

# **Saint Mary's Hospital**

## **Medical Staff Bylaws**

### **Volume II: Credentials Procedures**

**Approved by  
MEC: 11/11/2010  
Board of Directors: 11/09/2010:**

# St. Mary's Hospital Credentials Procedures

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## ARTICLE I.

### MEDICAL STAFF MEMBERSHIP

#### 1.1 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the Medical Staff of the Hospital are found in Volume I of these Medical Staff Bylaws in Article II, Section 2.1. In addition, the Board may impose further requirements on specific Practitioners where it believes these are warranted after a review of the Practitioner's credentials file, performance data, or other relevant material.

#### 1.2 CONDITIONS AND DURATION OF APPOINTMENT

##### 1.2-1 Initial Appointment and Reappointment

- a) Initial appointment and reappointment to the Medical Staff shall be made by the Hospital Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the MEC.
- b) Appointment to the Medical Staff will be for periods of twenty-four (24) calendar months (each an "appointment period").
- c) Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

##### 1.2-2 Reapplication After Modifications of Membership Status or Privileges

A Practitioner who has received a final adverse decision by the Board regarding membership or privileges, or who has resigned or withdrawn an application for appointment or reappointment or privileges while under investigation or to avoid investigation, will be ineligible to reapply to the Medical Staff or for privileges for a period of five (5) years from the date of such resignation or withdrawal or the date of notice of a final adverse action by the Board.

#### 1.3 LEAVE OF ABSENCE (LOA)

##### 1.3-1 Written Notice

A Medical Staff member may request, in writing, a voluntary leave of absence from the Medical Staff. Such request shall be received in the Medical Staff Services Department, at a minimum of thirty (30) days prior to the requested leave date. Request shall state the reason the Medical Staff member requests the leave and the exact period of leave time requested, which may not exceed one (1) year (exclusive of the time necessary to process an initial request or a request for reinstatement). Such request shall be submitted to the member's Clinical Service Chair, Medical Staff Credentials Committee, and MEC, which shall review such requests and recommend approval or disapproval to the Governing Board. The Governing Board shall make the final decision whether to approve or disapprove such request. Requests for a leave of absence will not be considered if the requesting member is under investigation, as described in Volume III, Investigation, Corrective Action and Fair Hearing Procedures of the Bylaws. In the event that a request for a leave of absence is approved, the Medical Staff member shall make necessary

arrangements to provide alternate coverage for patient care during his or her absence and shall complete all patient medical records before beginning his or her leave of absence. During the period of a leave, the staff member's membership status, Clinical Service affiliation, privileges and prerogatives, duty to pay Medical Staff dues, if any, and attendance requirements at Medical Staff , or Clinical Service meetings shall be suspended. In the event that the Board disapproves the request for a leave of absence, the affected staff member shall not be entitled to procedural rights unless otherwise provided in the Investigation, Corrective Action and Fair Hearing Procedures of the Medical Staff Bylaws.

#### 1.3-2 Obligations

A request for leave of absence shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

#### 1.3-3 Request to Return from LOA

Not less than forty-five (45) days prior to the termination of the leave, the Medical Staff member must request, in writing, reinstatement of his or her privileges. The Medical Staff member must submit a written summary of his or her relevant activities during the leave if so requested by members of the Clinical Service, Credentials Committee or MEC. Permission for reinstatement must be given by the Board. If the requested return date is past the time for the member's reappointment, he or she must submit a reapplication form and be reappointed before resuming his or her staff position.

#### 1.3-4 Failure to Request to Return from LOA

The failure of a Medical Staff member to request reinstatement from a LOA shall result in automatic relinquishment of membership status, Clinical Service affiliation and Privileges. The affected Practitioner shall not be entitled to procedural rights as outlined in the Investigation, Corrective Action and Fair Hearing Procedures of these Bylaws.

### 1.4 PHYSICAL HEALTH STATUS

#### 1.4-1 Health Requirements

Members of the Medical Staff and Practitioners holding privileges must maintain the physical and mental ability to deliver patient care and exercise privileges safely and at an appropriate level of quality at all times.

#### 1.4-2 Notification of Health Status

A Medical Staff member or Practitioner holding privileges must immediately report in writing to his or her Clinical Service Chair (or his or her designee), Chair of the Medical Staff Credentials Committee, or an Officer of the Medical Staff when he has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted privileges safely and at an appropriate level of quality at all times (as determined by the Practitioner, a treating physician, or a health care facility). Failure to do so may result in Corrective Action.

1.4-3 Health Examination

At any time that the MEC or Board have any reason to question whether a Practitioner has the requisite physical and/or mental health status to care for patients safely and with an appropriate level of care and skill, it may require that Practitioner to undergo an appropriate health examination. The nature and scope of the exam (including drug testing) and the examining clinician may be determined at the discretion of the MEC and/or Board. Where there is a concern that a Practitioner may be impaired by use of or addiction to drugs or alcohol, such examination may include the imposition of random drug or alcohol testing. Refusal of a Practitioner to comply with a request to submit a health examination will be considered a voluntary resignation from the Medical Staff and/or relinquishment of privileges.

## ARTICLE II

### PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

#### 2.1 GENERAL PROCEDURE

The Medical Staff through designated Clinical Services, committees, and officers shall evaluate and consider each application for appointment or reappointment and clinical privileges and each request for modification of staff membership or privileges and shall adopt and transmit recommendations to the Hospital Board. In the processing of applications for membership and privileges, references to Hospital shall include the organization's Medical Staff Services Department and its personnel.

#### 2.1-1 CREDENTIALS COMMITTEE

##### Composition

Membership of the Medical Staff Credentials Committee shall consist of at least five (5) members of the Active Medical Staff who are experienced leaders. The Medical Staff President, with input from the Clinical Service Chairs and with the confirmation of the MEC, will appoint the chair and other members of the Credentials Committee. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third 1/3 of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his or her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite ex officio members as desired.

##### Meetings

The Medical Staff Credentials Committee shall meet at least monthly. More frequent meetings may be scheduled upon on the request of the Credentials Committee chair.

##### Responsibilities

To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

To review and recommend action on all requests regarding Privileges from eligible Practitioners;

To recommend eligibility criteria for the granting of Medical Staff membership and Privileges;

To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff members or Hospital leaders;

To perform such other functions as requested by the MEC.

## Confidentiality

The Credentials Committee shall function as a Peer Review committee consistent with federal and state law. All members of the Credentials Committee shall, consistent with medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the Credentials Committee.

The credentials file is the property of the Hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical Staff officers and the CMO or his or her designee may access credential files for appropriate Peer Review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

Individual Practitioners may review their credentials file under the following circumstances:

Upon request which is authorized by the Credentials Committee chair, Clinical Service chair or the CMO. Review of such files will be conducted in the presence of the Medical Staff Services Department, a Medical Staff officer, or a designee of Hospital administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a Practitioner. Nothing may be removed from the file. The Practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of any review.

## 2.2 APPLICATION FOR INITIAL APPOINTMENT

### 2.2-1 Application Request form and Application Form

Any qualified practitioner who wishes to apply for membership on the Medical Staff shall contact the Hospital to request an application. Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form issued by the Hospital and signed by the applicant.

Upon request for an application, the Medical Staff Services Department will forward the Practitioner an application request form as well as an application for appointment to the medical staff and/or request for clinical Privileges. The packet will also contain a complete set or overview of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and other required documents or reference to an electronic source for this information. The information provided to the applicant will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership and/or Privileges (if such expectations have been adopted by the Medical Staff).

If the applicant believes he/she meets the outlined eligibility criteria, he/she will so attest by signing the application request form and then may complete the application and return both documents along with applicable delineation of privilege forms to the Medical Staff Services Department. Upon receipt of the application request form, the information provided will be reviewed to determine the applicant's eligibility to apply for membership and/or privileges. If it is determined that the applicant is not eligible to apply, the applicant will be so informed. If it is determined the applicant is eligible to apply, the submitted application will be processed.

## 2.2-2 Content of Application Form:

The application for appointment shall be in a form determined by the Hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but are not limited to, the following information:

- a) Acknowledgement and Agreement: A statement signed by the applicant to the effect that he or she has read and agrees to be bound by the Bylaws and any Medical Staff policies or procedures that are provided to the applicant as part of the application process. The applicant also agrees to be bound by these documents in all matters relating to consideration of his application whether or not he is granted membership and/or clinical privileges. Furthermore, the applicant agrees that if he is granted Medical Staff membership and/or privileges, he agrees to follow and be bound by any and all Medical Staff, Hospital, and Hospital policies and meet all the responsibilities of Medical Staff membership.
- b) Qualifications: Detailed information concerning the applicant's qualifications, including information in order to satisfy the Basic Eligibility and Qualifications of Medical Staff Membership (Article II of the Bylaws) and of any additional qualifications necessary to be granted any Privileges requested.
- c) Requests: Specific requests stating the Clinical Service and the Privileges for which the applicant wishes to be considered. The applicant shall be eligible to request only those privileges for a clinical service the Board has authorized the Hospital to perform.
- d) Peer References: The names of at least two (2) practitioners who have worked with applicant and observed his or her professional performance and who can provide references as to the applicant's professional ability and judgment, ethical character, and ability to work cooperatively with other Practitioners and Hospital personnel, such that patients treated by him receive quality care delivered in a professional and efficient manner. Information provided by the reference should address the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. In general, peer references should be submitted on a peer reference form provided by the Hospital and/or the reference should answer specific questions posed on this form.
- e) Ethical Pledges: A pledge signed by the applicant agreeing to provide professional services in an ethical manner and to adhere to generally recognized professional ethics, the Medical Staff Code of Conduct Policy, and the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops.

f) Professional Sanctions: Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to all other Practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

- membership/fellowship in a local, state or national professional organization;
- staff membership status or clinical privileges at any other Hospital or health care institutions;
- specialty board certification;
- licensure to practice any profession in any jurisdiction;
- Drug Enforcement (DEA) registration or a state controlled substance license; or
- Information as to any current or pending sanctions, affecting participation in any Federal Healthcare Program or any actions which cause the Practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included.

g) Criminal Proceedings: Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

h) Felony Convictions: Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any.

i) Alcohol or Substance Abuse: The applicant shall attest to past instances of alcohol and/or substance abuse and shall submit to any testing required by the Hospital and/or Medical Staff prior to being granted privileges.

j) History of Medical Staff Membership: A chronological history listing all of the applicant's past medical staff memberships and associated privileges, including the full addresses of the facilities at which such memberships or privileges were held.

k) Professional Employment History: A chronological history of applicant's entire employment history as a health care professional.

l) Education and Training History: A chronological history of the applicant's undergraduate education, all graduate education in the health care field, and all post-graduate training (internships/residencies) in a health care field.

- m) Notification of Release and Immunity Statement: Such releases, waivers, and authorizations as are presented to the applicant by the Hospital or HSHS. These will include a statement signed by the applicant authorizing and consenting to allow Medical Staff and Hospital representatives to provide other Hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital or Medical Staff may have concerning the applicant. This statement will also release from liability the Hospital, its Medical Staff, and their representatives for sharing with appropriate health care and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for staff appointment and privileges, including information otherwise privileged or confidential, to the full extent permitted by Illinois law. The applicant promises not to sue and to hold harmless all individuals who either provide information from or to the Hospital pertaining to the evaluation of the application, reapplication or privileges being requested.
- n) Professional Liability Actions: Particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and information concerning any cancellation, non-renewal, or limitation of malpractice insurance coverage.
- o) Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of Hospital resources, as may be deemed relevant by the MEC and the Hospital Board.
- p) Minimum Basic Criteria: The following basic criteria must be appropriately documented and the information reasonably confirmed:
- Evidence of Current Licensure: (unrestricted Illinois State License, unrestricted Federal DEA as appropriate to specialty). Licensure is verified with the primary source, copies of license are not necessary unless otherwise required.
  - Relevant Training, Board Certification, and/or Experience for Physicians (MD/DO): Relevant training and experience will be verified via the primary source or a designated equivalent, when feasible. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) in the area of requested privileges.

Board certification or board status will be verified through the primary source or a designated equivalent source. Applicants will be currently board certified in the area of requested privileges or become board certified within six (6) years of becoming eligible as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association or equivalent as determined by the Credentials Committee and will be required to maintain board certification in the area of requested privileges.

Exceptions: All practitioners who are current medical staff members and/or hold privileges as of January 1, 2011 and who have met prior qualifications for membership and/or privileges shall be exempt from initial board certification requirements. If board certified, these individuals shall be required to maintain board certification to maintain clinical privileges.

- Relevant Training and/or Experience for Dentists: Relevant training and experience will be verified via the primary source, when feasible. A dentist, DDS or DMD, must have graduated from an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation.
- Relevant Training, Board Certification, and/or Experience for Podiatric Physicians: Relevant training, board certification, and/or experience will be verified via the primary source, when feasible. A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within six (6) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.
- Current Competence: Recent letters of verification from the applicant's residency program director or designee if residency training was within ten years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board. Written documentation from individuals personally acquainted first hand with the applicant's recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, types of medical conditions managed as the responsible physician, clinical judgment and technical skills, and professional conduct.

- Ability to Perform Privileges Requested (Health Status): A health status statement provided by the Hospital and signed by the applicant indicating that no physical or mental health problems exist that could affect his or her practice, Medical Staff membership and the privileges granted by the Board. This document should be confirmed by the director of the applicant's training program, a chief of service or Medical Staff President at another Hospital, or a qualified physician who has examined the applicant.
- Possess current, valid professional liability insurance that covers all privileges requested with an insurance carrier authorized by the State of Illinois Department of Insurance as a licensed provider of professional malpractice insurance. Insurance must be carried in a form and amount as determined from time to time by the Board, and in no event less than \$1 million/\$3 million dollars in the aggregate coverage;
- Have a practice or residence close enough to the Hospital to provide timely and continuous care for their patients as determined by the Board;
- Be eligible to participate in Medicare, Medicaid, and other federally sponsored health programs;
- Be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect at all times. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations.

The Board may approve exceptions to the above Section 2.2-2, (p) on a case-by-case basis and after consultation with the MEC.

### 2.3 APPLICATION FEE

A non-refundable fee, in an amount established by the MEC and ratified by the Board, shall be payable upon request at the time of application for appointment or reappointment. Applications submitted without an accompanying fee will not be accepted for processing.

## 2.4 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

- a) Agrees to provide in a timely fashion any information to complete the application and to resolve any questions relating to his application that are requested or posed by Medical Staff, Hospital, or Board representatives. A completed application must be signed and dated and must include: a current picture ID card issued by a state or federal agency; copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency; a completed privilege delineation form; completed reference forms from peers knowledgeable about the applicant's competence to perform the privileges being requested; practitioner specific quality and clinical outcome data if available; all applicable fees.
- b) Agrees to appear for interview(s) upon request.
- c) Authorizes Hospital representatives to consult with other Hospitals and medical staffs who have been associated with the applicant and with anyone who may have information bearing on the applicant's clinical competence and qualifications for Medical Staff membership or privileges.
- d) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional and ethical qualifications for staff membership.
- e) Agrees that in the event of any adverse recommendations or decisions with respect to staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.
- f) Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information to Hospital representatives concerning the applicant's competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical privileges.
- g) Signifies that the information submitted in his or her application is true to the best of his knowledge and belief and that he/she understands that any significant misstatement(s) on or omission(s) from his application shall constitute grounds for rejection of the application.
- h) Agrees to provide to the Medical Staff Services Department, any requested information needed to process the application within forty-five (45) days of request or the application will be considered to be voluntarily withdrawn.

## 2.5 PROCESSING OF INITIAL APPLICATIONS

### 2.5-1 APPLICANT'S BURDEN

The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training, professional conduct, clinical competence, and ability to adequately perform the privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in associated Medical Staff procedures. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

### 2.5-2 APPLICANT INTERVIEW

All applicants for appointment to the Medical Staff and/or clinical Privileges may be required to participate in an interview at the discretion of the Clinical Service Chair, Medical Staff Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video or computer link at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant, to ask clinical questions pertaining to the privileges being requested and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

### 2.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Hospital, which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and supporting materials to the Clinical Service Chair to which the applicant will be assigned if granted staff membership.

If the requirements of Article II, Volume II of these Bylaws are not met, the applicant will be notified that he or she is ineligible to apply for membership or privileges. The application will not be processed and no right to due process or to a hearing will be triggered.

### 2.5.4 CLINICAL SERVICE CHAIR REVIEW

The relevant Clinical Service Chair, or designee, shall review the completed and verified application and supporting documentation for completeness and for the purposes of determining the character, professional competence, qualifications, and ethical standing of the applicant to fulfill the requirements of Staff membership and/or the Privileges requested.

The Clinical Service Chair may conduct an interview with applicant and shall utilize appropriate sources of information, request additional information from the applicant or elsewhere as needed, and evaluate applicant references, to determine whether the applicant satisfies the criteria set forth in the Bylaws relating to membership on the Medical Staff, and to determine whether the applicant possesses those professional and ethical qualities necessary to the provision of quality medical care. The Clinical Service Chair shall transmit a written report to the Medical Staff Credentials Committee and MEC as to Medical Staff appointment and, if appointment is recommended, as to the Staff category, Clinical Service affiliation, clinical Privileges to be granted, and any special conditions to be attached to the appointment. A Clinical Service Chair may also recommend that the Credentials Committee defer action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Chair, all of which shall be transmitted with the report.

#### 2.5-5 CREDENTIALS COMMITTEE ACTION

Once the Clinical Service Chair has reported on an application, the verified application and its supporting materials shall be forwarded by the Medical Staff Services Department to the Medical Staff Credentials Committee. This Committee shall review the application, supporting documentation, the Clinical Service Chair's report; and such other information available to it that may be relevant to consideration of the applicant's qualifications and it may conduct a personal interview.

After its review of the applicant's credentials, the Credentials Committee shall submit, together with the Clinical Service Chair report, a written recommendation to the MEC. This recommendation shall address the applicant's request for Medical Staff membership and category, or Clinical Service affiliation, Privileges, and any specific conditions relating to appointment and/or Privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

#### 2.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next meeting after receipt of the reports and recommendations of the Clinical Service Chair and the Medical Staff Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant's qualifications the MEC shall transmit to the Hospital Board a written report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend Staff category and Clinical Service affiliation. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s).

If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.

## 2.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation together with supporting documentation shall be forwarded to the Board.

Deferred: Any action by the MEC to defer a recommendation on the application in order to carry out further evaluation must be followed up within sixty (60) days with a recommendation to the Board.

Adverse Executive Committee Recommendation: When the MEC recommends denial or a restriction of membership or a requested privilege based on a determination of unprofessional conduct or inadequate clinical competence, the Medical Staff President or CEO shall inform the Practitioner by special notice within ten (10) days. The Practitioner shall be entitled to the procedural rights as provided in the Investigation, Corrective Action and Fair Hearing Procedures of the Medical Staff Bylaws. The Hospital CEO and Hospital Board shall also be notified.

## 2.5-8 ACTION OF THE HOSPITAL BOARD

### Applicants for Consideration by the Full Board

At its next meeting after receipt of the reports and recommendations of the MEC regarding an initial application for membership and/or privileges, the Hospital Board shall consider and act on such recommendations. If the Hospital Board decides to defer action on the application pending further consideration by the MEC, or if the Hospital Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Hospital Board by the MEC within sixty (60) days. At the meeting next following the receipt of the second report of the MEC, the Hospital Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation it shall act to grant the requested membership and/or privileges. The Board's decision and the notice of appointment shall include:

- the Staff category to which the applicant is appointed;
- the Clinical Service to which he or she is assigned;
- the Privileges he or she may exercise; and
- any special conditions attached to the appointment or exercise of privileges

If the recommendation of the MEC is adverse to the applicant because of concerns about professional competence or conduct, the Board will then determine its decision on the request for membership and/or privileges. Following the Board's adverse decision, if the applicant requests a fair hearing, the Board will make a determination on the applicant's requests which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, the Board's final determination will result from the decision made by the Board appellate review panel.

### Board Consideration of Expedited Applications:

A Board Executive Committee, composed of at least two (2) voting members of the Board may conduct an expedited credentials review when applicants present applications that raise no clear concerns from the MEC and/or members of the Board Executive Committee. In particular, the following criteria must be met in order to complete an expedited credentials review:

- (1) Applicant submits a completed application;
- (2) MEC makes a final positive recommendation and without limitation(s);
- (3) There are no current challenges or previously successful challenges to the applicant's licensure or registration;
- (4) Applicant has never received an involuntary termination of medical staff membership at another organization;
- (5) Applicant has never received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- (6) There is not an unusual pattern of, or extensive number of, professional liability actions.

This list is not exhaustive and the Hospital Board or the Board Executive Committee shall have the discretion to determine whether or not an application qualifies for expedited review.

After reviewing the recommendations of the MEC, a positive decision by the Executive Committee of the Board shall result in the status and/or privileges requested. If the decision by the Executive Committee of the Board is adverse the matter will be referred to the full Board for further evaluation at its next regularly scheduled meeting.

The full Board shall consider and ratify all positive committee decisions at its next regularly schedule meeting. If the Board does not ratify the positive recommendation of its Executive Committee, the application will be handled as in the same manner as an application that has not received expedited review.

### 2.5-9 CONFLICT RESOLUTION

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter for conflict resolution through the use of meetings and, if necessary, formation of a Joint Conference Committee as provided in Section 10.4 of Volume I of these Medical Staff Bylaws. Any such joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

### 2.5-10 NOTICE OF FINAL DECISION

Notice of the final action of the Hospital Board on an applicant shall be given to the Hospital CEO who will provide the applicant with either a written offer of membership and/or Privileges and/or special notice of any adverse action on the application in a timely manner. The Hospital Board shall give notice of its final decision through the Hospital CEO to the Medical Staff President, the MEC, and the appropriate Clinical Service Chair.

## 2.5-11 TIME PERIODS FOR PROCESSING

Applications for Medical Staff appointment and/or privileges shall be considered timely and in good faith by all individuals and groups required by Medical Staff Bylaws and policies to act upon them and shall be processed whenever possible within the time periods specified in this section. Any application that remains incomplete after six (6) months shall be considered voluntarily withdrawn.

Within forty-five (45) days after receipt by the Clinical Service Chair of a completed application for membership and/or clinical privileges, the Clinical Service Chair report shall be submitted to Medical Staff Credentials Committee.

Within sixty (60) days after the receipt of the Clinical Service Chair's report, the Medical Staff Credentials Committee through its Chair shall submit a written recommendation to the Medical Executive Committee.

Within sixty (60) days after receipt of recommendations from the Medical Staff Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or privileges to the Hospital Board.

The Hospital Board will act on recommendations from the MEC at its next regularly scheduled meeting that shall occur within ninety (90) days.

The time periods in this section are guidelines and deviations will not entitle the applicant to any procedural due process rights.

## 2.6 REAPPOINTMENT PROCESS

### 2.6-1 APPLICATION FOR REAPPOINTMENT

Reappointment will be for a period of two (2) years. At least one hundred twenty (120) days prior to the expiration date of current appointment of membership and/or privileges, the Hospital shall provide each Practitioner with an updated application form for reappointment and any required Hospital specific forms and documents for completion which must be received prior to the reappointment application being acted upon. Each Practitioner who desires reappointment shall, at least sixty (60) days prior to such expiration date must complete such forms and return them to the Hospital. Failure to return the completed form(s) prior to such expiration date may, at the discretion of the Hospital, be considered a voluntary resignation of membership and clinical privileges effective at the end of the Staff member's current term.

### 2.6-2 CONTENT OF APPLICATION

The application for reappointment shall be in a prescribed form setting forth, without limitation, the following information:

- a) Specific requests setting forth the category of Staff membership to which the applicant seeks to be reappointed, the Clinical Service to which the applicant seeks membership, and the privileges for which the applicant wishes to be considered.

- b) Continuing training, education, and experience that qualify the Staff member for the privileges sought on reappointment. Continuing education must relate, at least in part, to the privileges requested and is provided to the Hospital upon request.
- c) A statement that no health problems exist that could affect the applicant's ability to perform the privileges requested.
- d) The name and address of any other health care organization or practice setting where the Staff member provided professional services during the preceding appointment period.
- e) Any membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations.
- f) Current, unrestricted State License, Drug Enforcement (DEA) and State Board of Pharmacy License, as applicable.
- g) Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other Practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:
  - 1) staff membership status or clinical privileges at any other Hospital or health care institutions;
  - 2) membership/fellowship in a local, state or national professional organization;
  - 3) licensure to practice any profession in any jurisdiction; or
  - 4) Drug Enforcement (DEA) registration;

If any such actions were ever taken or if any such actions are now pending, the particulars thereof shall be included.
- h) National Practitioner Data Bank (NPDB) information which will also be checked during reappointment/renewal of privileges and whenever new privileges are requested.
- i) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.
- j) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.
- k) Evidence of continuous malpractice insurance coverage in an amount that may be determined from time to time by action of the Board,

- l) A list of all malpractice complaints filed against the Practitioner and the particulars regarding any adverse malpractice decisions or settlements.
- m) Such other specific information about the Staff member's professional ethics, qualifications, and ability that may bear on his ability to provide medical or surgical care in the Hospital.

#### 2.6-3 COMPLETION AND VERIFICATION OF INFORMATION

The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the Staff member's professional activities, performance and conduct in the Hospital and query reports from the National Practitioner Data Bank shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his qualifications and of resolving any questions regarding such qualifications. When collection and verification has been completed and the Hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Clinical Service Chair to which the applicant is assigned.

#### 2.6-4 CLINICAL SERVICE CHAIR REVIEW

The Clinical Service Chair or designee shall review the application for reappointment and all other pertinent information, including all supporting documentation. Such review shall consist of an appraisal of the following factors, without limitation:

- a) Professional performance, including applicant's patterns of practice in the performance improvement program, data from ongoing professional practice evaluation, utilization review, infection control activities, blood utilization, operative and invasive procedure review, medical records review, and pharmacy and therapeutic review, as appropriate.
- b) The privileges currently exercised by the applicant and the basis for any requested modifications.
- c) Applicant's health status, where relevant to ensure the safe practice of the privileges requested.
- d) Applicant's participation in relevant continuing education programs.
- e) Applicant's attendance at meetings of the Medical Staff and of the Clinical Service, as applicable.
- f) Applicant's service on Medical Staff and Hospital committees.
- g) Applicant's record relating to timely completion of medical records.
- h) Applicant's demonstrated ability to work cooperatively with other Practitioners and Hospital personnel, to comply with policies on professional conduct, and to avoid unprofessional conduct in the Hospital that may have a disruptive effect on patient care or impede the efficient and safe operation of the Hospital.

- i) Applicant's record of compliance with the Medical Staff Bylaws, rules, regulations and policies of the Medical Staff and with Hospital policies applicable to Medical Staff members or Practitioners granted privileges.

#### 2.6-5 ACTION OF THE CLINICAL SERVICE CHAIR

The Clinical Service Chair shall review the application and information in the Practitioner's file and shall submit his/her recommendation or report to the Credentials Committee regarding the reappointment of and/or privileges to be exercised by such member. The Clinical Services Chair report shall contain the following, without limitation:

- a) Recommendation or report for reappointment or denial of reappointment, including any suggested restrictions or conditions on reappointment.
- b) Report for Clinical Service affiliation and Staff category.
- c) The Privileges to be granted, including any restrictions on such Privileges.

#### 2.6-6 MEDICAL STAFF CREDENTIALS COMMITTEE ACTION

The Medical Staff Credentials Committee shall review each application and all other relevant information available to it, including the relevant Clinical Service Chair report. The Credentials Committee may choose to interview the applicant prior to rendering a recommendation. The Credentials Committee shall make a report to the Medical Executive Committee regarding its recommendations on the application for reappointment. The report of the Credentials Committee shall contain the same specific types of recommendations contained in the Clinical Service Chair report as set forth in the section above. The report of the Credentials Committee shall be accompanied by all relevant documentation, including the application, supporting information, and the Clinical Service Chair report.

#### 2.6-7 MEDICAL EXECUTIVE COMMITTEE ACTION

The Executive Committee shall review each application for reappointment and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the Hospital Board regarding its recommendations on the application for reappointment. The report of the MEC shall contain the same specific types of recommendations contained in the report of the Credentials Committee. The report of the MEC shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

#### 2.6-8 FINAL PROCESSING AND BOARD ACTION

Following the report of the Executive Committee to the Hospital Board, the procedure provided in the Credentials Procedures relating to initial applications shall be followed and the Hospital Board shall render a decision prior to the expiration date of the applicant's appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be addressed through the conflict resolution process as described in Section 10.4 in Volume I of these Bylaws.

2.6-9 BASIS FOR RECOMMENDATION

Each recommendation concerning the reappointment of a Practitioner's membership and/or Privileges shall be based upon review not only of those matters set forth in the Medical Staff bylaws and policies pertaining to such Practitioner, but also on any other information bearing on the ability and willingness of the Practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

2.7 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department affiliation, or clinical Privileges by submitting a written application to the Hospital in such form as may be prescribed by the MEC and the Hospital Board. Such Staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment to Medical Staff membership, except that the pertinent time limits shall be those applicable to appointments to Medical Staff membership, as provided in this Credentials Procedures.

2.8 EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES

Reappointments approved by the Hospital Board, including privileges awarded in connection with such reappointments, modifications of categories of Staff membership, Department, Division or Clinical Service affiliation, and/or Privileges, shall take effect on the date such modifications are approved by the Hospital Board.

## ARTICLE III

### DETERMINATION OF PRIVILEGES

#### 3.1 EXERCISE OF PRIVILEGES

Practitioners providing clinical services at the Hospital shall be entitled to exercise only those Privileges specifically granted to them by the Hospital Board, or emergency or disaster privileges as described in these Credentialing Procedures.

#### 3.2 DELINEATION OF PRIVILEGES IN GENERAL

##### 3.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical Privileges desired by the applicant. Practitioners who are ineligible for Medical Staff membership may apply for Privileges by requesting an application form from the Hospital. A request by a Practitioner for Privileges or the modification of privileges must be supported by all requested documentation regarding appropriate licensure, training and the evidence of current competence. Privilege requests will not be processed where the applicant does not meet the eligibility requirements to be granted the privilege at St. Mary's Hospital.

##### 3.2-2 Basis for Determinations of Privileges

Privileges shall be determined on the basis of the Practitioner's prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of Practitioner-specific performance improvement activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions and health care settings where a Practitioner exercises privileges. It is the burden of the Practitioner applying for Privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request.

Residents or fellows in training in an approved ACGME program and acting under the auspices of that program will not be required to request specific privileges. They must carry out any clinical care in accordance with the written educational protocols developed by the Hospital CMO and their training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how trainees' level of responsibility and scope of practice may expand over time and how this information will be transmitted to staff and personnel working in the Hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of its trainees and alert it to any performance concerns or matters that may threaten patient safety. The training program must work with the MEC to assure that all supervising Practitioners hold privileges commensurate with their oversight activities.

### 3.2-3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article II of this document (Volume II). Requests for privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular privilege for any Practitioner at the Hospital; where the privilege requested is covered by an exclusive contract granted by the Hospital Board and the requesting Practitioner is not a party to the contract or provider under the contract; or where the requesting Practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the Hospital's delineation of privileges documents.

### 3.2-4 New Technology or Cross-Specialty Privileges

In the event a Practitioner requests a privilege for which the Hospital has not adopted criteria (e.g. for a new technology, procedure, modality or multi/cross-specialty privilege), the request may be tabled for a reasonable period of time, usually not in excess of ninety calendar days. During this time the MEC and Board will review the community, patient, and Hospital need for the privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that privilege. Senior management will resolve any non – exclusive or exclusive contract issues as appropriate to avoid violating the contract provisions. The Medical Staff Credentials Committee will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with input of the MEC and approval by the Board, the necessary education, training, experience and evidence of current competence that will be required to request and be granted the privilege. Once these steps are taken, a request for the privilege will be evaluated.

The procedure to be used in determining if a procedure, modality of care or treatment requires new/updated/different competency criteria prior to being eligible to request and be granted the privilege by the Board is as follows:

When the Clinical Service Chief, or two (2) or more members of the Credentials Committee determine that two (2) or more of the following criteria are significantly different than the current privilege; new/additional competency criteria will be developed by the Credentials Committee: skill, knowledge, technique, equipment, risk, judgment or ability to manage complications the procedure, modality of care or treatment.

### 3.3 Confirmation of Competency to Hold Privileges

All Privileges that are initially requested by new applicants or existing members of the Medical Staff are subject to a time limited period of focused professional practice evaluation (FPPE). The Credentials Committee, after receiving a report from the Clinical Service Chair will define the conditions that warrant review/evaluation of the performance of each practitioner as part of the initial grant of clinical privileges at the Hospital. Review and monitoring may utilize retrospective, prospective, or concurrent review, including but not limited to: chart review, the monitoring and review of performance (factors) or indicators, external peer review, simulations, clinical reviews, and discussion with other healthcare individuals who have observed and/or participated in patient care with that practitioner. The Credentials Committee will define the duration for FPPE and the triggers that indicate the need for performance review and evaluation.

The medical staff participates in ongoing professional practice evaluation (OPPE) to identify practitioner practice outcomes and trends that impact the safety and quality of patient care. Information from the OPPE process will be used by leaders to determine if existing privileges are maintained, revised or revoked prior to or at the time of reappointment. The OPPE is part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to a FPPE when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

### 3.4 TEMPORARY CLINICAL PRIVILEGES

#### 3.4-1 Circumstances

Temporary privileges may be granted to a Practitioner who meets one of the following circumstances and the minimum criteria as defined below:

##### a) Important Patient Care Need

Temporary privileges may be granted on a case-by-case basis when an important patient care need or service mandates an immediate authorization to practice for a limited time—up to 120 days.

In special circumstances upon receipt of a written request, an appropriately licensed Practitioner of documented competence, who is not an applicant for membership or privileges, may be granted temporary privileges for the care of one or more specific patients.

At a minimum, the Practitioner must possess an unrestricted Illinois state license, unrestricted DEA registration, unrestricted State controlled substances certificate, certificate of current professional liability insurance in amounts satisfactory to the Hospital, membership in good standing in a primary practicing facility, acceptable National Practitioner Data Bank report, verbal or written reference establishing competency for the privileges requested.

##### b) Pendency of Application for Permanent Medical Staff:

Temporary clinical privileges may be granted for permanent medical staff membership and privileges, provided the application is complete, and the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. All required verifications and processes as outlined in Article II of Volume II of these Bylaws must be completed and the application is awaiting review and recommendation of the Medical Executive Committee. Such persons may only attend patients for a period not to exceed 120 days.

### 3.4-2 Conditions

Temporary privileges shall be granted by the Hospital CEO (or designee) acting on behalf of the Board and based on a recommendation of the Medical Staff President (or designee) and Clinical Service Chair. Before temporary privileges are granted, the Practitioner must first acknowledge in writing that he or she has received and read copies of the Medical Staff Bylaws and all other Medical Staff and Hospital policies relevant to his performance of temporary privileges, and that he agrees to be bound by them.

### 3.4-3 Termination

On discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the Medical Staff President or, in his absence, the Clinical Service Chair of which the Practitioner is a member, may terminate any or all of such Practitioner's temporary privileges. Where the life or well-being of a patient is determined to be endangered by continued treatment by a Practitioner exercising temporary privileges, the termination may be effected by any person entitled to impose Precautionary Suspensions under the Bylaws. In the event of such termination, the patients of such Practitioner then in the Hospital shall be assigned to another Practitioner by the Medical Staff President or, in his absence, by the Chair of the appropriate Department or Clinical Service Chair. Where feasible, the wishes of the patient shall be considered in choosing a substitute Practitioner.

### 3.4-4 Procedural Rights

A Practitioner shall not be entitled to procedural rights because of the denial of any request for temporary privileges, or because of any termination or suspension of temporary privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

## 3.5 EMERGENCY PRIVILEGES

In case of an emergency, any Medical Staff member attending a patient shall be expected and permitted to do everything in his or her power and to the degree permitted by his or her license, to save the life of the patient or prevent significant and disabling morbidity regardless of the member's Medical Staff status, Clinical Service affiliation or privileges. This duty shall be subject to the Medical Staff member's concurrent duty to take into account or abide by a patient's directive under the Illinois law to withhold or withdraw life-sustaining procedures, or to take into account 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 situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff who holds privileges appropriate to address the patient's medical conditions.

## 3.6 DISASTER PRIVILEGES

### 3.6-1 Authority

The authority to implement disaster privileges is at the direction of the Hospital Command Center, in consultation with the Medical Staff leadership, in the event the Emergency Management Plan is activated and the Hospital is unable to handle immediate patient care needs. One of the following individuals may grant disaster privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster:

- CEO or designee
- Medical Staff President or any elected Officer of the Medical Staff
- Credentials Chair
- Clinical Service Chair

### 3.6-2 Eligible Physician

Disaster privileges may be granted only to physicians, who hold a license in the State of Illinois to practice medicine and who volunteer their services but do not possess medical staff privileges at St. Mary's Hospital.

Primary source verification of licensure 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 circumstances where primary source verification cannot be completed within 72 hours, it will be completed as soon as possible. Reason for the Hospital's inability to verify will be documented with the following:

- 1) Reason primary source verification not completed in the specified time period
- 2) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
- 3) Attempts to rectify the situation as soon as possible.

### 3.6-3 Scope of Privileges

Volunteering physicians shall be paired with and supervised by a currently credentialed medical staff member. An approved form of identification must be worn at all times while volunteering at the Hospital. Scope of privileges for the volunteering physician shall be consistent with minimum core privileges and as determined by the onsite-supervising physician.

Within 72 hours of disaster privileges being granted the medical staff leadership will make a determination of the professional practice of the volunteer physicians and the need for continuation of disaster privileges.

### 3.6-4 Termination of Privileges

Disaster privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the Hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not cable of rendering services in an emergency such privileges shall be immediately terminated.

### 3.7 Telemedicine Privileges

Telemedicine privileges shall be granted to Practitioners who have either total or shared responsibilities for patient care, treatment, and services through a telemedicine link.

All Practitioners who provide services via a telemedicine link shall be credentialed and privileged to do so at the Hospital using the same processes as any other applicant for Medical Staff Privileges. If the applicant holds telemedicine privileges at more than ten (10) facilities within the United States, a random representative sample of at least 5 (five), including the primary facility along with the most recent 3 (three), facilities will be chosen for affiliation verifications and demonstrated competence.

The Practitioner must concurrently maintain privileges at a primary facility for the same scope of services as he or she is requesting at the Hospital.

The approval process for telemedicine staff privileges shall be the same process as outlined in Article II, Procedures for Appointment and Reappointment of the Credentials Procedures, Volume II.

Practitioners requesting telemedicine privileges shall be eligible for temporary privileges via the process outlined in the Temporary Privileges section of these Credentials Procedures.

### 3.8 Dental and Podiatry Privileges:

The scope and extent of surgical procedures that a dentist or podiatrist may perform shall be specifically delineated by the appropriate Clinical Service Chair. All such surgical procedures shall be performed under the overall responsibility of the appropriate Clinical Service Chair. A physician member of the Medical Staff shall be responsible for the care of any medical problems of a dental or podiatry patient that may be present or arise during hospitalization.

## ARTICLE IV

### PRACTITIONERS PROVIDING CONTRACTED SERVICES

#### 4.1 Exclusive Agreements

The Hospital Board may from time to time determine that specified Hospital clinical services will be provided on an exclusive basis pursuant to a contract or letters of agreement between the Hospital and specific qualified Practitioners. Privileges covered by such exclusive agreements will be available only to Practitioners who are specified under the terms of such agreements. Applications for initial appointment to provide services or requesting privileges that are covered under the exclusive arrangement will not be eligible for consideration and processing unless submitted in accordance with such arrangements. Practitioner's who have previously been granted privileges that become subject to an exclusive arrangement made by the Hospital will not be able to exercise those privileges unless they become a party to the agreement. Any Practitioner who will provide clinical services pursuant to an exclusive agreement issued by the Hospital will be required to meet the same qualifications and undergo the same evaluation and approval process for privileges as any other applicant. However, the exclusive contract may require such Practitioner to meet higher qualifications for privileges than those established for applicants who are not subject to the exclusive agreement.

#### 4.2 Termination of Contracted Arrangements

The effect of expiration or other termination of a contract for employment or professional services between the Hospital and a Practitioner upon that Practitioner's staff appointment and privileges will be governed solely by the terms of the Practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's staff appointment status or privileges. Where Medical Staff membership or privileges are terminated under the terms of such contracts the Practitioner will not have recourse to the due process provisions described in the Medical Staff Investigation, Corrective Action and Fair Hearing Procedures.