

MOUNT CARMEL

**Medical Staff
Credentials Policy**

MOUNT CARMEL HEALTH SYSTEM

A Medical Staff Document

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ARTICLE I
MEDICAL STAFF APPOINTMENT/PRIVILEGES

- 1.1 **Application Form.** The purpose of the application is to assure the compilation of sufficient information to establish general competency in the areas of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Applications for appointment with Privileges or for Privileges only shall contain the following:
- 1.1.1 Detailed information concerning the Applicant's qualifications including documentation in satisfaction of the basic requirements set forth in the Medical Staff Bylaws and for any particular Medical Staff category to which the Applicant requests appointment.
 - 1.1.2 A specific request for the Medical Staff category, Department/Section assignment, and Privileges for which the Applicant wishes to be considered. To the extent the Applicant believes his/her request for Privileges will or may require resources not currently available at the Hospital, the Applicant is responsible for advising the Hospital of such circumstances so that the Hospital may properly assess whether such resources will be made available.
 - 1.1.3 A complete chronological description of the Applicant's education and training.
 - 1.1.4 Satisfaction of the board certification requirements set forth in the Medical Staff Bylaws.
 - 1.1.5 A complete chronological description of the Applicant's professional experience/work history.
 - 1.1.6 The names of at least three (3) Practitioners in the Applicant's same professional discipline with personal knowledge (must have worked with the Applicant at least three (3) months within the past three (3) years) of the Applicant's ability to practice. Peer references may not be provided by the Applicant's relatives. Not more than one (1) peer reference may be from the Applicant's partner(s) or affiliate(s). One (1) peer reference shall be from the chair of the clinical department in which the Applicant has or most recently had privileges at another hospital, or from the director of the clinical training program from which the Applicant recently graduated. Peer recommendations shall be submitted on a Hospital approved form and include information regarding the Applicant's: medical/clinical knowledge; technical/clinical skills; clinical judgment; interpersonal skills; communication skills and professionalism. Peer recommendations may include written documentation reflecting informed opinions on the Applicant's scope and level of performance or a written peer evaluation of Practitioner-specific data collected from various

sources for the purpose of validating current competence.

- 1.1.7 Information as to whether the Applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other health care entity or are currently being investigated or challenged.
- 1.1.8 A copy of all current, valid professional licenses/certificates, certifications, DEA/controlled substance registration; the date of issuance; license, certificate, registration or provider number; and information as to whether the Applicant's license, certificate, registration or provider number has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged.
- 1.1.9 Documentation for the past ten (10) years of Professional Liability Insurance coverage including: the names of present and past insurance carriers and any information concerning the Applicant's professional liability litigation experience; past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings; and, the ultimate disposition.
- 1.1.10 Information as to whether the Applicant has ever been named as a defendant in a criminal action and/or convicted of, or pled guilty or no contest to a crime (other than minor traffic offenses).
- 1.1.11 Information as to whether the Applicant has been the subject of investigation by a Federal Healthcare Program and, if so, the outcome of such investigation.
- 1.1.12 Documentation of compliance with any Board approved conflict of interest policy as such policy may change from time to time.
- 1.1.13 Information regarding the Applicant's ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.
- 1.1.14 Results of the Applicant's criminal background check.
- 1.1.15 A current, valid picture identification issued by a state or federal agency (e.g., a driver's license). The picture will remain in Medical Staff Services for purposes of verifying that the Practitioner requesting appointment/Privileges is the same Practitioner identified in the credentialing documents. The picture will not be circulated with the application during the credentialing process; with the exception that the

picture identification will be made available to the appropriate chair during the interview process.

1.1.16 The Applicant's signature and current date.

1.2 **Effect of Application**. By signing and submitting an application for Medical Staff appointment and/or Privileges, the Applicant:

- 1.2.1 Attests to the truthfulness of the information provided and acknowledges that any material misstatement(s) in or omission(s) from the application constitutes grounds for denial of the application or termination of appointment and Privileges. In either situation, there shall be no entitlement to any hearing or appeal except for the limited purpose of resolving any dispute as to the materiality of the misstatement or omission and/or actual facts.
- 1.2.2 Attests that the Applicant has received, or has access to, the Medical Staff Bylaws, Policies, and Rules & Regulations and that he/she agrees to comply with and be bound by the terms thereof, including the authorization, confidentiality, immunity, and release of liability provisions in the Medical Staff Bylaws and the obligation to exhaust all administrative remedies provided by the Medical Staff Bylaws and Policies before resorting to legal action.
- 1.2.3 Acknowledges his/her responsibility to meet the obligations of Medical Staff appointment and/or Privileges set forth in the Medical Staff Bylaws.
- 1.2.4 Understands and agrees that if Medical Staff appointment and/or requested Privileges are denied based upon the Applicant's competence/quality of care or conduct, the Applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.
- 1.2.5 Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as he/she is a Member of the Medical Staff and/or has Privileges at the Hospital.
- 1.2.6 Agrees to comply in all respects with the CHE Trinity Health Integrity & Compliance Program, notice of privacy practices, and applicable Hospital and Medical Staff policies and procedures.
- 1.2.7 Acknowledges that the Hospital and Affiliate Hospital(s) are part of the Health System and that information is shared within the Health System. As a condition of appointment and/or grant of Privileges, the Applicant recognizes and understands that any and all information relative to his/her appointment and/or exercise of Privileges is shared between the Hospital and Affiliate Hospitals, including peer review that is maintained, received and/or generated by any of them. The Applicant further understands that

this information can and will be used as part of the respective Hospital's/Affiliate Hospital(s)' quality assessment and improvement activities and can form the basis for corrective action.

1.3 **Burden of Producing Information.** Practitioners seeking appointment, reappointment, and/or Privileges/regrant of Privileges have the burden of:

1.3.1 Producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, professional ethics and other qualifications and for resolving any concerns of the Medical Staff or Hospital.

1.3.2 Appearing for personal interviews, if required, in support of his/her application.

1.3.3 Providing a complete application, including adequate responses from references and evidence that all the statements made and information given on the application are accurate and complete. An application will not be considered until it is deemed "complete."

(1) An application shall be deemed complete when all questions on the application form have been answered, all related documentation has been supplied, and all information has been appropriately verified.

(2) An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. If an Applicant's file remains incomplete ninety (90) days after the initial application for appointment and/or Privileges, or more than thirty (30) days after any request that the Applicant provide additional information, the Applicant will be deemed to have withdrawn his/her application. The Applicant shall be notified that his/her application is deemed to have been withdrawn, and that the Applicant shall not be entitled to a hearing or any other procedural rights with respect to such application. Thereafter, the Applicant will need to submit a new application for appointment and/or Privileges.

(3) The application fee will not be refunded once primary source verification has begun.

1.3.4 Resolving any reasonable doubts with respect to the application and of satisfying reasonable requests for information. This burden may include submission to a medical or cognitive examination, at the Applicant's expense, if deemed appropriate for the Privileges requested. In such event, the Medical Executive Committee will select the service provider.

1.4 **Mount Carmel East/Grove City Primary Campus Affiliation.** Practitioners applying for Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges at Mount Carmel East and/or Mount Carmel Grove City shall comply

with the following requirements:

- 1.4.1 With the exception of Honorary, Retired, Affiliate, Consulting Peer Review, and Community Based Medical Staff Members, all Practitioners must declare on their application or reapplication for appointment and/or Privileges, a primary affiliation with the campus at which he/she intends to concentrate the majority of his/her clinical activity. If the Practitioner has requested an Active appointment, the Practitioner will only be deemed to be Active at the Practitioner's primary campus (including Emergency Department call) and shall be deemed to be in Courtesy status at the other campus. Should the focus of the Practitioner's clinical activity at the primary or alternate campus change, the Practitioner must notify Medical Staff Services.
- 1.4.2 A Practitioner may, at the time of initial application or reapplication, request the same Medical Staff category at both campuses. If the request is granted, the Practitioner may exercise the Prerogatives, and is required to fulfill the obligations, of the Medical Staff category to which he/she is appointed on both campuses, except that he/she will only have one (1) vote on Medical Staff matters and may not represent both campuses on any one committee.

**ARTICLE II
PROCEDURE FOR INITIAL APPOINTMENT/PRIVILEGES**

2.1 Application for Appointment with Privileges or for Privileges Only.

2.1.1 **Request for Application.** Applications shall be in writing and on forms approved by the Board upon recommendation of the MEC and Credentials Committee. The application form and eligibility criteria for appointment and Privileges shall be made available to Applicants. Applications may be provided to residents who are in the final six (6) months of their training. Such applications may be processed, but final action will not be taken until all applicable eligibility criteria are satisfied.

2.1.2 **Procedure.** A completed application form with copies of all required documents must be returned as provided for in the application within the time period set forth in the CVO Operating Manual. The application must be accompanied by the application fee.

Upon receipt, the application will be reviewed by the CVO to determine that all questions have been answered and that the Applicant satisfies all threshold criteria in which event a credentials file shall be established for the Applicant. Applicants who fail to return completed applications within the established time period or who fail to meet the threshold criteria will be notified that their application will not be processed with an explanation of the reason for this action.

The CVO will oversee the process of gathering and verifying relevant information, confirming that all references and other information or materials deemed pertinent have been received, and making all appropriate queries, including to the National Practitioner Data Bank.

2.1.3 **Interviews.** One (1) or more interviews with the Applicant will be conducted. The purpose of the interview(s) is to discuss and review the Applicant's qualifications for Medical Staff appointment and/or Privileges. Interviews may be conducted by one (1) or more of the following: the Department Chair, the Credentials Committee (or a designated representative), the MEC (or a designated representative), the Medical Staff President, or the Vice President of Medical Affairs.

2.1.4 **Department Chair Procedure**

(1) The CVO shall transmit the complete application and all related materials to the Chair of each Department in which the Applicant seeks Privileges.

(2) Each such Department Chair shall complete a form evaluating the evidence of the Applicant's training, experience, and demonstrated ability. In doing so, the Department Chair may:

- (a) Refer the matter back to the CVO for further consideration and responses to specific questions raised by the Department Chair prior to issuing his/her findings. In such instance, the Department Chair shall set a time frame within which the CVO must respond.
 - (b) Defer the application for further consideration. In such event, except for good cause, the Department Chair must issue his/her findings within thirty (30) days thereafter. The Medical Staff President shall advise the Applicant in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the Applicant and the time frame for response. Failure by the Applicant, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application.
- (3) The completed form shall be forwarded to the Credentials Committee and shall state the Department Chair's opinion as to whether the Applicant has satisfied all of the qualifications for appointment and/or Privileges along with the chair's opinion as to approval or denial of, and any special limitations on, appointment, Medical Staff category, Department/Section assignment, and/or Privileges.
 - (4) The Department Chair shall be available to the Credentials Committee, MEC, and the Board to answer any questions that may be raised with respect to the Department Chair's findings.
 - (5) If the Department Chair fails to submit a completed form within the time period set forth in §2.3, the Credentials Committee, after querying the Department Chair as to the cause for the delay and establishing a specified period in which a response is to be made, may proceed with its review and recommendation.

2.1.5 **Credentials Committee Procedure.**

- (1) Upon receipt of the Department Chair's findings, the Credentials Committee shall review and consider the Applicant's credentials file, the Department Chair's documentation, and such other additional information as the Credentials Committee deems appropriate. The Credentials Committee may:
 - (a) Adopt the findings and opinion of the Department Chair as its own.

- (b) Refer the matter back to the Department Chair for further consideration and responses to specific questions raised by the Credentials Committee prior to issuing its final report. In such instance, the Credentials Committee shall set a time frame within which the Department Chair must respond.
 - (c) Defer the application for further consideration. In such event, except for good cause, the report must be issued within thirty (30) days thereafter. The Medical Staff President shall advise the Applicant in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the Applicant and the time frame for response. Failure by the Applicant, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application.
 - (d) Make a recommendation different than that of the Department Chair stating the basis for its disagreement.
- (2) The Credentials Committee is then responsible for preparing and submitting a written report, which may be reflected by minutes, with its opinion(s) as to approval or denial of, and any special limitations on, appointment, Medical Staff category, Department/Section assignment, and/or Privileges to the MEC.
 - (3) If the Credentials Committee fails to submit a report within the time period set forth in §2.3, the MEC, after querying the Credentials Committee as to the cause for the delay and establishing a specified period in which a response is to be made, may proceed with its review and recommendation.

2.1.6 **Medical Executive Committee Procedure.**

- (1) At its next regular meeting after receipt of the report(s) of the Credentials Committee, the MEC may:
 - (a) Adopt the findings and recommendation of the Credentials Committee as its own.
 - (b) Refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation. In such instance, the MEC shall set a time frame within which the Credentials Committee must respond.

- (c) Defer the application for further consideration. In such event, except for good cause, a recommendation must be made within thirty (30) days thereafter. The Medical Staff President shall advise the Applicant in writing, by Special Notice, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the Applicant and the time frame for response. Failure by the Applicant, without good cause, to respond with the requested information within the specified time frame shall be deemed a voluntary withdrawal of the application.
 - (d) Make a recommendation different from that of the Credentials Committee stating the basis for its disagreement.
- (2) If the recommendation of the MEC is to appoint/grant Privileges, the recommendation shall be forwarded to the Medical Staff President for presentation, together with all accompanying information, at the next regularly scheduled Board meeting for a final decision.
 - (3) If the recommendation of the MEC is Adverse, the recommendation shall be forwarded to the Medical Staff President who shall promptly notify the Applicant, by Special Notice, of the MEC's recommendation and of the Applicant's procedural rights, if any, as provided in the Fair Hearing Policy. The Medical Staff President shall then hold the application until after the Applicant has exercised or waived his/her procedural due process rights, if any, at which time a final decision shall be made by the Board.

2.1.7 **Board Action.**

- (1) At its next regularly scheduled meeting following receipt of the MEC's recommendation, the Board may take any of the following actions:
 - (a) Defer the application for further consideration. If, as part of its deliberations pursuant to this section, the Board determines that it requires further information, it may defer action and shall notify the Applicant and the Medical Staff President in writing of the deferral and the grounds therefore. If the Applicant is to provide the additional information, the Board chair shall advise the Applicant, by Special Notice, including a request for the specific data/explanation or release/authorization, if any, required from the Applicant and the time frame for response. Failure

by the Applicant, without good cause, to respond with the requested information within the time frame specified shall be deemed a voluntary withdrawal of the application.

- (b) Adopt, in whole or in part, the recommendation of the MEC.
 - (c) Refer the matter back to the MEC for further consideration and responses to specific questions raised by the Board prior to its final decision. In such instance, the Board shall set a time limit within which the MEC must respond.
 - (d) Reject, in whole or in part, the recommendation of the MEC.
 - (e) Act without benefit of the MEC's recommendation. If the Board, in its determination, does not receive a recommendation from the MEC in timely fashion the Board may, after notifying the MEC of its intent, including a reasonable period of time for response, take action on its own initiative employing the same type of information usually considered by the Medical Staff leadership.
- (2) If the Board's action is favorable to the Applicant, it shall be effective as its final decision.
 - (3) In the case of an Adverse MEC recommendation, the Board shall take final action in the matter as provided in §2.1-6 (3).
 - (4) If the Board's action is Adverse to the Applicant, the Board chair shall promptly inform the Applicant, by Special Notice, of the Board's action and of the Applicant's procedural rights, if any, as provided in the Fair Hearing Policy. The Board shall not take final action on the application until after the Applicant has exercised or waived his/her procedural due process rights, if any.
 - (5) In the event that an Applicant withdraws his/her initial application prior to commencement of a hearing, the withdrawal shall be deemed to be a voluntary withdrawal of the application, and the Applicant's file shall be closed. Upon the commencement of a hearing on an initial application, the application may no longer be voluntarily withdrawn; rather the process shall be completed and final decision rendered by the Board.

2.1.8 **Conflict Resolution**. Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter will be submitted to an *ad hoc* Joint Conference Committee for review and recommendation before the Board makes its decision. The *ad hoc* Joint Conference Committee shall be composed of not less than two (2) Medical

Staff Members selected by the Medical Staff President and not less than two (2) members of the Hospital Board, selected by the Board chair. There shall be an equal number of Medical Staff Members and Board members on the Joint Conference Committee. The Medical Staff President and Board chair shall each appoint one (1) of its Joint Conference Committee designees to serve as co-chair of the committee.

2.1.9 **Procedure for Application for Appointment/Privileges at Multiple System Hospitals.**

- (1) In the event that a Practitioner applies for appointment and/or Privileges at more than one (1) System Hospital, he/she shall be asked to declare on the application a primary affiliation with the System Hospital at which he/she intends to concentrate the majority of his/her clinical activity.
- (2) The CVO, upon receipt of the application, shall follow the process set forth in §§2.1.2 and 2.1.3.
- (3) The Department Chairs at each of the System Hospitals to which the Practitioner has applied shall, upon receipt of the application, follow the process set forth in §2.1.4.
- (4) The Credentials Committee of the primary System Hospital shall, upon receipt of the application, make a recommendation in accordance with the process set forth in §2.1.5. The Credentials Committee of the other System Hospitals to which the Practitioner has applied shall table the application. The Credentials Committee chair of the primary System Hospital shall notify the Credentials Committee chairs of the other System Hospitals of its recommendation with regard to the application.
 - (a) If the Credentials Committee chairs of the primary and other System Hospitals to which the Practitioner has applied agree upon the recommendation, the primary Hospital's Credentials Committee recommendation shall be adopted by the other System Hospitals' Credentials Committees and the recommendations of the respective Credentials Committees shall be forwarded to the MECs of the respective System Hospitals.
 - (b) If the Credentials Committee chairs cannot agree, the Credentials Committees of the respective System Hospitals shall meet jointly to review the application and determine if consensus can be achieved. The Credentials Committees may, at their sole discretion, designate subcommittees (rather than the full Credentials Committees) to meet and

report actions back to their respective Credentials Committee for adoption. If consensus is reached, the Credentials Committees' recommendations are forwarded to the MECs of the respective System Hospitals. If the Credentials Committees cannot reach consensus, the differing recommendations shall be forwarded to the respective MECs.

- (5) The MEC shall, upon receipt of the application, take the following actions:
 - (a) If the recommendations of the Credentials Committees are the same, the MECs shall follow the process set forth in §2.1.6 (2) or (3), as applicable.
 - (b) If the recommendations of the Credentials Committees are different, the MECs of the respective System Hospitals shall meet jointly to achieve an agreed to recommendation. The MECs may, at their sole discretion, designate subcommittees (rather than the full MECs) to meet and report actions back to their respective MECs for adoption.
 - (i) If the recommendation of the respective MECs following the joint meeting is favorable to the Practitioner, the MECs shall follow the process set forth in §2.1.6 (2).
 - (ii) If recommendation of the respective MECs is Adverse to the Practitioner following the joint meeting, the MECs shall follow the process set forth in §2.1.6 (3).
 - (iii) If the recommendations of the respective MECs continue to differ following the joint meeting, then the affirmative recommendation(s) shall be held in abeyance until the Practitioner has exercised or waived his/her procedural due process rights, if any, at the Hospital whose MEC issued the Adverse recommendation.

2.2 **Notice of Final Decision.**

- 2.2.1 **Notice.** Notice of the Board's final decision shall be given by the CEO to the Medical Staff President, the MEC, each applicable Department Chair, and to the Applicant by Special Notice.
- 2.2.2 **Information to be Included in Notice.** A decision and notice to grant an appointment and/or Privileges shall include, as applicable, the Medical Staff category to which the Applicant is appointed, the

Department/Section to which the Applicant is assigned, the Privileges granted, and any special conditions attached to the appointment and/or Privileges.

- 2.3 **Time Periods for Processing Applications.** Completed applications for Medical Staff appointment and/or Privileges shall be considered in a timely and good faith manner by all individuals and groups required to act thereon. The time periods set forth in the CVO Operating Manual provide guidelines to assist these individuals and groups in meeting their obligations and do not create any right for the Applicant to have his/her application processed within such periods. This provision shall not apply to the time periods contained in the Fair Hearing Policy. When the fair hearing process is activated by an Adverse recommendation or action, as provided herein, the time requirements set forth therein shall govern the continued processing of the application.
- 2.4 **Application for Appointment Without Privileges.**
- 2.4.1 **Community Based.** Practitioners appointed to the Honorary, Retired, and Community Based Medical Staff categories shall be processed in accordance with the routine credentialing procedure set forth in Article II of this Policy.
- 2.4.2 **Consulting Peer Review.** Because applications for appointment to the Consulting Peer Review Medical Staff category do not include a grant of Privileges, Practitioners need only provide such information as is requested by the CVO following consultation with the Medical Staff President and VPMA. The MEC, or its executive committee, shall then review the information and make a recommendation to the Board as to whether such appointment should, or should not be granted, and the reasons in support thereof. The Board, or Chief Medical Officer if so authorized by the Board, shall thereafter take final action regarding the appointment.
- 2.4.3 **Affiliate.** Practitioners automatically appointed to the Affiliate Medical Staff are set forth in §4.1.9 (a)(i) of the Medical Staff Bylaws. All other eligible Practitioners who apply for appointment to the Affiliate Medical Staff shall provide such information as is requested by the CVO following consultation with the Medical Staff President and VPMA. The MEC shall then review the information and make a recommendation to the Board as to whether such appointment should, or should not be granted, and the reasons in support thereof. The Board, or Chief Medical Officer if so authorized by the Board, shall thereafter take final action regarding the appointment.
- 2.4.4 **Denial of Application for Appointment Without Privileges.**

- (1) Denial of appointment to the Consulting Peer Review, Affiliate, Retired, or Honorary Medical Staff category shall not constitute an Adverse action and the Practitioner shall not be entitled to the rights set forth in the Fair Hearing Policy.
- (2) Denial of appointment to the Community Based Medical Staff category may constitute an Adverse recommendation or action if based upon professional conduct concerns as determined by the Medical Executive Committee or Board consistent with the Bylaws.

2.4.5 **Effect of Application.**

- (1) By their signature, Applicants must agree to abide and be bound, as applicable, by the Medical Staff Bylaws, Policies, Rules and Regulations, and Hospital policies; and to maintain the confidentiality of any peer review and/or patient information to which they are privy as a result of their appointment.

2.5 **Resignation/Termination.**

2.5.1 **Resignation of Medical Staff Appointment and/or Privileges.**

Resignation of Medical Staff appointment and the reason for such resignation should be submitted in writing, at least thirty (30) days in advance, to the Board through the Medical Staff President.

A Member with Privileges who determines to no longer exercise, or wishes to restrict or limit the exercise of, particular Privileges which he/she has been granted should send at least thirty (30) days prior written notice to the Medical Staff President indicating the same and identifying the limitation. A request to resign Privileges will be presented to the respective Department Chair, the Credentials Committee, Medical Executive Committee and the Board.

Upon review, the Board shall determine if the Practitioner resigned his/her Medical Staff appointment and/or Privileges in Good Standing. When a Practitioner does not resign his/her Medical Staff appointment and/or Privileges in Good Standing, consideration shall be given by the Board to notifying the applicable state licensing board.

Notification of the resignation shall be forwarded to all appropriate Hospital personnel. The Chief Executive Officer will notify the Practitioner of the Board's receipt of his/her resignation.

2.5.2 **Termination of Medical Staff Appointment and/or Privileges.** In those cases when a Practitioner moves away from the area without submitting a forwarding address or the Practitioner's written intentions with regard to his/her Medical Staff appointment and/or Privileges, the

Practitioner's Medical Staff appointment and/or Privileges shall be terminated upon approval of the MEC and the Board. If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to Medical Staff appointment and/or Privileges and, if the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the Credentials Committee, MEC, and Board for approval of termination. In the event the Practitioner is not in Good Standing when his/her Medical Staff appointment and/or Privileges are terminated, consideration shall be given by the Board to notifying the applicable state licensing board. The Chief Executive Officer will inform the Practitioner of the approved termination by Special Notice.

2.5.3 **No Right to Fair Hearing.** Provided a resignation or termination pursuant to §§2.5.1 or 2.5.2 above is determined by the Board to be voluntary, such resignation or termination shall not give rise to any procedural due process rights under the Fair Hearing Policy.

2.6 **Reapplication after Final Adverse Decision, Resignation, Withdrawal or Automatic Termination.** A Practitioner whose Medical Staff appointment and/or Privileges are automatically terminated pursuant to §10.5.1 of the Medical Staff Bylaws, who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges, or who has resigned or withdrawn an application for appointment/reappointment and/or Privileges/regrant of Privileges while under investigation or to avoid an investigation may not reapply for appointment to the Medical Staff and/or for Privileges for a period of at least one (1) year from the later of: (i) the effective date of the automatic termination; (ii) the date of the notice of the final Adverse decision; (iii) the effective date of the resignation or application withdrawal; or, (i) the final court decision, as applicable. Any re-application after the one (1) year period will be processed as an initial application, and the Practitioner must submit such additional information as required by the Credentials Committee, MEC, or the Board to show that any basis for the earlier termination, resignation, withdrawal, or Adverse decision has been resolved.

ARTICLE III
PROCEDURE FOR REAPPOINTMENT/REGRANT OF PRIVILEGES

- 3.1 **Application for Reappointment with Privileges, Due Date.** An application for reappointment with Privileges shall be furnished to a Practitioner prior to the expiration of his/her current appointment/Privilege term in accordance with the time frames set forth in the CVO Operating Manual. A completed application must be returned to the CVO within the specified time frame. Failure to submit a complete application within the time frame set forth in the CVO Operating Manual shall result in termination of appointment and Privileges at the end of the Practitioner's current term. Any application filed after such termination pursuant to this section shall be treated as an initial application.
- 3.1.2 **Time Period.** Reappointment with Privileges shall be for a period of not more than two (2) years. A reappointment with Privileges for less than two (2) years shall not be deemed Adverse.
- 3.2 **Review of Application.** Appraisal for reappointment to the Medical Staff with Privileges will be based upon the following:
- 3.2.1 Updated information provided on the application form.
- 3.2.2 Ongoing professional practice evaluation data including, but not limited to, data regarding current clinical competence (including morbidity/mortality data to the extent available), judgment, and technical skill in the treatment of patients. If the Practitioner is subject to the Hospital's low volume/no volume policy, the Practitioner bears the burden of submitting such additional information as may reasonably be requested to establish current clinical competency before the application will be considered complete and further processed.
- 3.2.3 Compliance with the Medical Staff Bylaws, Policies, Rules and Regulations, and applicable Hospital, Medical Staff, and Department policies.
- 3.2.4 Fulfillment of Medical Staff duties.
- 3.2.5 Behavior at the Hospital, including the ability to work harmoniously with all members of the patient care team; recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care; and recognition that interpersonal skills, collaboration, communication, and collegiality are essential for the provision of quality patient care.
- 3.2.6 Current ability to safely and competently exercise the Privileges requested with or without reasonable accommodation.

- 3.2.7 Capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities.
- 3.2.8 Appropriate resolution of any verified complaints from patients and/or Hospital staff (defined as no further action deemed necessary by the Hospital or the Medical Executive Committee).
- 3.2.9 Other reasonable indicators of continuing satisfaction of the qualifications for Medical Staff appointment and/or Privileges.
- 3.2.10 Attestation of continuing medical and/or professional training and education activities completed during the prior appointment/Privilege period. The Hospital reserves the right to audit such activities upon request.
- 3.2.11 Any requests for additional or reduced Privileges.
- 3.2.12 Any requests for changes in Medical Staff category or Department/Section assignment.
- 3.2.13 Such other information as requested by the Hospital or Medical Staff.

3.3 **Processing Applications for Reappointment with Privileges.**

- 3.3.1 **In General.** Applications for reappointment with Privileges shall be processed in the same manner and pursuant to the same guidelines as those set forth for initial applications for appointment and/or Privileges. In the event that a Practitioner applies for reappointment and/or regrant of Privileges at more than one (1) System Hospital, the process set forth in §2.1.9 shall be followed with the exception that in §2.1.9 (3) only the primary Hospital Department Chair shall review the application and make a recommendation thereon.
- 3.3.2 **Discretionary Meeting.** The Department Chair, the Credentials Committee or the MEC may meet with the Practitioner at any time during the process. This meeting is not a hearing, and none of the procedural rights set forth in the Fair Hearing Policy shall apply. The Department Chair or applicable committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting as part of its minutes.

- 3.4 **Application for Reappointment (without Privileges).** The same process as set forth in §2.4 above shall be followed. In addition, information regarding activities of the Member during the prior appointment period shall be taken into consideration.

- 3.5 **Requests for Modification of Appointment Status and/or Privileges.** A Practitioner who seeks a change in Medical Staff status or modification of Privileges may submit such a request at any time upon a form developed by the Medical Executive Committee and approved by the Board, except that such application may not be filed within six (6) months of the time a similar request has been denied unless a different time period is approved by the Board. A request for modification of appointment status and/or Privileges shall be processed in the same manner as an application for appointment/reappointment and/or Privileges/regrant of Privileges. The applicable Department Chair will determine the need for focused professional practice evaluation when reviewing requests for new/additional Privileges. A Practitioner is required to continue to meet all of his/her current Medical Staff responsibilities until such time as the modification request has been approved by the Board.

**ARTICLE IV
DELINEATION OF CLINICAL PRIVILEGES**

- 4.1 **Exercise of Privileges.** Medical Staff appointment or reappointment shall not confer any Privileges at the Hospital. A Practitioner may only exercise the Privileges specifically granted to him/her.
- 4.2 **Basis for Privileges Determination.** Privileges recommended to the Board shall be based upon proof of general competency in the areas of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice consistent with the Bylaws and the Professional Practice Evaluation Policy, as such Policy may be amended from time to time.
- 4.3 **Requests for and Granting of Privileges.** An application for Privileges only, for appointment/reappointment with Privileges, or for Privilege modifications must contain a written request for all Privileges sought by the Practitioner. Requests for Privileges shall be processed in accordance with the procedures outlined in Article II, as applicable. Requests for temporary Privileges shall be processed according to §4.6 of this Article.
- 4.4 **Recognition of a New Service or Procedure.**
- 4.4.1 **Need for Privilege Criteria.** A Privilege set must be approved by the Board for all new services and procedures except for those that are clinically or procedurally similar to an existing modality.
- 4.4.2 **Considerations.** The Board shall determine the Hospital's scope of patient care services based upon recommendation from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:
- (1) The Hospital's available resources and staff.
 - (2) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).
 - (3) The availability of a qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure when needed.
 - (4) The quality and availability of training programs.
 - (5) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.
 - (6) Whether there is a community need for the service or procedure.

4.4.3 **Privilege Requests for a New Service or Procedure.** Requests for Privileges for a service or procedure that has not yet been recognized by the Board shall be processed in accordance with the *Request for New or Non-Credentialed Procedures Policy* as such policy may be amended from time to time.

- (2) If the Board approves the Privileges for a new service or procedure, the requesting Practitioner(s) may apply for such Privileges consistent with this Policy. If the Board does not approve the Privileges for a new service or procedure, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of the Fair Hearing Policy.

4.5 **Dentists, Oral & Maxillofacial Surgeons, Podiatrists, and Psychologists.** Dentists, Oral & Maxillofacial Surgeons, and Podiatrists may be granted Privileges to admit patients to the Hospital. Psychologists may not admit or co-admit patients to the Hospital, but may treat patients who have been admitted by a Practitioner with Privileges provided the Psychologist maintains a consultative relationship with the attending Practitioner during the course of treatment of the patient.

Privileges exercised by Dentists, Oral & Maxillofacial Surgeons, Podiatrists, and Psychologists shall be under the overall supervision of the chair of the applicable Department.

Upon admission of a dental or podiatric patient, a Physician with Privileges shall be responsible for completing the medical portion of the admission history and physical examination, and caring for any medical problem that may be present at the time of admission or during hospitalization. If a medical problem exists, the Physician shall determine the risk and effect of the proposed surgical procedure on the health of the patient. At or before admission of such patients, it is the responsibility of the Dentist, Oral & Maxillofacial Surgeon (if not otherwise privileged to do so) or Podiatrist to obtain medical consultation in accordance with the above provisions. An Oral & Maxillofacial Surgeon, if granted the Privilege to do so, may perform the admitting history and physical for his/her patients

The Dentist, Oral & Maxillofacial Surgeon, Podiatrist, or Psychologist is solely responsible for the dental, oral & maxillofacial, podiatric, or psychological history, examination, diagnosis, operative report, and discharge summary. The Dentist, Oral & Maxillofacial Surgeon, Podiatrist, or Psychologist is responsible for completion of medical records as relates to his/her care of the patient. If there is a medical problem, the consulting Physician shall participate in the discharge of the patient and the completion of the medical records.

4.6 **Temporary Privileges.**

4.6.1 **Conditions.** Temporary Privileges may be granted only in the circumstances and under the conditions described below. Special requirements of consultation and reporting may be imposed by the Department Chair responsible for supervision of the Practitioner exercising temporary Privileges as applicable. Under all circumstances, the Practitioner requesting temporary Privileges must agree in writing to abide by the Bylaws, Policies, Rules & Regulations, and policies of the Hospital in all matters relating to his/her activities in the Hospital.

4.6.2 **Circumstances.** Upon recommendation of the Medical Staff President, the Hospital CEO may grant temporary Privileges on a case-by-case basis in the following circumstances:

- (1) **Pendency of a Completed Application:** To an Applicant for new Privileges but only after: receipt of a completed application; consultation with the chair of the applicable Department; verification of the qualifications required by the Bylaws relating to current licensure, competency and relevant professional education, training and experience, DEA/controlled substances registration, and adequate Professional Liability Insurance; completion and evaluation of National Practitioner Data Bank queries; a fully positive written reference specific to the Practitioner's current competence for the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation; ability to perform the Clinical Privileges requested; results of a criminal background check; and a positive recommendation by the Credentials Committee or, if so authorized by the Credentials Committee, the Credentials Committee chair. Along with the completed application, the record must establish that the Applicant has no current or previously successful challenges to his/her licensure or registration; has not been subject to involuntary termination from a medical staff appointment at any other organization; has not been subject to any involuntary limitation, reduction, denial, or loss of privileges; and has not been suspended or terminated from any Federal Healthcare Program.
- (2) Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

- (3) **Important Patient Care Need:** To a Practitioner to meet an important patient care need (e.g., care of a specific patient or class of patients, necessary to prevent a lack or lapse of services in a needed specialty area, etc.) but only after: receipt of a written request for the specific Privileges desired; telephone verification (or receipt of a copy) of appropriate current licensure, DEA/controlled substances registration, and adequate Professional Liability Insurance; a fully positive written reference specific to the Practitioner's current competence for the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation; results of a National Data Bank query; and results of a criminal background check.
- (4) Temporary Privileges may be granted in this circumstance for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary. Temporary Privileges granted for an important patient care need shall be restricted to the specific patients or class of patients for which they are granted.

- 4.7 **Locum Tenens Privileges.** Practitioners seeking *locum tenens* Privileges shall submit an application for such Privileges and shall have such application processed in accordance with Article II. An approved application for Privileges as a *locum tenens* shall be valid for a period of one (1) year. In exceptional circumstances, a *locum tenens* Practitioner may initially qualify for temporary Privileges pursuant to §4.6 above. For purposes of this Policy, the term "*locum tenens*" shall include Practitioners providing temporary coverage during another Practitioner's absence (e.g. due to illness, vacation, etc.) and those Practitioners who provide additional temporary staffing at the Hospital as needed from time to time at the request of the Hospital.
- 4.8 **Emergency Privileges.** In case of an emergency as defined in this paragraph, any Practitioner is authorized and shall be assisted to render medical treatment to attempt to save the patient's life, or to save the patient from serious harm, as permitted within the Practitioner's scope of practice, and notwithstanding the Practitioner's Department/Section affiliation, Medical Staff category, or level of Privileges. A Practitioner exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger and delay in administering treatment could increase the danger to the patient.
- 4.9 **Disaster Privileges.** Disaster Privileges may be granted to licensed volunteer Practitioners when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs.

- 4.9.1 The Chief Executive Officer or Medical Staff President may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued picture identification in addition to at least one of the following: (i) primary source verification of licensure; (ii) a current license to practice; (iii) a current picture identification card from a health care organization that identifies professional designation; (iv) identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), The Medical Reserve Corps. ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP") or other recognized state or federal response organization or group; (v) identification indicating the individual has been granted authority to render patient care, treatment or services in disaster circumstances by a government entity; or, (vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Hospital Privileges.
- 4.9.2 The granting of disaster Privileges shall be done in the same manner as temporary Privileges to meet an important patient care need, except that primary source verification of licensure may be performed after the situation is under control and as circumstances allow. It is anticipated that these disaster Privileges may be granted to state-wide and out-of-state Practitioners as necessary.
- 4.9.3 Primary source verification of licensure shall occur as soon as the disaster is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. If primary source verification cannot be completed within seventy-two (72) hours (due to, for example, no means of communication or a lack of resources), verification shall be performed as soon as possible. In such event, the Hospital will document why primary source verification could not be performed in the required time frame; evidence of the volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and, an attempt to rectify the situation as soon as possible. A reassessment/decision must be made within seventy-two (72) hours after initial disaster Privileges have been granted to determine if there should be a continuation of disaster Privileges for the volunteer Practitioner.
- 4.9.4 All Practitioners who receive disaster Privileges shall be issued a temporary Hospital identification badge to assist Hospital and Medical Staff personnel to readily identify these volunteer Practitioners.
- 4.9.5 The activities of Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Medical Staff President or an appropriate designee (e.g., the chair of the Department of emergency services).

4.9.6 The disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer.

4.10 **Telemedicine Privileges**. Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws and this Policy, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in §4.6.

4.10.1 Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

- (1) The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Policy.
- (2) The Practitioner is credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in the Bylaws and this Policy with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:
 - (a) The distant site is a Medicare-certified hospital or a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that
 - (1) provides telemedicine services, (2) is not a Medicare-certified hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.
 - (i) When the distant site is a Medicare-certified hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital Practitioners providing telemedicine services.

(ii) When the distant site is a “distant site telemedicine entity” the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity’s medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.

(b) The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

(c) The individual distant site Practitioner holds an appropriate license issued by the State Medical Board of Ohio or other appropriate licensing entity.

(d) The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site’s periodic appraisal of the distant site Practitioner. At a minimum, this information must include:

(i) All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and,

(ii) All complaints the Hospital receives about the distant site Practitioner.

4.11 **Termination of Temporary, Locum Tenens, Emergency, Disaster, or Telemedicine Privileges.**

4.11.1 **Termination.** The Chief Executive Officer or the Medical Staff President may, at any time, terminate any or all of a Practitioner's temporary, *locum tenens*, emergency, disaster, or telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the

Practitioner's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

- 4.11.2 **Due Process Rights**. A Practitioner who has been granted *locum tenens*, temporary, emergency, disaster, or telemedicine Privileges is not a Member of the Medical Staff and is not entitled to the procedural due process rights afforded to Members. A Practitioner shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy because the Practitioner's request for *locum tenens*, temporary, emergency, disaster, or telemedicine Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.
- 4.11.3 **Patient Care**. In the event a Practitioner's Privileges are revoked, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Medical Staff President. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.
- 4.12 **Focused Professional Practice Evaluation**. The Hospital's focused professional practice evaluation ("FPPE") process is set forth, in detail, in the Professional Practice Evaluation Policy and shall be implemented for all: (a) Practitioners requesting initial Privileges and (b) existing Practitioners requesting Privileges during the course of an appointment/Privilege period. The Hospital's FPPE process in response to OPPE concerns regarding a Practitioner's ability to provide safe, high quality patient care is set forth in detail in the Ongoing Professional Practice Evaluation (OPPE) and Focused Practice Professional Evaluation (FPPE) Policy for Current Practitioners. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges.
- 4.13 **Ongoing Professional Practice Evaluation**. Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the Ongoing Professional Practice Evaluation (OPPE) and Focused Practice Professional Evaluation (FPPE) Policy for Current Practitioners and requires the Hospital to gather, maintain and review data on the performance of all Practitioners with Privileges on an ongoing basis.
- 4.14 **Moonlighting Residents**.
- 4.14.1 **Qualifications**. In order to provide coverage as a Health System Moonlighting Resident, individuals must meet the following criteria:
- (1) Have current, valid and unrestricted license to practice medicine in the State of Ohio;
 - (2) Be currently registered to administer and prescribe controlled

- substances by the United States Drug Enforcement Agency;
- (3) Be enrolled as a Resident in good standing in the Health System's sponsored Graduate Medical Education residency training program;
 - (4) Have and maintain current, valid Professional Liability Insurance with minimum coverage limits as established from time to time by the Board; and
 - (5) Have an attestation document signed by the Moonlighting Resident's Program Director indicating he/she has established that he/she has met the residency program's criteria for independently performing the required procedures as outlined in the Moonlighting Resident job description.

4.14.2 **Credentialing**. In order to be employed as a Health System Moonlighting Resident, a physician must undergo successful credentialing by the Health System's Credentialing Verification Office, with subsequent approval of the Health System's Central Medical Staff Credentials Committee, the Hospital's Medical Executive Committee, and the Credentialing Sub-Committee of the Quality & Safety Committee of the Health System Board of Trustees. The credentialing process includes the following:

- (1) The Moonlighting Resident must complete a Moonlighting Resident application, which includes:
 - (a) Identifying information as indicated on the application form;
 - (b) Medical license to practice in the State of Ohio;
 - (c) DEA registration number; and
 - (d) Completion of the Moonlighting Resident procedural verification form and recommendation from the applicant's current Program Director

**ARTICLE V
LEAVE OF ABSENCE**

5.1 **Generally.**

- 5.1.1 **General.** A Medical Staff Member may request a voluntary leave of absence (“LOA”) from the Medical Executive Committee or may be put on an administrative LOA. The Medical Staff President, with the concurrence of the Medical Executive Committee (“MEC”), may grant a voluntary LOA if conditions warrant such action. The Medical Staff President, with the concurrence of the Vice President Medical Affairs and/or the Chief Operating Officer, may place a Member on an administrative LOA if conditions warrant such action. An LOA means that the Member may not exercise Privileges at the Hospital, and that appointment rights and responsibilities will be inactive, with the exception that the Member’s obligation to pay dues and assessments, if any, will continue unless waived by the MEC for good cause shown.
- 5.1.2 **Medical Records/Patient Care.** All medical record deficiencies must be resolved before an LOA is granted, unless the Medical Staff President grants a specific exemption based upon extraordinary circumstances. In addition, prior to an LOA being granted, the Member shall have made arrangements, acceptable to the MEC, for the care of his/her patients during the leave.
- 5.1.3 **Focused Professional Practice Evaluation.** A Member returning from an LOA six (6) months or more in duration will undergo a period of Focused Professional Practice Evaluation (“FPPE”). The FPPE will begin immediately upon the granting or reinstatement of Privileges and will follow the protocol outlined in the Member’s Department. The duration of FPPE can be modified at the discretion of the Member’s Department Chair.
- 5.1.4 **Reappointment/Regrant of Privileges During LOA.** In the event a Member’s appointment and Privilege period ends during the Member’s LOA, he/she may apply for reappointment to the Medical Staff. For purposes of an LOA, a Member can be reappointed to his/her Medical Staff category without being granted Privileges and without otherwise having to meet the privileging requirements applicable to his/her appointment category (e.g. Patient Encounter requirements, etc.). If the Member fails to apply for reappointment, the Member’s appointment shall terminate at the end of his/her current appointment term without recourse to the procedural due process rights set forth in the Fair Hearing Policy. In the event the Member is incapacitated or unavailable due to military obligation, the Member’s legal representative (e.g. a POA) may act on the Member’s behalf.

A Member may not apply for a re-grant of Privileges during the LOA and the Member's Privileges shall terminate at the end of his/her current Privilege period without recourse to the procedural due process rights set forth in the Fair Hearing Policy. A Member whose Privileges lapse during an LOA must meet the then current standards for obtaining Privileges if they reapply for Privileges regardless of whether the Member was previously excused from meeting certain conditions of appointment or Privileges (*i.e.*, board certification).

- 5.1.5 **Professional Liability Insurance Coverage During LOA.** In order to qualify for reinstatement following an LOA, the Member must maintain Professional Liability Insurance coverage during the LOA or purchase tail coverage for all periods during which the Member held Privileges. The Member shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage, or tail coverage, as required by this provision upon request for reinstatement.

5.2 **Voluntary Leave of Absence.**

- 5.2.1 **Request for Leave.** A Member may request an LOA at any time by submitting a written request to the Medical Executive Committee stating the approximate period of the leave desired (which may not exceed one (1) year or be less than thirty (30) days), the reason for the leave, and a description of the activity that will occur during the leave. During the period of the leave, the Member may not exercise Clinical Privileges at the Hospital, and appointment rights and responsibilities will be inactive. The obligation to pay dues and assessments, if any, will continue unless waived by the MEC for good cause shown. Subject to any limitations in this section, upon written request and a finding of good cause, the Medical Staff President, with the concurrence of the MEC, may extend an existing LOA, but in no event may an LOA be extended beyond one (1) year.

5.2.2 **Termination of Voluntary Leave.** At least thirty (30) days prior to the termination of a voluntary LOA, a Member shall request reinstatement of appointment and Privileges by submitting a written notice to that effect to the Medical Executive Committee. The Member must submit a summary of relevant activities during the leave and may be requested to submit proof of current competency and such additional information, as requested by the MEC, as is reasonably necessary to reflect that the Member is qualified for reinstatement. If the Member requested an LOA based upon health issues, the Member may be requested to establish that the basis of these concerns has been resolved such that he/she is able to perform his/her Privileges with or without a reasonable accommodation. Once the Member's request for reinstatement is deemed complete, the MEC shall take final action on the request for reinstatement and shall send notice of the MEC's decision to the Member and to the Board. In the event of an Adverse action by

the MEC, the Member shall be entitled to the procedural due process rights granted under the Fair Hearing Policy.

- 5.2.3 **Failure to Request Reinstatement.** Failure to timely request reinstatement will be deemed a voluntary resignation from the Medical Staff without entitlement to any procedural due process pursuant to the Fair Hearing Policy unless the MEC determines, after consultation with the Vice President Medical Affairs, that a reportable event exists. Reapplication will not be accepted for one (1) year after termination of appointment and Privileges; after that time, reapplication will be treated as a new application for appointment and/or Privileges.

5.3 **Administrative Leave of Absence.**

- 5.3.1 **Grounds.** In the event the Medical Staff President is unable to reasonably contact a Practitioner, and it appears that the Practitioner is absent from his/her practice, has a health problem, has a licensure problem, or if the Medical Staff President, in consultation with the Vice President Medical Affairs and/or the Chief Operating Officer, believes that a Practitioner may not be currently competent to exercise existing Privileges, the Medical Staff President, with the concurrence of the Vice President Medical Affairs and/or the Chief Operating Officer, may place the Practitioner on an administrative LOA. An administrative LOA means that the Practitioner may not exercise Privileges at the Hospital, and that appointment rights and responsibilities are inactive, with the exception that the obligation to pay dues and assessments, if any, continues.

- 5.3.2 **Notice.** The Medical Staff President shall send the Practitioner written notice, by Special Notice at the last known address of the Practitioner as reflected in the Practitioner's credentials file, of the action placing the Practitioner on an administrative LOA. Within thirty (30) days of receipt of the written notice the Practitioner may, in writing to the Medical Staff President, either:

- (1) Request that the administrative LOA be changed to a voluntary LOA consistent with §5.2 of this Policy; or,
- (2) Request that the administrative LOA be lifted explaining the reason(s) why the Practitioner has been out of contact.

Upon receipt of a request pursuant to (1), the process as set forth in §5.2 of this Policy will be followed. The administrative LOA will remain in effect until the voluntary LOA is granted or the request is denied and alternative action is taken.

Upon receipt of a request pursuant to (2) above, the request must be granted; provided, however, that the Medical Staff President may

thereafter take whatever other action is appropriate consistent with the applicable Medical Staff governing documents (e.g., no action, imposition of a summary suspension, recommendation for corrective action, etc.)

- 5.3.3 **Failure to Request Reinstatement.** If a Practitioner placed on an administrative LOA does not contact the Medical Staff President, in writing, within thirty (30) days of receipt of the written notice from the Medical Staff President, the Practitioner shall be deemed to have voluntarily resigned his/her appointment and/or Privileges as of that date unless the circumstances are such that the MEC, in consultation with the Vice President Medical Affairs, determines that a reportable event exists.

**ARTICLE VI
PRACTITIONER WELLNESS POLICY**

6.1 Introduction.

- 6.1.1 The Hospital and its Medical Staff are committed to providing patients with quality care. The delivery of quality care can be compromised if a Practitioner is suffering from an impairment. Impairment may result from a physical, psychiatric, or emotional condition.
- 6.1.2 The Peer Support Committee shall recommend to the Credentials Committee, the Medical Executive Committee, and the Chief Operating Officer additional educational materials beyond this Policy that address Practitioner health and emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional illness.
- 6.1.3 Practitioners who are suffering from an impairment that affects their ability to practice are encouraged to voluntarily bring the issue to the Peer Support Committee so that appropriate steps can be taken to protect patients and to help the Practitioner to practice safely and competently.
- 6.1.4 To the extent possible, and consistent with quality of care concerns, the Peer Support Committee will handle impairment matters in a confidential fashion. The Peer Support Committee shall keep the Chief Operating Officer, the Medical Staff President and the chair of the Credentials Committee apprised of matters under review.
- 6.1.5 For purposes of this Article VI (Practitioner Wellness Policy), the term "Practitioner" shall include Allied Health Professionals ("AHPs") with Privileges at the Hospital.

6.2 Mechanism for Reporting and Reviewing Potential Impairment.

- 6.2.1 If any individual has a concern that a Practitioner may be impaired in any way that may affect his or her practice at the Hospital, a written report shall be given to the Chief Operating Officer, the Medical Staff President, the chair of the Credentials Committee, or any member of the Peer Support Committee. The report shall include a factual description of the incident(s) that led to the concern.
- 6.2.2 If, after discussing the incident(s) with the individual who filed the report, the Chief Operating Officer, the Medical Staff President, the chair of the Credentials Committee, and/or any member of the Peer Support Committee believes there is enough information to warrant a review, the matter shall be referred to the Peer Support Committee.

- 6.2.3 The Peer Support Committee shall act expeditiously in reviewing concerns of potential impairment that are brought to its attention.
- 6.2.4 As part of its review, the Peer Support Committee may meet with the individual(s) who filed the report.
- 6.2.5 If the Peer Support Committee has reason to believe that the Practitioner is or might be impaired, it shall meet with the Practitioner. At this meeting, the Practitioner should be told that there is a concern that he or she might be suffering from an impairment that affects his or her practice. The Practitioner should not be told who filed the initial report, but should be advised of the nature of the concern.
- 6.2.6 As part of its review, the Peer Support Committee may request that the Practitioner be evaluated, at the Practitioner's expense, by an independent third party Practitioner and have the results of the evaluation provided to it. The Practitioner subject to evaluation shall agree to execute any and all authorizations and releases necessary to ensure information is provided to the Peer Support Committee.
- 6.2.7 Depending upon the severity of the problem and the nature of the impairment, the Peer Support Committee has the following options available to it:
- (1) Recommend that the Practitioner voluntarily take a Leave of Absence, during which time he or she would participate in a rehabilitation or treatment program, at the Practitioner's expense, to address and resolve the impairment.
 - (2) Recommend that appropriate conditions or limitations be placed on the Practitioner's practice.
 - (3) Recommend that the Practitioner voluntarily agree to refrain from exercising some or all Privileges in the Hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure that the Practitioner is able to practice safely and competently.
 - (4) Recommend that some or all of the Practitioner's Privileges be suspended if the Practitioner does not voluntarily agree to refrain from practicing in the Hospital.
- 6.2.8 If the Peer Support Committee recommends that the Practitioner participate in a rehabilitation or treatment program, the committee should assist the Practitioner in locating a suitable program.
- 6.2.9 If the Practitioner agrees to abide by the recommendation of the Peer Support Committee, then a confidential report will be made to

the Chief Operating Officer, the Medical Staff President and the chair of the Credentials Committee. In the event there is concern by the Chief Operating Officer, the Medical Staff President, and/or the chair of the Credentials Committee that the action of the Peer Support Committee is not sufficient to protect patients, the matter will be referred back to the Peer Support Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee.

- 6.2.10 This Policy does not preclude any person authorized to impose a summary suspension pursuant to the Medical Staff Bylaws or AHP Policy from doing so. Further, this Policy does not preclude an authorized individual from summarily suspending a Practitioner pursuant to the Medical Staff Bylaws or AHP Manual based upon information that the authorized individual learns as a result of this Policy, nor is any individual who imposes such suspension precluded from continuing as a participant in the procedure set forth herein.

6.3 **Reinstatement.**

- 6.3.1 Upon sufficient proof that a Practitioner who has an impairment has successfully completed a rehabilitation or treatment program, the Peer Support Committee may recommend that the Practitioner's Privileges be reinstated. In making a recommendation that an impaired Practitioner be reinstated, the Peer Support Committee must consider patient care interests as paramount.
- 6.3.2 Prior to recommending reinstatement, the Peer Support Committee must obtain a letter from the Practitioner overseeing the rehabilitation or treatment program. The Practitioner undergoing rehabilitation or treatment shall agree to execute any and all necessary authorizations and releases so that reports/records from the treatment provider can be submitted to the Peer Support Committee. The letter from the treatment provider must, at a minimum, address the following:
- (1) The nature of the Practitioner's condition.
 - (2) Whether the Practitioner is participating in a rehabilitation or treatment program and a description of the program.
 - (3) Whether the Practitioner is in compliance with all of the terms of the program.
 - (4) To what extent the Practitioner's behavior and conduct need to be monitored.
 - (5) Whether the Practitioner is rehabilitated.

- (6) Whether an after-care program has been recommended to the Practitioner and, if so, a description of the after-care program.
 - (7) Whether the Practitioner is capable of resuming practice and providing continuous, competent care to patients.
- 6.3.3 Before recommending reinstatement, the Peer Support Committee may request a second opinion on the above issues from a Practitioner of its choice.
- 6.3.4 Assuming that all of the information received indicates that the Practitioner is capable of resuming care of patients, the following additional precautions shall be taken before the Practitioner's Privileges are reinstated:
 - (1) The Practitioner must identify at least one (1) Practitioner on the Active Medical Staff who is willing to assume responsibility for the care of his or her patients in the event of the Practitioner's inability or unavailability.
 - (2) The Practitioner shall be required to provide periodic reports to the Peer Support Committee from an approved Practitioner, for a period of time specified by the committee, stating that the Practitioner is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.
 - (3) If the Practitioner has an impairment relating to substance abuse he/she must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the Chief Operating Officer, the Medical Staff President, the chair of the Credentials Committee, or any member of the Peer Support Committee.
 - (4) Additional conditions may also be recommended for the Practitioner's reinstatement.
- 6.3.5 The final decision to reinstate a Practitioner's Privileges must be approved by the Chief Operating Officer in consultation with the Medical Executive Committee at its next regular meeting.
- 6.3.6 The Practitioner's exercise of Privileges in the Hospital shall be monitored by the Department Chair or by a Practitioner appointed by the Department Chair. The nature of that monitoring shall be recommended by the Peer Support Committee in consultation with the Medical Staff President and the chair of the Credentials Committee.

6.4 **Commencement of an Investigation**

- 6.4.1 Nothing in this Policy should be construed as requiring its implementation as a condition precedent to any action that might otherwise be taken pursuant to the Medical Staff Bylaws or AHP Policy including the initiation of corrective action proceedings.
- 6.4.2 The Hospital and the Medical Staff believe that issues of impairment can best be dealt with by the Peer Support Committee to the extent possible. If, however, the Peer Support Committee makes a recommendation, including a recommendation for an evaluation or a restriction or limitation on Privileges, and the Practitioner refuses to abide by the recommendation, the matter shall be referred the Medical Executive Committee for an investigation to be conducted pursuant to the Medical Staff Bylaws or AHP Policy, as applicable, and for appropriate reporting to state authorities, as may be required.

6.5 **Documentation and Confidentiality**

- 6.5.1 The original report and a description of any recommendations made by the Peer Support Committee shall be included in the Practitioner's credentials file. If the review reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the Practitioner's credentials file and the Practitioner's activities and practice shall be monitored until it can be established whether there is an impairment that might affect the Practitioner's practice. The Practitioner shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her credentials file.
- 6.5.2 The Chief Operating Officer or the Medical Staff President shall inform the individual who filed the report that follow-up action was taken. No individual who in good faith reports suspected impairment, or who otherwise participates in the procedure set forth herein, shall be retaliated against for such report or participation.
- 6.5.3 All individuals filing a report or otherwise engaged in the investigation of such report shall act appropriately and in a confidential manner and shall avoid speculation, conclusions, and gossip. All conversations regarding the matter shall be limited to those individuals who have a need to know.
- 6.5.4 If at any time it becomes apparent that the matter cannot be handled internally, or jeopardizes the safety of the Practitioner or others, the Chief Operating Officer may contact law enforcement authorities or other appropriate agencies.
- 6.5.5 All requests for information concerning the impaired Practitioner shall be forwarded to the Chief Operating Officer for response.

- 6.5.6 All letters, reports, minutes, or other writings or communication submitted or generated pursuant to this Policy shall be treated as confidential peer review documents to the full extent permitted by law. The identity of individuals providing information pursuant to this Policy, whether in writing or verbally, shall be maintained as confidential peer review information to the full extent permitted by law. It is the intent of the Hospital and the Medical Staff that all individuals who participate in the process set forth in this Policy, including those who provide information, shall be deemed to be engaged in a peer review activity and entitled to immunity to the full extent permitted by law.
- 6.5.7 The Credentials Committee and MEC shall be advised of matters resolved pursuant to this Policy, or currently pending, as part of the credentialing information needed to make recommendations regarding Medical Staff reappointment/regrant of Privileges, and for the purpose of evaluating, maintaining, and/or monitoring the quality of healthcare services provided by the Medical Staff at the Hospital.

**ARTICLE VII
MISCELLANEOUS**

7.1 Definitions

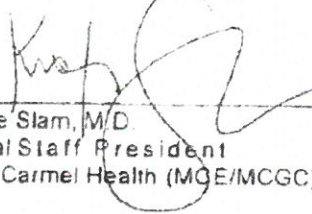
The definitions set forth in the Medical Staff Bylaws shall apply to this Credentials Policy unless otherwise specified herein.

7.2 Adoption and Amendment

This Credentials Policy may be adopted and amended in accordance with the applicable procedures set forth in the Medical Staff Bylaws.

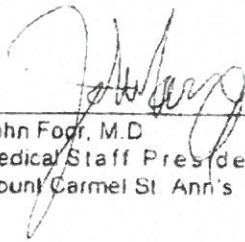
CERTIFICATION OF ADOPTION AND AMENDMENT

ADOPTED by the Medical Executive Committee on October 20, 2020.



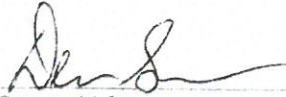
Kristine Slam, M.D.
Medical Staff President
Mount Carmel Health (MCE/MCGC)

ADOPTED by the Medical Executive Committee on October 19, 2020.



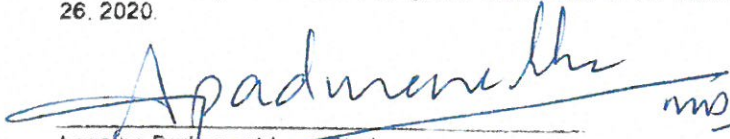
John Fogr, M.D.
Medical Staff President
Mount Carmel St. Ann's

ADOPTED by the Medical Executive Committee on October 19, 2020.



Derek Snook, M.D.
Medical Staff President
Mount Carmel New Albany

APPROVED by the Credentialing Sub-Committee of the Board of Trustees on October 26, 2020.



Anantha Padmanabhan, Chair
Credentialing Sub-Committee of the Board of Trustees
Mount Carmel Health System