the board determines to offer the procedure or service, it shall then establish the minimum threshold qualifications that an individual must demonstrate to be eligible to request the clinical privileges in questions.

MEDICAL STAFF CREDENTIALS POLICY

Requests from eligible Medical Staff members who wish to perform the procedure or service may be submitted for review and consideration.

41. **CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES.**

a. Request for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the scope outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
b. As an initial step in the process, the individual seeking the privilege shall submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals.
c. The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department or Section Chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
d. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
    1. the appropriate education, training, and experience necessary to perform the clinical privileges in question.
    2. the clinical indications for when the procedure is appropriate.
    3. the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual.
    4. the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence.
    5. the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and the impact, if any, on emergency call responsibilities.
e. The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.
f. Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.
g. The Department Chair for the specialty that currently holds the privilege(s) will be notified of a request that crosses specialty lines.

42. CLINICAL PRIVILEGES FOR DENTISTS AND ORAL AND MAXILLOFACIAL SURGEONS.

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

43. CLINICAL PRIVILEGES FOR PODIATRISTS.

a. The scope and extent of surgical procedures that a podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
b. Surgical procedures performed by podiatrists shall be under the overall supervision of the Department of Surgery. A medical history and physical examination of each patient shall be made and recorded by an Active or Courtesy Staff member of the Medical Staff before podiatric surgery shall be performed (with the exception of subsection (c) below), and an Active or Courtesy Staff member shall be responsible for the medical care of the patient throughout the period of hospitalization.
c. Podiatrists who admit patients without underlying health problems for minor outpatient procedures may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and the MEC, and in accordance with the following guidelines:
    1. If the anesthesiologist is of the opinion that the patient needs a physician to complete the H&P, the podiatrist is responsible for ensuring that it is complete by an appropriate physician.
    2. Pre-op assessment for elective cases must be selected at least three business days prior to the scheduled surgery to allow timely evaluation of each patient if it is deemed necessary; and
    3. Notes from the patient's primary physician (whether a member of the Medical Staff or not) will be accepted in addition to the H&P from the podiatrist to aid the anesthesiologist in their assessment of the patient's health status.

MEDICAL STAFF CREDENTIALS POLICY

44. CLINICAL PRIVILEGES FOR ALLIED HEALTH PRACTITIONERS.

a. The scope of clinical privileges available to a category of Allied Health Practitioners shall be established in accordance with the applicable state and federal laws and contained in the clinical privileges form for each category of practitioner, subject to the needs of each Hospital.
b. An Allied Health Practitioner providing clinical services at the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body.
c. In an emergency and so long as permitted by their license, an Allied Health Practitioner with clinical privileges may provide care, treatment, and services as a means to prevent serious injury, further harm or to save the life of a patient.
d. Request for Expansion of Current Scope of Practice. Any Allied Health Professional seeking to increase their knowledge and skill base to perform clinical privileges for which they have limited or no training and experience, must follow the procedure for requesting an expansion of privileges outlined below.
e. No Allied Health Professional may be trained on clinical privileges without proper action by the Department Chair, Credentials Committee, Medical Executive Committee, and the Governing Body.
    1. In the event there is a request for a privilege for which there is no established criteria for Allied Health Practitioners, or the privilege was previously only granted to a physician member, the Medical Executive Committee must make a recommendation to the Governing Body to determine whether it will allow Allied Health Practitioners to perform the privilege(s) in question. If approved by the Governing Body, criteria for the privilege will be developed.
    2. At the approval of the Governing Body, Allied Health Practitioners may be allowed to train for privileges under direct supervision of their collaborative/sponsoring physician or designee.
    3. Allied Health Practitioners must submit a written request for additional privileges to the Credentialing Representative. The collaborative/sponsoring physician or designee must have the privilege(s) being requested and in good standing.
    4. The request must include:
        a) The specific privilege(s) requested
        b) Name of the Preceptor
        c) Anticipated length of training
        d) Competency measures
        e) Patient population (if applicable)
    5. The request for privileges under direct supervision will be considered in accordance with Medical Staff Bylaws related to clinical privileges, department chair review and recommendation, credentials committee review and recommendation, medical executive committee review and recommendation, and governing body action.
    6. If the AHP holding privileges under direct supervision wishes to request the independent practice of the privilege and confirmation of competency has been confirmed by the collaborative/sponsoring physician, then the

medical staff policy for modification of clinical privileges should be followed.
NOTE: *Patient consent must be obtained for invasive procedures under direct supervision.*

45. **TEMPORARY PRIVILEGES.**

a. **Circumstances.** A request for temporary privileges may be granted on a case-to-case basis: (i) fulfill an important patient care treatment, or services need such as the need for locum tenens; or (ii) an Applicant who has a completed Application, meets all requirements set forth below, has received approval by the Credentials Committee or its Chair as described below, and is awaiting review by the Medical Executive Committee and the Governing Body.

b. **Authority.** Upon receipt of a completed Application from a qualified Applicant, the Administrator or designee may, upon the basis of information then available which may reasonably be relied upon as to the competence and professionalism of the Applicant, and written concurrence of the Medical Staff President and Credentials Committee Chair or their respective designees, grant temporary privileges.

c. **Term.** Temporary privileges will be in effect until the Governing Body takes final action on the Application, but not more than one hundred twenty (120) days.

d. **Requirements.** A request for temporary privileges shall be considered only upon verification of the following:

1. A signed and completed Application for privileges.
2. Current license to practice in the state of Indiana with no current or past successful challenges to licensure.
3. Status as a Qualified Provider.
4. Three (3) positive peer references who have had extensive experience observing and working with the Applicant.
5. Competence to perform clinical privileges requested.
6. No history of subjection to involuntary limitations, reduction, denial, or loss of clinical privileges. No history of subjection to involuntary terminations of medical staff membership in another organization.
7. The reason temporary privileges are being requested.
8. Query and evaluation of a National Practitioner Data Bank Report.
9. No findings on a criminal background check.
10. No history of exclusion from any federal or state government healthcare program.
11. Limitations. Any practitioner granted temporary privileges to provide for locum tenens services for a Member shall be limited to admitting and treating patients of the Member including any on call responsibilities.

e. **Termination.** Temporary privileges may be suspended, modified, or revoked at any time by the Administrator and Medical Staff President with the concurrence of the Medical Executive Committee without giving rise to the right of a hearing and appeal under these Bylaws. Upon suspension or termination of temporary

privileges, the Medical Staff President in collaboration with the applicable department chair shall assign a member of the Medical Staff to assess the condition of any patient(s) then in the Hospital under the care of the practitioner whose privileges have been suspended or terminated. The Medical Staff President in collaboration with the applicable department chair shall ensure medical care is provided to such patient and/or to discharge the patient(s) from the Hospital. 7.6.7.

f. **No Procedural Rights**. The denial of any request for temporary privileges or termination or suspension of temporary privileges, whether in whole or in part, do not give rise to any procedural rights under the Bylaws.

46. **TELEHEALTH AND DISTANT SITE PROVIDER PRIVILEGES.**

a. **Clinical Privileges Exercised through Telehealth Link**. The Governing Body upon the advice of the Medical Staff determines which services are appropriate to be delivered via a telehealth link. Members currently credentialed and privileged, who provide the same services via a telehealth link to patients, do not require any additional credentialing or privileging. There is no requirement that telehealth be delineated as a separate clinical privilege.

b. **Distant Site Telemedicine Privileges Limited Eligibility.** Distant Site Telemedicine Privileges are only available to Applicants who have existing clinical privileges at a Joint Commission accredited distant site hospital or organization that has a written contract with the Hospital to provide distant site telemedicine services to Hospital patients (hereinafter referred to as "Distant Site Hospital").

c. **Application Process.** When distant site telemedicine services are to be furnished to the Hospital through such contract, in lieu of the process in Section 6.2.5, the applicable department chair, Credentials Committee, and Medical Executive Committee may rely upon the credentialing and privileging decision of the Distant Site Hospital to make recommendations on an individual distant site Applicant so long as:

    1. the individual Applicant is privileged at the Distant Site Hospital to provide the telemedicine services;
    2. the Distant Site Hospital provides a current list of the distant site individual providers which includes the Applicant; and
    3. the Distant Site Hospital provides evidence of an internal review of its distant site individual Privileged Practitioners.

d. **Additional Effect of Acknowledgement.** Such Applicant acknowledges that the Hospital will send information, including otherwise privileged or confidential information, to the Distant Site Hospital that is useful to assess the distant site telemedicine Privileged Practitioner’s quality of care, treatment, and services for performance improvement, and recredentialing as set forth in these Bylaws.

e. **Limited Membership.** Individuals granted distant site telemedicine privileges shall not be eligible to be voting members of the medical staff.

f. **Temporary Privileges.** Applicants requesting distant site telemedicine privileges may be eligible for temporary privileges through the process outlined in Section 7.6. Section 7.10. Voluntary Leave of Absence.

47. PROFESSIONAL PRACTICE EVALUATIONS.

During the initial appointment period, the Member and any existing Member granted new clinical privileges shall be subject to focused professional practice evaluation (FPPE) in accordance with the Medical Staff Bylaws and the Professional Practice Evaluation Policy. If any Member fails to satisfactorily perform during the FPPE period, those specific clinical privileges may be terminated or limited. Upon such termination or limitation, the Member shall be entitled to a hearing, upon request, pursuant to these Bylaws.

The Medical Staff also participates in ongoing professional practice evaluation (OPPE) to identify practice outcomes and trends that impact the safety and quality of patient care by Privileged Practitioners. The OPPE Process is outlined in the Professional Practice Evaluation Policy.

48. RESIGNATIONS AND RELINQUISHMENT OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES.

A request to resign Medical Staff appointment and relinquish all clinical privileges must be specify the desired date of resignation which is recommended to be at least 30 days from the date of the request. Upon receipt, the Credentialing Representative will confirm that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation.
Medical Staff files are retained for 10 years after a provider resigned membership and/or privileges.

49. EMERGENCY PRIVILEGES.

In case of an emergency as defined below, any Privileged Practitioner attending a patient shall be expected and permitted to do everything in their power and to the degree permitted by their license, to save the life of the patient or prevent significant and disabling morbidity regardless of the delineation of clinical privileges. This duty shall be subject to the Privileged Practitioner's concurrent duty to consider or abide by a patient's directives under Indiana law to withhold or withdraw life-sustaining procedures or to consider and abide by the requirements of sound medical practice. For purposes of this section, an emergency is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient's life or the danger of serious harm. When such an emergency no longer exists, the patient shall be assigned to an appropriate Member who holds clinical privileges appropriate to address the patient's medical conditions.

MEDICAL STAFF CREDENTIALS POLICY

50. RECIPROCAL DISASTER AND DISASTER PRIVILEGES.

Whenever an emergency management plan is activated and the Hospital is unable to handle immediate patient care needs, the authority to implement disaster privileges is at the direction of the Hospital Command Center, in consultation with the Medical Staff leadership. In such a circumstance and for the duration of the emergency, all clinical privileges currently granted to Members and Allied Health Practitioners at any Network hospital or any facility where Network is the majority owner ("Network facility") may be exercised at any Network hospital, Network facility, or any other location being used by the hospitals for patient care (hereinafter referred to as "Reciprocal Disaster Privileges") so long as the Hospital has clinical privileges forms and policies that include the category of health care professional.

51. DISASTER PRIVILEGES.

Disaster Privileges may be granted to a Physician who volunteers but does not hold clinical privileges at any Network hospital or facility by the Administrator or designee, any elected Medical Staff Officer, or the Credentials Committee Chair once appropriate identification is obtained from the Physician. Primary source verification of licensure and current photo identification card will begin as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer Physician presents to the Hospital. Primary source verification applies only to volunteer Physicians who provided care, treatment, and services while under Disaster Privileges. In extraordinary circumstance in which primary source verification cannot be completed within 72 hours, it will be completed as soon as possible. The reason for the Hospital's inability to verify will be documented with evidence of the volunteer Physician’s demonstrated ability to continue to provide adequate care, treatment, and services.

a. **Scope of Privileges.** Any Practitioner exercising Reciprocal Disaster Privileges or volunteering Physician exercising Disaster Privileges shall be paired with and supervised by an on-site Member with clinical privileges and wear an approved form of identification. The scope of the Disaster Privileges shall be consistent with established core clinical privileges and as determined by the on-site supervising Member.

b. **Evaluation of Privileges.** Within 72 hours of exercising Reciprocal or Disaster Privileges, an evaluation of competency will be completed by the on-site Member and submitted to Medical Staff leadership for review. Upon review of the evaluation, Medical Staff leadership will assess the professional practice of the volunteer Physician or Practitioner and the need for continuation or modification of Disaster Privileges or Reciprocal Privileges granted. Whenever any information received through the verification process or the professional practice evaluation review indicates adverse information suggesting the practitioner is not capable of rendering services in an emergency, the privileges may be immediately terminated by Medical Staff leadership.

c. **Termination of Privileges.** Reciprocal and Disaster Privileges will be in effect for the duration the declared emergency. Such privileges will automatically expire when the declared emergency is no longer in effect.

52. VOLUNTARY LEAVE OF ABSENCE.

a. **Written Request.** A Member may request a voluntary leave of absence from the Medical Staff using the Medical Staff Leave of Absence Form. Except for leaves precipitated by an acute, unavoidable need such as a medical condition or military duty, the written request should be submitted as soon as possible and prior to the requested leave date, and state (1) the reason for the leave, (2) the requested period of leave time, which may not exceed one (1) year, (3) the plan for alternate coverage for proper and necessary patient care during the requested absence, and (4) pledge to complete all medical records before the leave takes effect, if granted. Absence based on military duty shall be deemed an automatic leave of absence. To prevent gaps in appointments, the Member may need to submit a reappointment Application with the request.

b. **Leave Review Process.** A request for leave of absence, except those precipitated by an acute medical condition or military duty, will not be considered until all obligations to the Hospital have been met or the request sets forth a plan of action to address such obligations, including completion of all medical records, payment of any outstanding dues and fines, and fulfillment of any emergency department or other call obligations. The request will be submitted to the applicable department chair who will submit it to the Medical Executive Committee for its consideration at its next regular meeting. The Medical Executive Committee will review such requests and approve or disapprove the request. The Medical Executive Committee will routinely report all leaves to the Governing Body.

c. **Approved Requests.** Whenever a request is approved, the Member shall complete all patient medical records before the leave of absence takes effect, pay in advance any dues anticipated to accrue during the absence, and make necessary arrangements to provide alternate coverage and advise the applicable department chair in writing of such arrangements.

d. **Effect of Leave.** During the period of a leave, the Member's membership and clinical privileges are inactivated, and the Member is relieved from all prerogatives, responsibilities, and duties of membership and clinical privileges.

e. **Denied Requests.** Whenever the Medical Executive Committee does not approve such request, the requesting Member shall not be entitled to procedural rights as outlined in the Hearing and Appeal Sections of these Bylaws.

f. **Request to Return.** Prior to the expiration of the leave, the Member must request reinstatement in writing which may be through electronic communication. As part of the request, the Member must submit a written summary of any clinically relevant activities during the leave if requested by Members of the applicable department, Credentials Committee or Medical Executive Committee. Whenever a leave was requested due to potential impairment because of a medical condition, aging, or alcohol or drug abuse, the Member will be required to demonstrate that the Member meets the Threshold Eligibility Criteria related health status.

g. **Return Request Review Process.** All requests for reinstatement must be reviewed by the applicable department and acted on by the Medical Executive Committee. If the requested return date is after the Member's current appointment expires, the returning Member will be required to submit a reapplication form and be reappointed by the Governing Body.

h. **Adverse Recommendation on Return Request.** If the recommendation of the Medical Executive Committee is a proposed Adverse Action giving rise to a hearing under these Bylaws, then the Member shall be entitled to the procedural process under the Hearing and Appeals Article of these Bylaws.

i. **Failure to Request Return.** If the Member fails to request reinstatement before the expiration of the leave, and/or the appointment term expires during the leave, the membership and clinical privileges will be deemed relinquished. Such a relinquishment may be reportable if the Member was the subject of an investigation or non-routine FPPE at the time the leave was granted. The affected Member shall not be entitled to any procedural rights as outlined in the Hearing and Appeal Articles of these Bylaws. A Member in good standing who fails to timely seek reinstatement may be reinstated upon the completion and approval of a reappointment Application within 12 months of the start of the leave of absence.

53. CONTRACTS FOR SERVICES.

a. From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts shall obtain and maintain clinical privileges, in accordance with the terms of this Policy. In addition, if any such individual is the subject of an adverse credentialing or peer review recommendation by the MEC based upon the individual's clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in this Policy before the Board takes final action on the matter.
b. To the extent that:
    1. any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, OR
    2. the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of Community Health Network or its affiliates, no other practitioner except those authorized by the exclusive contract or Board resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications shall be processed.
c. If any such exclusive contract or Board resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

1. The affected Medical Staff member shall be given at least 90 days advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.
2. At the meeting, the affected Medical Staff member shall be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract or enact the Board resolution, the affected Medical Staff member shall be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.
3. The affected Medical Staff member shall not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 6 or any other provision of this Credentialing Policy or the Medical Staff Bylaws.
4. The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Indiana licensure board or to the National Practitioner Data Bank.

d. In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.