# BYLAWS

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DEFINITIONS

The following definitions shall apply to terms used in this policy:

1. “Board” or “Board of Directors” shall mean the governing body of Saint Francis Healthcare, which has ultimate authority and responsibility for establishing policy, maintaining quality care, and providing for organizational management and planning. For purposes of these Bylaws, except as context otherwise requires, the Board shall be deemed to act through the authorized actions of the officers of the Corporation and through the Chief Executive Officer of the Hospital.

2. “Chief Executive Officer” shall mean the individual appointed by the Board to act on the Hospital’s behalf in the overall management of the Hospital.

3. “Clinical Privileges” shall mean the scope of diagnostic, therapeutic, medical, dental, podiatric or surgical services that a practitioner is authorized to provide to patients at the Hospital, based upon such factors as licensure, education, training, experience, competence, health status, insurance and professional judgment.

4. “Allied Health Professionals” shall mean an individual, not a member of the Medical Staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed, after approval by appropriate bodies, to provide specific services to patients at the Hospital under the responsibility and supervision of a Medical Staff member.

5. “Emergency” shall mean a condition in which the life or bodily function of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6. “Hospital” shall mean Saint Francis Healthcare of Wilmington, Delaware.

7. “MEC” shall mean the Medical Executive Committee of the Medical Staff.

8. “Patient” shall mean any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

9. “Patient Encounter” shall mean an inpatient admission, inpatient consultation, surgical procedure, ambulatory surgery, gastrointestinal laboratory procedure, or emergency room consultation.

ARTICLE I.
NAME AND PURPOSE

The physicians, dentists, podiatrists and psychologists who practice at Saint Francis Healthcare hereby establish an organization to be known as the Medical Staff of Saint Francis Healthcare.

ARTICLE II.
MEDICAL STAFF MEMBERSHIP

2.1. MEDICAL STAFF MEMBERSHIP

Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and in policies of the Medical Staff and Hospital.
Membership on the Staff shall confer on the Member only such clinical privileges and prerogatives as have been granted by the Board. No practitioner may admit or provide services to patients in the Hospital unless he or she is a Member of the Staff, has been granted temporary privileges, or is otherwise authorized to provide services pursuant to these Bylaws or the Credentialing Policy.

2.2. QUALIFICATIONS FOR MEMBERSHIP

The specific qualifications for Medical Staff membership shall be set forth in the Credentialing Policy.

2.3. CONDITIONS AND DURATION OF APPOINTMENT

A. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Directors. The Board shall act on appointments and reappointments only after there has been a recommendation from the Credentials Committee and the Medical Executive Committee ("MEC") in accordance with the provisions of these Bylaws and the Credentialing Policy.

B. Appointments to the Staff will be for no more than twenty-four (24) calendar months.

C. Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with the Credentialing Policy.

2.4. STAFF DUES

A. Annual Medical Staff dues shall be governed by the most recent action recommended by the MEC.

B. Emeritus Staff members will not be required to pay dues.

C. Dues shall be payable annually by March 31st. A practitioner’s failure to pay dues shall be deemed a voluntary resignation from the Staff.

2.5. RESPONSIBILITIES OF STAFF MEMBERSHIP

Each Staff member shall:

1. Direct the care of his or her patients and will supervise the work of any Allied Health Professionals under his/her supervision;

2. Assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care;

3. Assist other physicians in the care of their patients when reasonable and appropriate;

4. Act in an ethical, professional and courteous manner;

5. Act in accordance with the Ethical and Religious Directives for Catholic Health Care Services with regard to his or her practice at the Hospital;

6. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner.
ARTICLE III.
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board of Directors and shall be designated as one of the categories of the Staff listed below. All Medical Staff appointees shall be assigned to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and the Credentialing Policy and approved by the Board of Directors.

- Medical staff categories will automatically be changed based on activity level.

3.1. ACTIVE STAFF

3.1.1. Qualifications

The Active Staff shall consist of those physicians, dentists and podiatrists who have demonstrated an interest in and commitment to the Hospital through both patient care activities and Hospital and Medical Staff service, and who:

1. Continuously meet the full requirements and qualifications for appointment and reappointment as noted in Section 2.2 of these Bylaws and described in the Credentialing Policy;

2. Are located (office and residence) close enough to the Hospital to fulfill their Medical Staff responsibilities and provide timely and continuous care for their patients in the Hospital, in accordance with those specific requirements that are recommended by the MEC and approved by the Board of Directors.

3. Have a minimum of twelve (12) patient encounters at the Hospital during each 2-year reappointment cycle. (Failure to have the required twelve (12) patient encounters in a reappointment cycle shall render the appointee ineligible to apply for reappointment to the Active Staff. Such appointee shall be automatically reassigned to the Associate or Community Staff category).

4. Participate in Continuing Medical Education programs as required by the MEC.

3.1.2. Prerogatives

Active Staff members shall be:

1. Entitled to admit and treat patients within the limits of their assigned clinical privileges;

2. Eligible to vote at Medical Staff and applicable department, section, and committee meetings; and,

3. Eligible to hold office in the Medical Staff organization (as Medical Staff officers, department chairpersons, section directors and Committee chairs).

3.1.3. Responsibilities

Active Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Medical Staff membership set forth in Section 2.5. of these Bylaws.

2. Caring for unassigned (“service”) patients.
3. Accepting emergency service calls, as assigned by the Hospital.

4. Participating in quality assessment, performance improvement, and monitoring activities, including the evaluation of provisional appointees.

5. Serving on Medical Staff committees,

6. Vote of Medical Staff committees.

7. Paying Medical Staff dues.

3.2. ASSOCIATE STAFF

3.2.1. Qualifications

Associate Staff members must continuously meet the full requirements and qualifications for Medical Staff membership as noted in Section 2.2 of the Bylaws and as described in the Credentialing Policy.

1. Have 1-11 patient encounters at the Hospital during each 2-year reappointment cycle. (Failure to have the required one - eleven (1-11) patient encounters in a reappointment cycle shall render the appointee ineligible to apply for reappointment to the Associate Staff. Such appointee shall be automatically reassigned to the Community Staff category).

3.2.2. Prerogatives and Restrictions

A. Associate Staff members shall be entitled to:

1. Admit and treat patients within the limits of their assigned clinical privileges and their professional licensure.

2. Serve on Medical Staff committees.

3. Vote on Medical Staff committees.

4. Attend Medical Staff and Hospital education programs.

B. Associate Staff members shall not be entitled to:

1. Hold Medical Staff office; serve as Department Chairpersons, Section Directors, or committee chairpersons.

2. Vote at Medical Staff meetings.

3.2.3. Responsibilities

Associate Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Staff membership set forth in Section 2.5. of these Bylaws.

2. Participating in Quality/Risk/Utilization Review and Improvement Programs.

3. Pay Medical Staff dues.
3.3.  EMERITUS STAFF

3.3.1. Qualifications

The Emeritus Staff shall consist of those physicians who were members of the Medical Staff of Saint Francis Healthcare but who have retired from active practice.

3.3.2. Prerogatives and Restrictions

A. Emeritus Staff members shall be entitled to attend Staff and Hospital education programs.

B. Emeritus Staff members may not admit or attend patients in the Hospital.

C. Emeritus Staff may serve on Medical Staff committees.

D. Emeritus Staff members shall not be entitled to hold office in the Medical Staff organization, to serve as Department Chairpersons or Section Directors or to vote at Medical Staff, Department, Section or Committee meetings.

E. Emeritus Staff members shall not be required to pay Medical Staff dues.

3.4. COMMUNITY STAFF

3.4.1. Qualifications

A. The Community Staff shall consist of physicians, dentists, and podiatrists desiring to be associated with Saint Francis Healthcare but who do not intend to establish an inpatient practice. Such individuals would be those professionals who are interested in the affairs of Saint Francis Healthcare and who may wish to refer patients to members of the Staff, visit such patients, and provide information to the Attending physician.

New members applying for Community Staff category shall be appointed if requested, without fulfilling the Provisional Category requirements for patient encounters.

B. Additional qualifications include:

1. Maintain Delaware licensure.

2. Be certified by State and Federal Controlled Substances registration, as appropriate.

3. Have current professional liability insurance coverage in at least the minimum amounts specified in the Bylaws.

3.4.2. Prerogatives and Restrictions

A. May refer patients to other members of the Medical Staff for admission, evaluation and/or care and treatment as appropriate.

B. May visit their hospitalized patients, provide information to the Attending physician and review the patient’s hospital medical record.

C. May attend educational programs sponsored by Saint Francis Healthcare or the Medical Staff.

D. Shall receive Medical Staff communications.
E. May serve on Medical Staff Committees and at Section and Departmental meetings.

F. May not vote at meetings of the entire Medical Staff nor for any Medical Staff Bylaws changes.

G. May not be entitled to hold office in the Medical Staff organization or serve as departmental chairpersons or section directors.

H. May not admit patients, write orders, or exercise any clinical privileges at Saint Francis Healthcare.

3.4.3 Responsibilities

A. Shall submit a renewal application every two years as required by Medical Staff Bylaws.

B. Attend Medical Staff and Departmental meetings as required.

C. Pay Medical Staff dues in an amount determined by the MEC.

3.5. PROVISIONAL STAFF

3.5.1. Duration of Initial Provisional Appointment and Increased Privileges

A. All initial appointments to the Medical Staff (regardless of the category of the Staff to which the appointment is made) and all initial clinical privileges shall be provisional for a period of up to twenty four (24) months from the date of appointment or longer if recommended by the Credentials Committee.

B. All grants of increased clinical privileges to existing Medical Staff members are also provisional. The duration and supervision terms of this provisional period will be recommended by the Credentials Committee, after consulting with the appropriate Department Chairperson, and approved by the Board of Directors.

C. During the term of this provisional appointment, the individual shall be evaluated by the appropriate Department Chairpersons and by the relevant committees of the Medical Staff as to the individual’s clinical competence and general behavior and conduct in the Hospital.

D. Provisional privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner if warranted.

3.5.2. Duties of Provisional Appointees

A. Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Medical Staff or the Board of Directors shall require.

B. During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations attendant to his/her staff category.

C. Each provisional appointee must arrange or cooperate in the arrangement of at least eight (8) patient encounters in order to attain non-provisional status. The Department
Chairperson may specify the types of cases to be reviewed/observed by the appropriate Department Chairperson and/or designated proctors. Depending upon the circumstances involved, it may also be necessary for an appointee to provide information from sources other than the Hospital regarding the individual’s professional performance, judgment, and clinical or technical skills, as indicated in, among other things, quality assessment and improvement activities. If this information is requested by the Department Chairperson, the appointee shall provide this information to be used in the assessment of the appointee’s provisional period in the Hospital.

D. Failure of the provisional appointee during the provisional period to have eight (8) patient encounters, or failure of the appointee, during the provisional period, to fulfill all requirements of appointment relating to completion of medical records and/or cooperation with monitoring or proctoring conditions, as outlined in this Policy, shall render the provisional appointee ineligible for continued appointment and clinical privileges, unless the failure to meet these requirements is based upon good cause. In the event that, at the expiration of the provisional period, the individual is ineligible, the individual’s appointment and clinical privileges shall expire without recourse to the hearing and appeal provisions of the Fair Hearing Plan. The individual shall be permitted to reapply for initial appointment in accordance with this Policy, if the individual can demonstrate to the satisfaction of the Hospital that the relevant issue has been fully resolved.

3.5.3. Prerogatives and Restrictions

Provisional Staff members shall be:

1. Entitled to admit and treat patients within the limits of their assigned clinical privileges.
2. Provisional Staff members may not vote at Medical Staff meetings.
3. Provisional Staff members shall be ineligible to hold office in the Medical Staff organization (e.g., serve as Medical Staff officers, department chairpersons, section directors or committee chairpersons).
4. Chairpersons and Directors for Departments and Sections with exclusive contracts will be allowed to hold office and serve on committees as required by contract.

3.5.4. Responsibilities

Provisional Staff members shall assume the following functions and responsibilities:

1. Fulfilling the basic responsibilities of Medical Staff membership set forth in Section 2.5. of these Bylaws;
2. Caring for unassigned (“service”) patients;
3. Accepting emergency service calls, as assigned by the hospital;
4. Participating in Quality Assessment, Performance Improvement, and monitoring activities;
5. Serving on committees; and
6. Paying Medical Staff dues.
ARTICLE IV.
MEDICAL STAFF OFFICERS AND VICE PRESIDENT OF MEDICAL
AFFAIRS/CHIEF MEDICAL OFFICER

4.1. OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be the President, the Vice President, the Secretary, and the Treasurer.

4.2. QUALIFICATIONS OF MEDICAL STAFF OFFICERS

Officers must be members in good standing of the Active Medical Staff at the time of nomination and election, and must remain members in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital medical staff.

4.3. ELECTION OF MEDICAL STAFF OFFICERS

A. Officers shall be elected at the annual meeting of the Medical Staff. All officers must be confirmed by the Board of Directors.

B. The Nominating Committee shall prepare a slate of nominees for each office, present the slate to the MEC, and post the list at least 30 days prior to the annual meeting.

C. Nominations for officer positions may also be made by a petition signed by at least 10 members of the Active Staff. Such petition must be submitted to the MEC at least 15 days prior to the annual Medical Staff meeting. In order to be included on the ballot as a candidate, each nominee must possess all the qualifications set forth in Section 4.2.

D. The candidate who receives a majority vote of those Medical Staff members eligible to vote and present at the meeting at the time the vote is taken shall be elected. In any election, if there are three (3) or more candidates for an office and no candidate receives a majority vote on the first ballot, there shall be a run-off ballot between the two (2) candidates receiving the highest number of votes.

4.4. TERM OF OFFICE

All officers shall take office on the first day of the calendar year and shall serve a period of two (2) years.

4.5. VACANCIES IN OFFICE

In the event that the President is unable to fulfill the term of office for any reason, the Vice-President shall be appointed President. Vacancies in other officer positions shall be filled by the MEC for the remainder of the Officer’s term.

4.6. DUTIES OF MEDICAL STAFF OFFICERS

4.6.1. President of the Medical Staff

The President of the Medical Staff shall serve as the Chief Administrative Officer of the Medical Staff and shall perform the following duties:
1. Serve as the Chair of the MEC (call, preside at, and be responsible for the agenda at MEC meetings and business meetings);

2. Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;

3. Make appointments of Committee members and Chairs for all standing and special Medical Staff committees, except as otherwise provided in these bylaws;

4. Provide guidance on the overall medical policies of the Hospital and enforce the Bylaws, Rules and Policies of the Hospital and Medical Staff;

5. Work with the Medical Staff and Administration to implement systems that will enhance utilization of resources for providing care to patients;

6. Represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the Staff to the Vice President of Medical Affairs, the Chief Executive Officer and the Board of Directors;

7. Consult on medical matters with the Vice-President for Medical Affairs (“VPMA”) /Chief Medical Officer (“CMO”), the Chief Executive Officer, and the Board of Directors.

8. Perform such other duties commensurate with his/her office as may from time to time be reasonably necessary for the benefit of the Medical Staff;

4.6.2. Vice President of Medical Staff

The Vice President of Medical Staff shall be the President-elect of the Medical Staff and shall perform the following duties:

1. In the absence of the President, shall assume all of his/her duties and have all of his/her authority;

2. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President of the Medical Staff;

3. Serve as the Chair of the New and Investigative Activities Committee.

4.6.3. Secretary of the Medical Staff

The Secretary of the Medical Staff shall perform the following duties:

1. Keep accurate and complete minutes of all MEC and Medical Staff meetings;

2. Call meetings on order of the President of the Medical Staff;

3. Attend to all correspondence;

4. Present the report of the MEC at the annual Medical Staff meetings;

5. Receive and retain reports of all Medical Staff committees;

6. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President or Vice-President of the Medical Staff.

4.6.4. Treasurer of the Medical Staff
The Treasurer of the Medical Staff shall perform the following duties:

1. Collect staff dues and funds;
2. Make disbursements authorized by the MEC or its designee;
3. Submit a complete and detailed written stewardship report quarterly at the MEC meetings;
4. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him or her by the President or Vice-President of the Medical Staff.

4.7. REMOVAL OF OFFICERS

A. The Medical Staff may initiate the removal of an Officer by submitting a petition to the MEC signed by 10% of the Active Staff members. The MEC shall call a special meeting of the Medical Staff solely to address the petition. The Officer shall be removed if removal is supported by ballots from two-thirds of the Active Staff present and voting at the special meeting.

B. The MEC, by a two-thirds vote, may remove any Medical Staff Officer if that individual exhibits conduct that is detrimental to the interests of the Hospital or Medical Staff or if the Medical Staff officer is suffering from a physical or mental infirmity that prevents the individual from fulfilling the duties of that office.

C. If removal is being considered by the Medical Staff or the MEC, the Officer in question must be provided with written notice of the meeting at which such action is scheduled at least ten (10) days prior to the date of the meeting. The Medical Staff officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal.

4.8. VICE PRESIDENT OF MEDICAL AFFAIRS (“VPMA”)/CHIEF MEDICAL OFFICER (“CMO”)

4.8.1. Qualifications

The VPMA/CMO shall be a Board Certified physician who is qualified by experience and/or training to participate in medically-related professional and administrative aspects of the Hospital.

4.8.2. Appointment and Duties

The VPMA/CMO shall be appointed by the Board and his/her duties shall be designated by the Board. The Medical Director’s term of office shall be governed by his/her employment contract with the Hospital.

4.8.3. Medical Staff Membership and Prerogatives

The VPMA/CMO, a member of the Administrative Staff of the Hospital, shall be (or become) a member of the Medical Staff. The VPMA/CMO shall be an ex-officio member without vote of all committees of the Medical Staff.
ARTICLE V.
DEPARTMENTS AND SECTIONS

5.1. ORGANIZATION AND FUNCTIONS OF DEPARTMENTS AND SECTIONS

5.1.1. Functions of Departments and Sections

Each department and/or section shall:

1. Assist in the development of privileging criteria;

2. Participate in monitoring the quality of patient care and in the performance improvement program.

5.1.2. Organization of Departments and Sections

The Medical Staff shall be organized into the following departments and sections:

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine
4. Internal Medicine
   a. Allergy
   b. Cardiology
   c. Dermatology
   d. Endocrinology & Metabolism
   e. Gastroenterology
   f. Hematology/Oncology
   g. Hospitalist Medicine
   h. Infectious Diseases
   i. Nephrology
   j. Neurology
   k. Pain & Palliative Care
   l. Physical Medicine & Rehab
   m. Psychiatry
   n. Pulmonary Diseases
   o. Rheumatology
5. Obstetrics and Gynecology
6. Pathology and Laboratory Medicine
7. Pediatrics
   a. Neonatology
8. Radiology
   a. Radiation Oncology
9. Surgery
   a. Acute Surgical Services
   b. Bariatric Surgery
   c. Cardiothoracic Surgery
   d. General Surgery
   e. Neurosurgery
   f. Ophthalmology
   g. Oral & Maxillofacial Surgery
   h. Orthopaedics
   i. Otolaryngology
j. Plastic and Reconstructive Surgery
k. Podiatry
l. Urology
m. Vascular Surgery

5.2. ASSIGNMENTS TO DEPARTMENTS

A. Each member of the Staff shall be assigned membership in at least one Department, but may be granted membership and/or clinical privileges or specified services in one or more of the other Departments or Sections. The MEC, after consideration of the recommendations of the Chairperson of the appropriate Clinical Departments and Sections as transmitted to the Credentials Committee, shall recommend to the Board of Directors Department assignments for all Medical Staff members in accordance with their qualifications.

B. The exercise of clinical privileges or the performance of specified services within any Department shall be subject to the rules and regulations of the pertinent Department and/or Section and the authority of the Department Chairperson and/or Section Director.

5.3. DEPARTMENT CHAIRPERSONS

5.3.1. Qualifications of Department Chairpersons

Each Department Chairperson shall be a member of the Active Staff, shall have demonstrated ability in at least one (1) of the clinical areas covered by the Department, shall be Board Certified in an appropriate specialty (or otherwise determined by the MEC to possess equivalent qualifications) and be willing and able to discharge the functions of his/her office.

5.3.2. Selection of Department Chairpersons

A. The Chairpersons of the Departments of Surgery, Internal Medicine, Family Medicine, Obstetrics and Gynecology, Pediatrics, and Psychiatry shall be appointed by the President of the Medical Staff after consultation with the following individuals: Medical Staff officers, VPMA/CMO, and five (5) representatives who are members of the pertinent Department. The Department representatives will be volunteers. If more than five (5) members volunteer, the MEC will select the five (5) representatives by ballot.

B. The Chairpersons of the Departments under contract with the Hospital (currently, Anesthesiology, Pathology, Emergency Medicine, and Radiology) will be appointed in accordance with the provisions of contracts.

C. The Chairpersons of all Departments must be approved by the Chief Executive Officer and the Board of Directors.

5.3.3. Term of Office, Removal and Vacancies

A. Department Chairpersons shall serve a two-year term and shall be eligible to succeed him or herself in office.

B. Department Chairpersons may be removed from office by a two-thirds vote of the Active Staff members of the department or by the Board of Directors after a Joint Conference with representatives of the MEC.
C. If a vacancy occurs in a Department Chairperson position, the President of the Medical Staff shall name an Acting Chairperson until a new Director is appointed in accordance with the provisions of Section 5.3-2 above.

5.3.4. Duties of Department Chairpersons

Each Department Chairperson shall perform the following duties:

1. Clinically related activities of the Department;

2. Establish, together with the Medical Staff and Administration, the type and scope of services required to meet the needs of patients and the Hospital;

3. Participate in the strategic planning activities for development of the Department;

4. Build upon the reputation of the Hospital, support and improve programs within the Hospital;

5. Recommend sufficient numbers of qualified and competent persons to provide care or services;

6. Recommend space and other resources needed by the Department;

7. Assume responsibility for all clinically and administratively related activities of the Department;

8. Integrate and coordinate interdepartmental and intra-departmental services;

9. Integrate the Department or service into the primary functions of the organization;

10. Recommend to the Medical Staff criteria for clinical privileges that are relevant to the care provided by the Department;

11. Recommend specific clinical privileges for each Department member;

12. Determine the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services;

13. Assess and improve the quality of care and services provided in the Department;

14. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment and services not provided by the Department or the organization;

15. Lead in the implementation of ongoing quality monitoring of blood usage, drug usage, operative and other procedures, and medical record documentation;

16. Support hospital-wide performance improvement initiatives;

17. Maintain quality control programs, as appropriate;

18. Provide continuous surveillance of the professional performance of all individuals within the department who have delineated clinical privileges;

19. Develop and implement policies and procedures that guide and support the provision of services within the department;
20. Plan, develop, organize and manage departmental orientation and continuing education for all persons in the department;

21. Recommend to the MEC an appropriate person to be the Director of each Section in his/her Department, if any;

22. Enforce the Medical Staff Bylaws, Rules and Regulations within the Department including initiating Peer Review and initiating corrective action.

5.4. SECTION DIRECTORS

5.4.1. Qualifications

Section Directors must meet the same qualifications as Department Chairpersons, which are set forth in section 5.3.1.

5.4.2. Selection of Section Directors

Section Directors shall be appointed by the Chairperson of the pertinent Department after consultation with the President of the Medical Staff and the VPMA/CMO.

5.4.3. Term of Office, Removal, Vacancies

A. Section Directors shall serve a two-year term and shall be eligible to succeed him or herself in office.

B. A Section Director may be removed from office by the pertinent Department Chairperson.

C. If a vacancy occurs in a Section Director position, the Chairman of the pertinent Department shall name an Acting Director until a new Director is appointed in accordance with Section 5.4.2. above.

5.4.4. Duties of Section Directors

Each Section Director shall perform the following duties:

1. Assist the Department Chairperson in all administratively and clinically related activities; and,

2. Provide advice to Chairperson on area of expertise.

ARTICLE VI.
COMMITTEES

6.1. GENERAL PROVISIONS

A. The Medical Staff shall have the committees described in this Article and such other committees that may be established from time to time by the Staff. Each Active Staff member is encouraged to serve on at least one Staff committee.

B. Unless otherwise prescribed by these Bylaws, the President of the Medical Staff shall appoint the Members and Chairpersons of the various Committees.

C. Unless otherwise prescribed by these Bylaws, the Chairperson and Members of each Medical Staff committee shall serve a two-year term and may be reappointed for an
unlimited number of additional terms. All appointed members of committees may be removed and vacancies filled at the discretion of the President of the Medical Staff.

D. The President of the Medical Staff, the VPMA/CMO and the Chief Executive Officer shall be members, *ex officio*, without vote, on all Committees.

E. Committee Chairpersons: Only those Active Staff members who satisfy the following criteria shall be eligible to serve as Committee Chairpersons:

1. Are appointed to and in good standing on the Active Medical Staff and continue so during their term of office;
2. Have no adverse recommendations concerning staff appointments or clinical privileges;
3. Have demonstrated interest in maintaining quality medical care;
4. Have constructively participated in Medical Staff affairs, including Peer Review activities;
5. Have actively served on at least two (2) Medical Staff committees;
6. Are knowledgeable concerning the duties of the position and are willing to discharge faithfully the duties and responsibilities of the position;
7. Possess and have demonstrated ability for harmonious interpersonal relationships.

F. All committees of the Medical Staff shall keep permanent records of their actions and regularly transmit reports on the same to the MEC;

G. Committee members shall, at all times, maintain confidentiality with regard to Credentialing, Peer Review and Performance Improvement activities.

6.2. MEDICAL EXECUTIVE COMMITTEE (MEC)

6.2.1. Composition

A. The MEC shall consist of the Officers of the Medical Staff, all Department Chairpersons, the Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer of the Hospital, the VPMA/CMO, the Chairperson of the Credentials Committee and two Members-at-Large from the Staff.

B. Selection and Term of At-Large-Members: The Nominating Committee shall nominate four (4) candidates to serve as Members-at-Large of the MEC. The MEC shall select two (2) of the four (4) nominees to serve. Members at large shall serve staggered two-year terms so that only one (1) Member-at-Large shall be elected each year.

C. The President of the Medical Staff shall be Chairperson of the MEC and the Secretary of the Medical Staff shall serve as Secretary of the Committee.

D. The Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer and VPMA/CMO shall be *ex officio* members of the Committee, without vote.

6.2.2. Duties

The MEC shall perform the following duties:
1. Represent and act on behalf of the Medical Staff between meetings of the organized Medical Staff within their scope of responsibility;

2. Coordinate the activities and general policies of the Medical Staff;

3. Receive and act upon committee reports;

4. Implement policies of the Medical Staff not otherwise the responsibility of the Departments;

5. Provide a liaison between the Medical Staff and the Chief Executive Officer;

6. Recommend action to the Chief Executive Officer on medico-administrative matters;

7. Make recommendations on Saint Francis Healthcare management matters (for example, long-range planning) to the Board of Directors;

8. Ensure that the Medical Staff is kept abreast of the Accreditation Program and informed of the accreditation status of the Hospital;

9. Fulfill the Medical Staff organization’s accountability to the Board of Directors for the medical care of patients in the Hospital;

10. Review the report of the Credentials Committee on all applicants and make recommendations for Staff membership, Department assignments, and delineation of clinical privileges;

11. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;

12. Report at each general staff meeting;

13. Assessing and recommending off site sources not provided by the Department or organization on an annual basis;

14. Ensure that there will always be medical staff representation and participation in any deliberation affecting the discharge of Medical Staff responsibilities;

15. Ensure that there is consistency between the Medical Staff Bylaws, Rules and Regulations and Policies and the Governing Body’s Bylaws;

16. Recommends clinical services to be provided by telemedicine;

17. Recommends Medical Staff membership termination;

18. Recommends to the Board the structure of the Medical Staff;

19. Recommends to the Board the process used to review credentials and delineate privileges.

6.2.3. Staff Functions Coordinated by the MEC

The MEC will assign committees as necessary to perform the following functions:

1. Monitor, evaluate and improve care provided in, and develop clinical policy for, special care areas such as intensive or coronary care units; patient care support
services, such as respiratory therapy, physical medicine, and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

2. Conduct or coordinate quality, appropriateness and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical record and other reviews; medical assessment and treatment efficiency of clinical practice patterns;

3. Conduct or coordinate utilization review activities;

4. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs, and supervise the Hospital’s professional library services;

5. Develop and maintain surveillance over drug utilization policies and practices;

6. Investigate and control nosocomial infections and monitor the organization’s infection control program;

7. Plan for response to fire and other disasters, for organizational growth and development, and for the provision of services required to meet the needs of the community;

8. Direct staff organizational activities, including staff bylaws, review and revision, liaison with the Board of Directors and Hospital administration and Hospital accreditation;

9. Provide support for faculty and members of the Medical Staff who participate in the supervision and education of Resident Staff;

10. Coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

11. Engage in other functions reasonably requested by the MEC and the Board of Directors.

6.2.4. Meetings

The MEC shall meet as often as necessary to fulfill its responsibilities. Special meetings of the MEC may be called at any time by the President of the Medical Staff.

The MEC shall maintain a permanent record of its proceedings and any actions taken.

6.3. CREDENTIALS COMMITTEE

6.3.1. Composition

A. The Credentials Committee shall consist of a Chairperson and at least six (6) other members appointed by the President of Medical Staff. At least one (1) member is to be appointed from each of the following Departments: Surgery, Obstetrics and Gynecology, and Medicine/Family Practice.

B. Members serving more than three (3) consecutive two (2)-year terms will need approval by the current President of the Medical Staff to remain on the committee.

6.3.2. Duties

The Credentials Committee shall perform the following duties:
1. Review the credentials of all applicants for initial Medical Staff appointment, reappointment and clinical privileges; make investigations of and interview such applicants as may be necessary, and make recommendations to the MEC regarding appointment, reappointment, delineated Clinical Privileges, Staff category and department;

2. Review the credentials of all Allied Health Professionals who request to practice in the Hospital, make investigations of and interview such practitioners as may be necessary, and make recommendations to the MEC regarding appointment, reappointment, and delineated Clinical privileges;

3. Review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of Allied Health Professionals practicing in the Hospital and, as a result of such review, provide a written report of its findings and recommendations;

4. Investigate the credentials of all applicants for membership (primary source verification and consultation with the Chairperson of any pertinent department and, if applicable, the director of any pertinent section) and make recommendations in conformity with the Credentialing Policy;

5. Investigate any breach of ethics that may be referred to it;

6. Review any records that may be referred to it by the MEC to arrive at a decision regarding the performance of staff members;

7. Review the status of each Staff member being reappointed, his/her medical work, and his/her responsibilities to the Staff, and make recommendations to the MEC concerning the reappointment to the Staff, change of status, and the assignment of members to services;

8. Develop, in conjunction with department chairs and section chiefs, criteria for granting Clinical Privileges, to submit to the MEC and Board for approval and use in the credentialing and privileging process;

9. Develop credentialing policies, to submit to the MEC and Board for approval and use.

6.3.3. Meetings

The Credentials Committee shall meet at least 10 months of the year or more often if necessary to accomplish its duties. The Chairperson of the Credentials Committee shall be available to meet with the MEC and/or the Board of Directors or its Committee on all recommendations of the Credentials Committee.

6.4. NOMINATING COMMITTEE

6.4.1. Composition

The Nominating Committee will consist of five (5) members. Four (4) members shall be nominated by the Nominating Committee. No member shall serve more than two (2) consecutive 2-year terms.

6.4.2. Duties
The Nominating Committee shall nominate and present at the annual meeting of the Staff a proposed slate of candidates for general Staff officers, the Members-at-Large of the MEC, and four (4) members of the Nominating Committee.

6.4.3. Meetings

The Nominating Committee shall meet as necessary to discharge its responsibilities.

6.5. CANCER COMMITTEE

6.5.1 Composition

A. The President of the Medical Staff, with the advice of the MEC, shall appoint the Chairman and the members of the Cancer Committee.

B. The membership of this committee should include, but is not necessarily limited to, Representatives from the Department of Surgery, Medical Oncology, Diagnostic Radiology, Radiation Oncology and Pathology. The hospital will be asked to recommend Committee members from the Department of Patient Care Services, the Department of Clinical Effectiveness, the Tumor Registry, Health Information Systems, and Administration.

6.5.2 Duties

A. The Cancer Committee responsibilities include the following:

   1. Develops and evaluates the annual goals and objectives for the clinical, educational and programmatic activities related to cancer;
   2. Promotes and coordinates a multi-disciplinary approach to patient management;
   3. Establishes and ensures educational and consultative Cancer Conferences are held regularly and cover all major sites and related issues;
   4. Encourage all members of the Medical Staff to present their newly diagnosed, difficult cases for assistance in pretreatment evaluation, staging, treatment strategy and rehabilitation;
   5. Ensures an active supportive care system is in place for patients, families and staff;
   6. Monitors quality management and improvement through completion of quality management studies which focus on quality, access to care and outcomes;
   7. Promotes clinical research;
   8. Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting;
   9. Performs quality control of registry data;
   10. Encourages data usage and regular reporting;
   11. Ensures content of the Annual Report meets requirements;
   12. Publishes the Annual Report by November 1 of the following year;
   13. Upholds medical ethical standards;
   14. Give surveillance to the entire spectrum of care for all cancer patients admitted to Saint Francis Healthcare encompassing diagnosis, treatment, rehabilitation, follow-up and end results reporting.

6.5.3 Meetings

A. The Cancer Committee will meet quarterly. Minutes of these meetings shall be kept in Tumor Registry and shared with the MEC.
6.6. PEER REVIEW COMMITTEE

6.6.1. Composition

The Peer Review Committee will consist of VPMA/CMO, Chairpersons of Departments of Anesthesiology, Emergency Medicine, Medicine/Family Practice, Obstetrics and Gynecology, Pathology, Radiology and Surgery, President of the Medical Staff, Past President of Medical Staff and support staff from the Performance Improvement Department.

The VPMA/CMO will be Chairman of the Peer Review Committee.

6.6.2. Duties

The Peer Review Committee will perform the following duties:

1. Through the use of approved clinical indicators it will perform ongoing screening reviews relating to corporate, Federal, State and departmental guidelines;

2. Coordinate ongoing review of cases referred for peer review;

3. Fulfill the Peer Review Policy as outlined in Rules and Regulations, Section L;

4. Make recommendations for individual, departmental or hospital-wide performance improvement activity;

5. The Peer Review Committee reports activities and decisions to the MEC for final action:

6. Peer Review Committee shall delegate matters related exclusively to behavioral and non-clinical issues to the Professional Review Committee, a subcommittee of the Peer Review Committee. This subcommittee shall be comprised of members of the Peer Review Committee and report matters reviewed, findings and recommendations to the Peer Review Committee. The Chair of the Professional Review Committee will be a non-peer review committee medical staff physician, Chair of the Department of the person in review and second non-peer review medical staff physician. If the Chair of the Professional Review Committee is involved in the review, the President of the Medical Staff will act in place of the Chair.

7. Matters, clinical and non-clinical, appropriate for reporting to State Board of Medical Licensure and Discipline shall be reported as per current State law reporting mandates.

6.6.3. Meetings

The Peer Review Committee will meet monthly and minutes will be prepared and shared with the MEC.

6.7. OTHER COMMITTEES

6.7.1. Committees of the Medical Staff
A. The standing Committees of the MEC shall include the Bylaws Committee and the Education and House Staff Committee. The members of Committees of the MEC shall be appointed by the President of the Medical Staff, shall meet as necessary to discharge their responsibilities, maintain records of their activities and actions, and shall regularly report thereon to the MEC.

B. The MEC may, by resolution and upon approval of the Board of Directors, without amendment of these Bylaws, establish additional committees to perform one (1) or more staff functions. In the same manner, the MEC may, by resolution and upon approval of the Board of Directors, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws, which is not assigned to a standing or special committee, shall be performed by the MEC.

6.7.2. Special Committees

As necessary, the MEC may establish temporary special committees. Special committees will be established for a specific defined purpose and required to report back to the Medical Staff or the MEC at a definite time.

ARTICLE VII.
MEDICAL STAFF MEETINGS

7.1. MEETINGS OF THE MEDICAL STAFF

7.1.1. Annual Staff Meeting

The regular Medical Staff meeting in the last quarter of the year shall be the Annual Staff Meeting. At the Annual Staff Meeting, elections will be held for any open position(s) for Medical Staff officers.

7.1.2. Special Staff Meetings

A. Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the MEC, twenty-five percent (25%) of members of the Active Staff, or the Board of Directors.

B. The President of the Medical Staff shall designate the time and place for any special meeting. No business shall be transacted at any special meeting except that stated in the notice of the meeting.

7.2. DEPARTMENT AND COMMITTEE MEETINGS

7.2.1. Department Meetings

A. Members of each Department shall meet on a regular basis at a time and date set by the chair of the Department to review and evaluate the clinical work of the department.

B. Each Department shall maintain a permanent record of its findings, proceedings and actions, and shall report regularly to the MEC and the Chief Executive Officer.

7.2.2. Committee Meetings
A. Committees may, by resolution, provide the time for holding regular meetings without notice other than the resolution.

B. Each committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof after each meeting to the MEC and the Chief Executive Officer.

7.2.3. Special Department and Committee Meetings

A special meeting of any department or committee may be called by or at the request of the pertinent chairperson.

7.3. QUORUM

A. There shall be no quorum requirements for Medical Staff and Department meetings. For Departments, the quorum requirement shall be ten percent (10%) of the Department for policy decisions. For Committee meetings, the quorum requirement shall be fifty percent (50%) of the Committee.

B. Once a quorum is established, the business of the meeting may continue and all actions shall be binding even if less than a quorum exists at a later time in the meeting.

C. Departments may use mail ballots for voting on major policy issues.

7.4. NOTICE OF MEETINGS

Reasonable notice of all meetings of the Medical Staff and regular meetings of Departments and Committees shall be delivered, either in person or by mail, to each Medical Staff member. A single notice of all meetings shall be sufficient. Such notice shall state the date, time and place of the meeting. The attendance of any individual at any meeting shall constitute a waiver of that individual’s notice of said meeting.

7.5. ATTENDANCE REQUIREMENTS

A. Members of the Active Staff are strongly encouraged to attend applicable Medical Staff, department and committee meetings each year.

B. Members of the MEC and the Credentials Committee are expected to attend at least fifty percent (50%) of the meetings held.

C. Any Medical Staff appointee whose clinical work is scheduled for discussion at a regular Department meeting shall be given special notice and shall be expected to attend such meeting. In the special notice, the Chairperson of the Department shall give the individual advance written notice of the time and place of the meeting and state that his or her attendance is mandatory. Whenever apparent or suspected deviation from standard clinical practice is involved, the special notice to the individual shall so state. Such special notice shall be given by certified mail, return receipt requested.

D. An individual given special notice of a meeting may make a timely request to the Chairperson of the Committee or Department for postponement or rescheduling of the meeting. Such a request must be supported by an adequate showing that the individual’s absence will be unavoidable. If such a timely request is not made, and the individual fails to attend the required meeting, the Chairperson of the applicable Department or Committee shall notify the President of the Medical Staff. Unless excused by the President of Medical Staff, upon showing of good cause, such failure shall constitute voluntary
relinquishment of all or such portion of the individual’s clinical privileges as the President of the Medical Staff shall direct. Such relinquishment shall remain in effect until the practitioner attends the pertinent meeting.

7.6. EXECUTIVE SESSION

Any person may attend meetings of the Staff, Departments, Sections and Committees. An Executive Session may be called by the Staff President, the Department Chairperson, Section Director or Committee Chairperson at any time during the meeting. During an Executive Session, only members of the Staff, Department, Section or Committee, as pertinent, may be present and all matters discussed shall be confidential. Executive Sessions shall not be used unreasonably to impair the access of Board and Hospital representatives to Staff concerns and actions.

ARTICLE VIII.
ADOPTION AND AMENDMENT OF THE BYLAWS

8.1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, adopt and recommend to the Board Medical Staff Bylaws, Rules and Regulations and Policies. The Medical Staff Bylaws, Rules and Regulations and Policies, the Bylaws of the governing body and the hospital policies are compatible with each other and compliant with governing laws and regulations. The Medical Staff complies with the Medical Staff Bylaws, Rules and Regulations and Policies. The Medical Staff enforces the Medical Staff Bylaws, Rules and Regulations and Policies by recommending action to the governing body in certain circumstances and taking action in others. The governing body upholds the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the governing body. The Medical Staff shall review the Bylaws at least annually and propose them directly to the governing body. The Medical Staff Bylaws and any amendments thereto, shall be effective when approved by the Board.

8.2. METHODS OF AMENDMENT OF THE MEDICAL STAFF BYLAWS

A. The Medical Staff adopts and amends Medical Staff Bylaws. Adoption or amendments of Medical Staff Bylaws cannot be delegated. After adoption or amendment by the Medical Staff, the proposed Bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.

B. If the voting members of the Medical Staff propose to adopt a Rule, Regulation, or Policy, or an amendment thereto, they first communicate the proposal to the MEC. If the MEC proposes to adopt a Rule or Regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff; when it adopts a policy or an amendment thereto, it communicates this to the Medical Staff. Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the active Medical Staff, by the Bylaws Committee, or by the MEC.

C. All proposed amendments must be reviewed by the MEC prior to a vote by the active Medical Staff. The MEC shall provide notice of all proposed amendments, including amendments proposed by a petition of the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably.
D. The proposed amendments will be provided via electronic mail allowing 30 days for ballot return. Failure to respond by the defined 30 days will be considered a vote for adoption and approval. To be adopted, the amendment must receive 51% of the votes cast for adoption and approval.

E. The MEC may also present any proposed amendments to the voting staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast (51% of the votes cast).

F. The MEC shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling or other errors of grammar or expression.

G. All amendments shall be effective only after approval by the Board.

H. If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

8.3. RELATED POLICIES AND MANUALS

The MEC shall recommend to the Board of Directors related policies and procedures governing various aspects of Medical Staff governance. Such documents shall consist of the following documents:

1. Credentialing Policy
2. Fair Hearing Plan
3. Rules and Regulations

The MEC may, through the same procedure as that for adoption and amendment of the Medical Staff Bylaws, adopt other policies and procedure manuals. Upon approval by the Board, these policies and manuals shall be incorporated by reference and become part of these Medical Staff Bylaws.

8.4. STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Staff shall adopt and may from time to time amend such Rules and Regulations as may be consistent with these Bylaws and as may be necessary to implement more specifically the general principles found in these Bylaws. These Rules and Regulations shall relate to the proper conduct of Staff organizational activities as well as define the level of practice that is to be required of each Staff member or dependent health care practitioner in the Hospital. The Rules and Regulations shall not be part of these Bylaws. They shall be reviewed at least annually by the Bylaws Committee and the MEC.

8.5. COMMUNICATION

As a mechanism of communication between the Medical Staff, Hospital, and Governing Board two (2) avenues of communication will be established: 1) all activities of the MEC as recorded in
their minutes shall be reviewed by the Governance Committee of the Board. The Governance Committee will then report to the Governing Board regular activities of the Medical Staff including Credentials, Bylaw changes, and other clinical activities. In return, concerns of the Board will be relayed back to the MEC by the CEO who is a member of the MEC. 2) besides written communication, representation on the Governing Board will be provided through attendance of the President of the Medical Staff or his/her designee.

Any issues requiring greater participation of both the MEC and Governing Board can be handled by a Joint Conference as outlined in the next Section 8.6.

8.6. JOINT CONFERENCE AMENDMENT

If the Board of Directors has determined not to accept a recommendation submitted to it by the MEC, the MEC is entitled to a Joint Conference between the Officers of the Board and the Officers of the Medical Staff. Such Joint Conference shall be for purposes of further communicating the Board’s rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the Medical Staff’s recommendation. Such a joint conference shall be scheduled by the Chief Executive Officer within two weeks after receipt of a request for a joint conference from the President of the Medical Staff.

8.7. ADOPTION OF MEDICAL STAFF BYLAWS

These Medical Staff Bylaws are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all previous Medical Staff Bylaws. Henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges shall be taken under and pursuant to the requirements of these Bylaws.

8.8 CONFLICT MANAGEMENT PROCESS

A. When there is a conflict between the Medical Staff and the MEC with regard to: (a) proposed amendments to the Medical Staff Rules and Regulations, (b) a new policy proposed by the MEC, or (c) proposed amendments to an existing policy that is under the authority of the MEC, a special meeting of the Medical Staff will be called in accordance with the process for calling special meetings. The agenda for that meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to strive to resolve the differences that exist with respect to Medical Staff Rules and Regulations or policies. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the governing body on a Rule, Regulation, or Policy adopted by the Medical Staff or the MEC. The governing body determines the method of communication.

B. If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies offered by the voting members of the Medical Staff, to the Board for final action.

8.9 URGENT AMENDMENT PROCESS

The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation. The MEC voting members of the Medical Staff may provisionally adopt and the governing body may provisionally adopt and provisionally approve an urgent amendment without providing prior
notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff immediately. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts shall be implemented. If necessary, a revised amendment is then submitted to the governing body for action.
# RULES AND REGULATIONS

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A. RIGHTS OF PATIENTS AND ORGANIZATIONAL ETHICS

1. An invasive procedure or transfusion of blood products shall be performed only with the consent of the patient or his/her legal representative, except in an emergency.

2. Physicians admitting private patients shall be held responsible for giving such information as may seem necessary to assure the protection of other patients and personnel from those patients who are a source of danger from any cause whatsoever, or to assure the protection of the patient from self-harm.

3. All patients noted to have attempted suicide as a reason for admission to the hospital or during hospitalization or who are identified as having illness of an emotional nature or related to substance abuse should be offered psychiatric consultation and treatment as soon as they are well enough physically to make an evaluation possible. Such offer shall be documented on the medical record with the response of the patient.

B. ASSESSMENT OF PATIENTS

1. Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after the admission as possible.

2. An adequate and appropriate history and physical shall in all cases be documented within twenty-four (24) hours after admission of the patient. The Patient receives a medical history and physical examination no more-than 30 days prior to, or within 24 hours after, registration or inpatient admissions, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia.” The physician must document that: “I have re-examined reassessed the patient and there are no significant changes.” Including the date, time and signature. A history and physical should have the medical history with chief complaint, the details of present illness, past medical history, relevant social history, family history, review of systems, and physical exam. Also required would be the practitioner’s conclusion, impressions, and plan of action for this episode of care. These examinations must be dictated through the central dictating system or completed through the EMR charting system. If dictated, a signed electronic note giving the assessment and plan must be done in the electronic medical record. In the case of a patient going to surgery, except for emergency procedures, the transcribed copy of a dictated history and physical or an electronically generated history and physical performed by a member of the Medical Staff must be on the chart prior to the surgery. The history must contain at least the following: indications/symptoms for the surgical procedure, a list of current medications and their dosages, any known allergies and drug reactions, and any co-morbid conditions. Documentation of the physician exam must include a heart and lung exam and an evaluation of the general condition and mental status of the patient. The preoperative diagnosis must be recorded in the chart prior to surgery. History and physicals performed by Allied Health Professionals, who have privileges to perform a history and physical, do not require countersignature by a supervising physician.

3. Patients admitted for dental or podiatric procedures shall be admitted on the Dentist’s or Podiatrist’s service. Each patient must have an adequate history and physical by a member
of the Medical Staff of Saint Francis Healthcare or qualified Allied Health Professional, or in
the case of podiatric procedure, the podiatrist. Appropriate consultation shall be held in
complicated cases. The Dentist is responsible for the patient’s history related to the
indications/symptoms for the dental procedure only.

**Assessment of Patients (Continued)**

4. Appropriate action shall be taken to rule out pregnancy in any procedure, operation, etc.
which could interrupt a known, or suspected pregnancy. Such action shall be documented
in the medical record.

5. For Non-Inpatient services, patient assessment requirements will be fulfilled as follows:

<table>
<thead>
<tr>
<th>Anesthetic Characterization:</th>
<th>Categories and Examples:</th>
<th>Documentation Requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None to Minimal Anesthesia Services:</td>
<td>♦ Phlebotomy ♦ Transfusions ♦ Diagnostic Imaging with Contrast Dye ♦ Non-OR procedures e.g. skin lesion removal, foley insertion</td>
<td>• None • Allergies; Indications for blood products • Allergies; Risk factors for contrast reaction; Reason for examination • Allergies; Indications for procedure</td>
</tr>
<tr>
<td>Moderate Sedation/Analgesia Services:</td>
<td>♦ GI Endoscopies ♦ Angiographic/Interventions (e.g. peripheral artery stenting, vascular access procedures, biopsies) ♦ Cardiac Catheterizations ♦ Bronchoscopies ♦ Emergency Department Treatments All other moderate sedation services.</td>
<td>• Completion of Outpatient H &amp; P Form or equivalent, or Emergency Department Patient Assessment Form, or Equivalent Inpatient documentation</td>
</tr>
<tr>
<td>Deep Sedation/Analgesia and Anesthesia</td>
<td>♦ OR Procedures</td>
<td>• Completion of Outpatient H &amp; P Form or equivalent, or Equivalent Inpatient documentation</td>
</tr>
</tbody>
</table>
Documentation requirements must be fulfilled prior to the initiation of the procedures or treatments.

The extent of the patient's assessment should equate with the anesthetic risk and potential for complication for the intended procedure. As risks for anesthesia and complications rise, so should the appropriate documentation allowing for proper evaluation and decision-making at critical times for the patient. Since the potential for inpatient admission increases as well, these documentation requirements allow for initial comparison of key parameters and initiation of treatments. Meanwhile, lengthier inpatient assessments can be performed by the attending clinicians.

The Outpatient Form contains: 1) a medical history including present illness and chief complaint, relevant past medical and surgical history, medications, allergies and drug reactions, and a relevant social history, family history, and review of systems; 2) the physical exam that is relevant to the procedure and must include general condition, heart, lung, and mental status of the patient; 3) an assessment noting conclusions and impressions, and 4) a plan of treatment.

C. TREATMENT OF PATIENTS

1. As far as possible, only drugs in the hospital Formulary shall be prescribed. Occasionally, a non-formulary product may be requested when no therapeutic equivalent formulary product exists, or formulary medications have been used and proven unsuccessful in a specific patient. A non-formulary drug will be obtained upon receipt of the Request of Non-Formulary Drug Form, completed by the physician for each patient. Assent to the use of a Formulary system shall be implied by the acceptance of privileges and the agreement to abide by the Bylaws, Rules and Regulations of the Medical Staff.

A request for the inclusion of a drug or preparation to the Formulary shall be made by submitting a Formulary Addition Request Form to the Director of Pharmacy. This form is available from the Pharmacy upon request of Medical Staff members. Each application shall be reviewed by the Medication Use Committee with whatever consultation may be deemed necessary. (AS PER SFH FORMULARY)

2. Specific medications must be renewed on a regular basis during the patient’s stay in the hospital.

   (a) These specific medications include: (AS PER SFH FORMULARY)

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Renewal Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Renew every 24 hours (except for “mini-dose” heparin regimens that do not result in changes in whole blood PTT/PT. Doses such as 5,000 units, every 12 hours, (subcutaneously)</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Renew every 7 days unless ordered by a physician for a specific length of time</td>
</tr>
<tr>
<td>Narcotics, barbiturates,</td>
<td>Renew every 72 hours unless ordered by a physician sedatives &amp; hypnotics for a specific length of time.</td>
</tr>
</tbody>
</table>
All other medications  Renew every 30 days
Primary IV solutions  Renew every 30 days

(b) Intermittent positive breathing, Aerosol Therapy and Incentive Spirometry which are ordered without time limitation shall be automatically discontinued at 72 hours.

(c) The attending physician must be notified of the discontinuance of the drugs and procedures noted.

3. Oxytoxic drugs will be administered to undelivered patients under such regulations promulgated by the Chairman of the Department of Obstetrics after proper consultation with the other members of the department.

4. All new, experimental and investigative procedures and drugs must be approved by the Saint Francis Healthcare IRB Committee (Institutional Review Committee) prior to implementation. A complete protocol for such procedures or drugs must be submitted through the appropriate Departmental Chairman to the VPMA/CMO.

This rule applies equally to investigative drugs, i.e., drugs that had been developed for one purpose, available for medical use that several months or years later are used for a completely different purpose.

Such medications and drugs are investigational during the appropriate transition. Therefore, if a member of the staff has knowledge that the use of a medication or drug is investigational and he/she wishes to use it for its investigational purpose, he/she must inform the patient of the investigational aspect and make known on a detailed progress note this fact. On the Order Sheet he/she would request that the VPMA/CMO be notified in order to obtain the appropriate consent for permission for investigational drugs. The physician is responsible for obtaining an informed consent from the patient.

All papers to be submitted for publication utilizing information from Saint Francis Healthcare or any reference including a bibliography or biography in which Saint Francis Healthcare will be identified, must be reviewed and approved for publication by the IRB Committee.

The Committee will also provide these same functions for all components of Saint Francis Healthcare, as well as its Medical Staff.

5. A physician wishing to establish standing orders shall submit them to the Chairperson for the Department in which he/she is a member. Upon approval by the MEC, the Standing Orders will be implemented. The nursing leader shall notify all personnel concerned. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician, they shall constitute the orders for treatment. Standing Orders shall not, however, replace or cancel those orders written for a specific patient.

6. Pre-printed orders may be submitted by a physician. Such pre-printed orders should be submitted to the Vice President of Patient Services for implementation. Each physician shall be requested to review such pre-printed orders once every two years.
7. The use of restraints requires a physician’s order. The order shall include:

a. The reason for restraint,

b. Type of restraint to be used,

c. Time limitation not to exceed 24 hours,

d. Written orders for restraint/seclusion are limited to:
   1. Twenty-four (24) hours;
   2. Four (4) hours for adults with primary behavioral health needs;
   3. Two (2) hours for children and adolescents, ages 9-17 with primary behavioral health needs; or,
   4. One (1) hour for patients under the age of nine (9) with primary behavioral health needs.

D. OPERATIVE AND OTHER INVASIVE PROCEDURES

1. Preoperative Testing

(a) Patients scheduled for surgery should be encouraged to utilize the preadmission testing program at Saint Francis Healthcare. Such patients should report to the Central Registration Desk at least two days and not more than thirty (30) days prior to their scheduled surgery for the preoperative tests outline below with a written order from the attending physician at the same time.

(b) For all patients for whom the service of a member of the Department of Anesthesiology is required, the following minimum laboratory work shall be completed, recorded and available to the anesthesiologist prior to performance of the procedure for which the anesthesia is required. Laboratory studies may be obtained at any licensed laboratory within thirty (30) days prior to hospitalization except as noted below.

(c) Variations in this rule are permitted by the application of appropriate clinical judgment or at such time as meeting these requirements would be detrimental to patient care, such as the time delay when definitive action should occur immediately. All variations or exceptions must be written on the Physician’s Order Sheet and the reason documented in the Progress Notes.

(d) Any suggestion of any change in the patient’s condition, as noted by the anesthesiologist or attending physician, may warrant re-evaluation the day of the procedure with additional or verification testing.

(e) Medical, Surgical Gynecological, Dental Patients and Pediatric Patients
- CBC
- Potassium (for all patients on diuretics or cardiac medications)
- Glucose (the day of surgery for insulin dependent diabetics)
- Chem 7 Profile (for all patients with major organ system disease)

(f) EKG will be required after the age of 45 years for men and 50 years for women.
EKG within six months for patients without history of cardiovascular disease.
EKG within one month for patients with history of cardiovascular disease.

(g) For such patients who are on anticoagulants: the PT, PTT and platelet count should be obtained within 4 hours of the procedure. For interventional procedures in addition to the above, a complete Blood Count (CBC) should be obtained within 1-2 days of the procedure unless recent blood loss indicates a shorter interval.

(h) Patients not anti-coagulated, but who are to have angiography or other such radiological interventional procedures: A platelet count, PT, and PTT within one week of the procedure. In patients over 40 years of age or diabetic patients or those with multiple myeloma: a BUN.

(i) For all C-Section patients: Routine Type and Screen

(j) A patient who is in the hospital for more than 96 hours and who is subsequently scheduled for any procedure under general or regional anesthesia must have a CBC performed and recorded on his/her chart within 48 hours prior to the procedure. If a series of Electroshock Therapy (EST) is planned, this requirement must be fulfilled before the first treatment is given but not before each treatment.

(k) Patients scheduled for tonsillectomy and/or adenoidectomy: At the Discretion of the Attending Otolaryngologist specific orders must be written for patients to have performed:

- Bleeding time
- Prothrombin time
- Activated Plasma Partial Thromboplastin Time

2. **Preoperative Assessment**

(a) An adequate and appropriate history and physical examination (H&P) is required on the chart before the operation. Under emergency situations each patient will be assessed on an individual basis.

In non-emergent situations an H & P must be on the chart and been performed within 30 days prior to admission (inpatient or outpatient). If the H & P was performed more than 24 hours prior to admission, the H & P must be updated by a qualified physician or allied health professional with clinical privileges to perform a history and physical prior to surgery within 24 hours of admission noting any change of status for the patient, updating
any relevant studies, and documenting the continued need for the procedure or admission and validity of the H & P.

(b) A pre-anesthesia consultation shall be performed, including a review of the medical history and physical examination within 48 hours prior to the operation by the Anesthesiologist or the physician in charge of the anesthesia. An anesthesia record shall be completed for each patient receiving general or regional anesthesia and a post-anesthesia note shall be recorded for each patient concerning the general condition of the patient. A pre-induction assessment will be performed prior to administration of anesthesia.

3. **Specimen/Tissue Removal**

Operative material and tissue for examination will follow these rules:

“All material of any type that is removed from the patient should be recorded. Tissue may be sent for regular histologic examination or with a request for gross examination and description only with the understanding that the pathologist will go further with histologic examination if he/she feels it is necessary”;

“Exceptions to sending specimens removed during a surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely employed and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include the following:

(a) Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, portion of rib removed only to enhance operative exposure, scars, and normal tissue removed in cosmetic surgery.

(b) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

(c) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.

(d) Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

(e) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin for the circumcision of a newborn infant.

(f) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

(g) Teeth, provided the number, including fragments, is recorded in the medical record.
E. COORDINATION OF CARE

1. The admitting physicians or his/her qualified substitute will visit his/her hospital patients daily while in any section of the acute care departments of the hospital. This rule is in order to provide adequate quality, cost-effective care along with adequate communication with the patient, family and other staff members. The physician, or his/her qualified substitute, must be constantly available to care for patient problems. Failure of a physician to make daily visits to his/her patients will be reviewed by the Department Chairperson and may result in curtailment of the physician’s privileges. All visits should be appropriately documented on the chart on the date of the visit and provide a meaningful description of the status of the patient as of that time.

2. Each member of the Medical Staff shall name another member of the Medical Staff who may be called in his/her absence or when he/she is not available to attend his/her patients. Such substitute physician must hold at least the same privileges and have at least the same delineation of privileges. In the event of failure to name such a substitute (or of the named substitute to respond), the Chief Executive Officer of the hospital and the Chairperson of the Department involved, shall have the authority to call any member of the staff to attend the patient in the emergency situation.

3. When an attending physician requests consultation, he/she must specify on the appropriate form his/her expectation from the consultation. He/she will ensure, except in an emergency, that an appropriate and adequate history and physician examination is recorded on the chart. The attending physician remains responsible for the patient and will be queried as to any questions concerning the activity of the consultant.

4. The transfer of responsibility from one physician to another physician, whether interdepartmental or within the same Department shall be by order of the attending physician. The performance of major surgery shall of itself constitute a de facto transfer to that surgical service (physician) unless otherwise ordered by the surgical physician. Major surgery includes that surgery on inpatients requiring a general or a spinal anesthetic. It is understood that ALL pre-operative orders cease at the time of major surgery and must be rewritten post-operatively.

When a patient is transferred from one physician’s care to another, the transferring physician shall write a progress note summarizing the patient’s record up to that time so this information can easily be incorporated later into the Discharge Summary. A transfer of a patient will require a written order for the transfer. The current attending Staff Member shall provide care of the patient until the transfer has been fully completed.

5. All service patients shall be attended by members of the Active Staff, Associate Staff and shall be assigned to the service concerned with the treatment of the disease which necessitated admission. Those physicians shall attend the patient until discharge. No physician shall receive compensation for attendance in the case of any service patient, unless it is payable by a third party. In the case of a paying patient applying for admission who has no attending physician, he/she shall be assigned to the member of the Active Staff on duty in the service to which the illness of the patient indicated assignment.
On a rotating basis, by a schedule provided to the Medical Staff Office by the Departmental Chairman or Section Director, physicians in all Departments as part of their voluntary service obligation to Saint Francis Healthcare, shall be responsible for the care of patients who present themselves to the Emergency Room (without a physician having privileges at Saint Francis Healthcare), patients referred from the Family Practice Center and related patient care centers, a service patient already admitted who may need a consultation as an outpatient, or a patient in another area of the hospital needing an attending physician. It will further be the obligation of the person assigned to arrange for appropriate coverage for service patients in accordance with Rule #E-2 when he is off call. Failure to meet this obligation shall result in appropriate disciplinary action by the Departmental Chairperson.

6. All patients registering in the Emergency Department will be evaluated by an Emergency Physician with the following exceptions:

   (a) If a member of the Medical Staff has arranged to meet his/her patient in the Emergency Department, he/she may, instead, evaluate the patient. If the attending physician is not present and the patient’s condition becomes unstable while in the Emergency Department, the patient will be evaluated by an Emergency Physician.

   (b) Admitted patients who are held in the Emergency Department pending bed availability shall be the responsibility of the admitting physician. If at any time the patient’s condition becomes unstable, the Emergency Department Physician will evaluate the patient. The admitting physician will be called and informed of the patient’s status. Admission orders are the responsibility of the admitting physician.

7. The Emergency Department Physician is responsible for the management and treatment of the patient until the patient is either discharged from the Emergency Department, transferred to care of another physician, admitted to the hospital, or transferred to another facility.

8. The attending physician should be consulted by the Emergency Department physician regarding treatment, follow-up, major change in the management of the patient and/or concerning the need for admission to the hospital, when circumstances warrant.

   If the patient’s attending physician has not responded, the on-call physician on service shall be contacted. In the event of further delay, the Chairman of the Department or Section Director, if appropriate, are to be called.

   On-Call Physicians called by the Emergency Department must respond within 15 minutes. If there is no response within 15 minutes, the Emergency Department will call the physician again. If there is no response within an additional 15 minutes, the Emergency Department physician will contact other physicians to facilitate expeditious care. The failure of an on-call physician to respond will be reported to the VPMA/CMO.

9. Mandatory Consultation Criteria – To assure that each patient is treated by an appropriately qualified practitioner who is competent and credentialed to deliver the required clinical care the following criteria shall be used to determine circumstances that require consultation by the appropriate medical staff member:
a. All cases of attempted suicide shall have a psychiatric consult during hospitalization.

b. Obstetric patients admitted to an intensive care unit should be followed by a practitioner credentialed for obstetrics care and a Medical Staff member credentialed to provide care for an intensive care patient.

c. Newborns admitted to NICU are required to have a consult with a Neonatologist.

d. Any time the condition of the patient calls for a procedure, a type of care, or treatment that exceeds the privileges of the Medical Staff member attending the patient, a consult will be requested for a Medical Staff member with that privilege.

e. Family Practice obstetrical patients with specific diagnoses outlined in the Delineation of Clinical Privileges will require an Obstetrics/Gynecology consult.

10. Consulted physicians are expected to perform consultations the same day as requested, or at least within 24 hours unless other satisfactory and specific alternative arrangements are made directly with the requesting physician. The consultant will enter in the EMR or dictate an initial consultation report. For a single consultation visit, the initial consultation report may serve as the final report. If the patient requires additional visits by the consulting physician or if the clinical situation requires ongoing care by the consulting physician, a sign off or discharge consultation report, including post-discharge follow-up plans, must be entered into the EMR or dictated.”.

11. To ensure the appropriate use of telemetry beds (excluding ICU), a Medical Director for Critical Care may be appointed by the Hospital. The Medical Director, who must be a member of the Medical staff and Board Certified in Cardiology, will have the authority to implement a triage system, which includes the authority to order discontinue telemetry, and transfer of patients to an alternative inpatient level of care.

12. Consistent with the Hospital’s goals of improving the quality and efficiency of care provided in the ICU, the hospital will establish an ICU Critical Care Consult Service Pursuant to which Physicians of Physician Group will be consulted by the admitting physician for each ICU patient, except for single system cardiology patients and CT Surgery patients. The Hospital will adopt such policies or procedures as may be required to implement the Consult Service. Physician Group understands and agrees that:

a. The admitting physician may actively participate in the patient care and decisions; and

b. The admitting physician has final decision-making authority in all patient care decisions.

Admission or transfer to the ICU will require that the admitting physician, or their coverage, will directly exam the patient and complete the admitting orders within one hour of the admission. If the patient is not seen within the hour, the admitting physician will be changed to the designated hospitalist covering group and care will continue under their direction until discharge of the patient from the hospital.
F. MANAGEMENT OF INFORMATION

1. The attending physician shall be held responsible for the preparation of a legible, complete medical record on each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, X-ray studies and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary and discharge note, and follow-up and autopsy report when performed. No medical record shall be filed permanently until it is complete, except on order of the MEC.

Attending physicians supervising resident physicians must countersign, date and time the history and physical examination, the face sheet and attestation statement, and discharge summaries. All emergency room records of patients evaluated by resident physicians must also be countersigned by the appropriate supervising physician.

Attending physicians supervising their Allied Health Professionals may not delegate the performance of history and physical examinations except to qualified Physician Assistants (PA) or Nurse Practitioners (NP) and must countersign all history and physicals, orders, progress notes and discharge summaries dictated/written by the assistant within 24 hours. NP’s and PA’s who have prescriptive authority in Delaware do not require cosigners for progress notes and orders.

2. The physician in attendance at the time of discharge shall be responsible for the medical record including a complete discharge summary which encompasses the entire hospital course and not just the part of the patient’s care dating from the time of the transfer. The discharge summary shall include the reason for hospitalization, the significant findings, the procedures performed and treatment rendered the patient’s condition on discharge, and any specific instructions given to the patient and/or family, as pertinent. The discharge summary must be completed electronically or dictated.

A final progress note may be substituted for the discharge summary only in the case of normal newborn infants and uncomplicated obstetric deliveries.

3. The discharge diagnosis must be recorded and electronically signed by the physician at the time of discharge. By electronically signing the discharge order, the date and time of the discharge order will be electronically recorded. If the final diagnosis for some reason cannot be provided, then an explanatory progress note as to why such diagnosis cannot be furnished must be provided on the progress notes with the tentative date of providing the discharge diagnosis.

4. All orders for patient care must be complete, dated, timed, entered and authenticated in electronic format. An order must be entered by the physician or Allied Healthcare Provider privileged to write orders in their respective areas. The following personnel are authorized to receive and transcribe verbal/telephone orders:

   1. Registered Nurse
   2. Registered Pharmacists
   3. Registered Respiratory Therapists and certified Respiratory Therapists
   4. Registered Radiologic Technologists and Registered Diagnostic Medical Sonographers
   5. Registered Dietitians
6. Medial Laboratory Technologists, Medical Laboratory Technicians, Laboratory Assistants and Laboratory Clerks

7. Licensed Physical/Occupational/Recreational/Speech Therapists

Verbal/telephone orders must be entered directly into the EMR as it is heard than immediately read back to the physician/AHP who gave the verbal or telephone order for confirmation of accuracy of the order. In general the use of verbal orders is discouraged due to the potential for medical error and should be handled in an expedited manner. Verbal orders, given in person to the appropriately designated staff, should only be used in emergency situations, and be electronically signed immediately after the emergency. Likewise, the practitioner should sign, date and time telephone orders within 48 hours.

Verbal orders are to be used infrequently, and should be authenticated by the ordering physician as noted above. Occasionally the ordering physician may not be able to authenticate her/his verbal order, and in such cases, it is acceptable for a covering physician to co-sign, date and time the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for her/his colleague’s order as being complete, accurate, and final.

In order to facilitate patient care, when unable to communicate with a physician, a registered professional nurse, pharmacist, respiratory therapist, physical therapist or other appropriately designated personnel may accept the following delegated or intermediary orders from a representative of a doctor, i.e., a nurse or secretary. The attending physician shall sign, date and time such orders within 48 hours.

The representative of the doctor may inform the nurse on the unit of the procedure and the posted time. Nurse accepting orders must write under orders the name (at least the first initial and last name) of the physician’s representative, date and time.

The physician agreeing to utilize this policy is required to sign, date and time a designated form stating that he/she will accept responsibility for these orders.

Intermediary orders must be renewed annually.

5. All operations performed must be fully described by:

- A brief post operative note electronically generated in the EMR AND
- An electronically generated operative report in the EMR or a dictated operative report immediately after the surgery has been performed.

6. Timelines for Completion of Medical Records

A. Notification Process for Incomplete Records:

1) Staff members and residents will be notified on a weekly basis of any incomplete record. The notification will include the patient’s name,
medical record number, when the record must be completed and the location of the record.

2) A follow-up reminder phone call will be made to Staff members six (6) days prior to the thirty (30) day delinquent date.

B. Actions:

1) If a record remains incomplete thirty (30) days after becoming available for completion, the Staff member will be sent a “Notice of Delinquency” with a request to complete all delinquent records.

2) If a staff member does not complete all delinquent records within thirty (30) calendar days from the date of the notice of delinquency, the Staff member will be:

- Notified by certified mail that if all delinquent records are not completed within the next fifteen (15) calendar days, the Staff member’s actions will be considered a voluntary resignation from the Medical Staff; and if the Staff member fails to complete his/her records within those fifteen (15) calendar days, he/she will be notified by certified mail that his/her privileges will be administratively terminated thirty (30) calendar days from the date of notification for failure to comply with the Medical Staff Rules and Regulations.

(Administrative termination is not reportable to the National Practitioner Data Bank (NPDB))

3) If a staff member receives a fourth (4th) “Notice of Delinquency” within a twelve (12) month period beginning October 1st of each year, the Staff member will be:

- Notified by certified letter that if he/she does not complete all delinquent records within the next thirty (30) calendar days, or if the Staff member receives another “Notice of Delinquency” within the remainder of the twelve (12) month period, the Staff member’s actions will be considered a voluntary resignation with administrative termination of staff appointment and privileges.

This will become effective thirty (30) calendar days from the notification for failure to comply with Medical Staff Rules and Regulations as described previously.

4) Following resignation and administrative termination, no further clinical activity of any type will be permitted until the remedies described below have been implemented.

C. Remedies

1) At any time during the thirty (30) day period between a notice of administrative termination and implementation of that action, the Staff member may rescind his/her resignation by:

- Completing all delinquent records
- Requesting re-instatement by letter to the President of the Medical
Staff; and
- Paying the existing Staff application fee.

2) After administrative termination has taken place, the Staff member may request reappointment to the Medical Staff by:
- Completing all remaining delinquent records;
- Requesting re-instatement by letter to the President of the Medical Staff;
- Completing the full application process including all required documentation and approvals; and
- Paying the existing application fee.

7. All records are the property of the hospital and shall not be taken away without permission of the Chief Executive Officer. In cases of readmission of a patient, previous records shall be available for the use of the attending physician. This shall apply whether the patient be service or private, and whether he be attended by the same physician or another.

8. CONFIDENTIALITY: All participants in Credentialing and Peer Review activities shall respect the confidential nature of matters brought before them. In addition, participants shall respect the confidential nature of information reported to or disclosed by the NPDB, and shall not disclose such information in response to a subpoena or a discovery request as such disclosure is prohibited by law. Requests for such information should be reported to the VPMA/CMO, and appropriate legal action will be initiated in response to such requests.

G. MANAGEMENT OF THE ENVIRONMENT OF CARE

An Emergency Management Plan for mass casualties shall be kept current. In the event of a disaster, the Chairman of this Committee shall be charged with the responsibility of initiating and implementing this plan. The plan for the care of mass casualties will be rehearsed at least twice a year.

H. AUTOPSIES

Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible, or when the cause of the patient’s death is uncertain or the death was unexpected. No autopsy shall be performed without the written consent of the legal next of kin of the deceased patient, except as required by law. All autopsies shall be performed by the hospital pathologist, or a physician to whom he/she may delegate this duty.

I. CREDENTIALING, PRIVILEGING AND REAPPOINTMENT

1. Except in an emergency, consultation with another qualified physician shall be required in all patients whose disease extends beyond or out of the qualifications or specialty of the attending physician.

2. In order for a Staff member to engage a consultant who is not on the hospital staff, the consultant must obtain temporary privileges from the Chief Executive Officer with the concurrence of the pertinent Department Chairperson and the President of the Medical Staff in accordance with Section I.6 of the Saint Francis Healthcare Credentialing Policy.
3. (a) **Direct Supervision** requires the supervising physician to be physically present, and to perform an evaluation of the care which is being supervised.

   (b) **Indirect Supervision** requires the physician to be either physically present on the premises or readily available by an electronic device. Readily available necessitates the ability to become physically present within 20 minutes of notification.

4. Members of the Staff who wish permission to use assistants, employed by them, to assist in the care of their own hospitalized patients shall adhere to the Allied Health Professional Policy and the following stipulations:

   (a) The staff member must submit an application to the VPMA/CMO. The application form must include details of the employee’s qualifications, training, and experience and must state what level of privileges is being requested.

   (b) The application must be processed as specified in the Policy and Procedures on Allied Health Professionals.

   (c) The extent of activities and degree of supervision shall be recommended by the Credentials Committee after consultation with the Vice President of Nursing.

   (d) If permission is given to use an assistant, the staff member shall be responsible for limiting the employee to the performance of functions within the delineation of permitted activities. The staff member shall assume all liabilities arising out of all functions performed by the employee and shall hold the hospital harmless for Activities of the assistant.

**J. CODE OF CONDUCT POLICY**

**POLICY STATEMENT**

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

2. This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the process in the Credentials Policy.

3. This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.
4. In dealing with all incidents of behavior or behaviors that undermine a culture of safety, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

5. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

EXAMPLES OF BEHAVIOR OR BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

To aid in both the education of Medical Staff members and Allied Health Professionals and the enforcement of this Policy, examples of "behavior or behaviors that undermine a culture of safety" include, but are not limited to:

• threatening or abusive language directed at patients, nurses, Hospital personnel, Allied Health Professionals or other physicians (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

• degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;

• profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

• inappropriate physical contact with another individual that is threatening or intimidating;

• derogatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual outside of appropriate Medical Staff and/or administrative channels;

• inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff members or any other individual;

• imposing onerous requirements on the nursing staff or other Hospital employees;

• refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs); and/or

• "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:
(a) **Verbal:** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

(b) **Visual/Non-Verbal:** derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

(c) **Physical:** unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

(d) **Other:** making or threatening retaliation as a result of an individual's negative response to harassing conduct.

**GENERAL GUIDELINES/PRINCIPLES**

1. Issues of conduct by members of the Medical Staff or Allied Health Professionals (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy. If the matter involves an employed practitioner, hospital management in consultation with appropriate medical staff leaders and legal counsel will determine which of any applicable policies will be applied.

2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address concerns about behavior or behaviors that undermine a culture of safety by practitioners. However, a single incident of behavior or behaviors that undermine a culture of safety or a pattern of behavior or behaviors that undermine a culture of safety may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Executive Committee or the elimination of any particular step in the Policy.

3. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the Professional Review Committee/Peer Review Committee, the practitioner's counsel shall not attend any of the meetings described in this Policy.

4. The Medical Staff leadership and Hospital Administration shall provide education to all Medical Staff members and Allied Health Professionals regarding appropriate professional behavior by sending out the policy electronically, use a read receipt and by placing a copy in the new applications and reappointment applications that will go out. The Medical Staff leadership and Hospital Administration shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of behavior or behaviors that undermine a culture of safety and prompt action as appropriate under the circumstances.

**REPORTING OF BEHAVIOR OR BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY**

1. Nurses and other Hospital employees who observe, or are subjected to, behavior or behaviors that undermine a culture of safety by a practitioner shall notify their
supervisor about the incident or, if their supervisor's behavior is at issue, shall notify any member of the Professional Review Committee/Peer Review Committee and also make such reports as are required by applicable Hospital human resources policies. Any practitioner who observes such behavior by another practitioner shall notify any member of the Professional Review Committee/Peer Review Committee directly.

2. The individual who reports an incident shall be requested to document it in writing. If he or she does not wish to do so, the supervisor may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.

3. The documentation should include:

   (a) the date and time of the incident;
   (b) a factual description of the questionable behavior;
   (c) the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
   (d) the circumstances which precipitated the incident;
   (e) the names of other witnesses to the incident;
   (f) consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;
   (g) any action taken to intervene in, or remedy, the incident; and
   (h) the name and signature of the individual reporting the matter.

4. The supervisor shall forward the report to the Professional Review Committee/Peer Review Committee.

5. The supervisor shall follow up with the individual who made the report by informing him/her that the matter is being reviewed, thanking him/her for reporting the matter and instructing him/her to report any further incidents of behavior or behaviors that undermine a culture of safety. The individual shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.

INITIAL PROCEDURE

1. The Professional Review Committee shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

2. If the Professional Review Committee determines that an incident of behavior or behaviors that undermine a culture of safety has likely occurred, the Professional
Review Committee has several options available to it, including, but not limited to, the following:

- notify the practitioner that a report has been received and invite the practitioner to meet with one or more members of the Professional Review Committee to discuss it;

- send the practitioner a letter of guidance about the incident;

- educate the practitioner about administrative channels that are available for registering concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the practitioner, as appropriate;

- send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or

- have a Professional Review Committee member(s), or the Professional Review Committee as a group, meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question.

3. The identity of an individual reporting behavior or behaviors that undermine a culture of safety will generally not be disclosed to the practitioner during these efforts, unless the Professional Review Committee members agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Peer Review Committee and referral to the MEC pursuant to the Bylaws or Credentials Policy.

4. If the Peer Review Committee prepares any documentation for a practitioner's file regarding its efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Peer Review Committee’s documentation.

5. If additional reports are received concerning a practitioner, the Peer Review Committee may continue to utilize the collegial and educational steps noted in this Section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

**REFERRAL TO MEDICAL EXECUTIVE COMMITTEE**

1. At any point, the Peer Review Committee may refer the matter to the MEC for review and action. The MEC shall be fully apprised of the actions taken by the Peer Review Committee or others to address the concerns. When it makes such a referral, the Peer Review Committee may also suggest a recommended course of action.

2. The MEC may take additional steps to address the concerns including, but not limited to, the following:
• require the practitioner to meet with the full MEC or a designated subgroup;

• require the practitioner to meet with specified individuals (including any combination of current or past medical staff leaders, outside consultant(s), the Board Chair or other Board members if medical staff leaders, hospital management and legal counsel determine that board member involvement is reasonably likely to impress upon the practitioner involved the seriousness of the matter and the necessity for voluntary steps to improve);

• issue of a letter of warning or reprimand;

• require the physician to complete a behavior modification course;

• impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it; and/or

• suspend the practitioner's clinical privileges for 30 days or less.

The imposition of any of these actions does not entitle the practitioner to a hearing or appeal.

3. The MEC may also direct that a matter be handled pursuant to the Impaired Physician Policy.

4. At any point, the MEC may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that does entitle the practitioner to a hearing as outlined in the Credentials Policy, or may refer the matter to the Board without a recommendation. If the matter is referred to the Board, any further action, including any hearing or appeal, shall be conducted under the direction of the Board.

SEXUAL HARASSMENT CONCERNS

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2. If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the MEC for review pursuant to the Credentials Policy.

3. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Peer Review Committee. If the investigation results in a finding
that further improper conduct took place, the Peer Review Committee shall refer the matter to the MEC for a formal investigation or other steps in accordance with the Credentials Policy. Such referral shall not preclude other action under applicable hospital human resources policies. Should the MEC make a recommendation that entitles the individual to request a hearing under the Credentials Policy, the individual shall be provided with copies of all relevant reports so that he or she can prepare for the hearing subject to agreement of the practitioner and counsel, if any, not to retaliate in any way.

K. IMPAIRED PHYSICIAN MANAGEMENT POLICY

1. It is the responsibility of the Hospital and its Medical Staff to ensure that its practitioners perform their professional duties in a skillful, competent manner. A practitioner's ability may become limited or impaired by injury, physical disease, alcohol use or chemical dependency, organic or emotional mental illness. As a result, the impaired practitioner may pose a direct or potential threat to themselves and to the health and safety of others.

2. The Hospital and its Medical Staff shall, while monitoring patient care activities, identify the practitioner whose competence may be impaired and assist the practitioner in obtaining treatment, should the condition be amendable to therapy.

3. In dealing with the practitioner, the Hospital and its Medical Staff, recognize the importance of the right to privacy, and shall keep all records confidential except where reporting is required by law, ethical obligations, or when the safety of a patient is threatened.

Procedure:

1. If any individual has a concern that a member of the Medical Staff is impaired, a signed written report should be given to the President of the Medical Staff or designee, the Chairperson of the involved physician's assigned department, or the VPMA/CMO. The report shall include a description of the incident(s) that led to the concern and must be factual in nature.

2. The report shall be given to the Impaired Physician Committee (IPC) for further investigation corroboration, and review. This IPC will be composed of the President of the Medical Staff or designee and the Chairperson of the involved physician's assigned department, and the VPMA/CMO. Depending on the circumstances, they may make a referral to the Physicians Health Committee (PHC), pursue further inquiry, or follow other investigative avenues outlined in these Bylaws.

3. A Licensed Independent Practitioner may also self-refer him/herself to the IPC, by requesting assistance from any one of the IPC, by requesting assistance from any one of the IPC members.

4. The Physicians Health Committee is a Committee of the Medical Society of Delaware, which operates under a Memorandum of Understanding with the Board of Medical Practice, Division of Professional Regulation, of the State of Delaware.
5. The PHC will act expeditiously in reviewing the concerns of potential impairment, and provide a confidential report to the VPMA/CMO, detailing the results of the review and the recommendation(s) made.

6. The IPC may then accept, request further deliberation from the PHC, or reject and institute its own investigation, based on the evidence presented and the level of concern for patient safety.

7. If the recommendations of the PHC include that the physician participates in a rehabilitation or treatment program and the physician agrees to abide by the recommendation, the PHC will assist the physician in locating a suitable program.

8. The progress of the ongoing treatment/rehabilitation as specified by the treatment program will be monitored by the PHC and periodic feedback to the VPMA/CMO will be provided.

9. If the practitioner refuses to acknowledge a problem, violates the agreement to begin treatment or remain in treatment or relapses after completion of therapy, then concern for patient safety mandates that the issue be reported to the Peer Review Committee for consideration of disciplinary action.

10. Documentation of the activities involving an impaired physician shall be maintained in the physician's credentials file. The physician shall have an opportunity to provide a written response to the concern about the potential impairment and it will be maintained in the physician's credentials file.

L. PEER REVIEW/MEDICAL STAFF PRACTICE EVALUATIONS POLICY

1. PURPOSES:

The purposes of this Policy include to: (a) establish triggers for focused professional practice evaluation and data elements for ongoing professional practice evaluation to facilitate a meaningful review of the care provided; (b) effectively, efficiently, and fairly evaluate care provided; and (c) provide constructive feedback, education, and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide. This Policy encourages collegial efforts and progressive steps to address issues that may be identified in the professional practice evaluation process. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, informal discussions, education, mentoring, letters of guidance, sharing of comparative data, and Performance Improvement Plans as outlined in this Policy. All collegial efforts and progressive steps are part of the Hospital’s confidential peer review activities. These efforts are encouraged, but are not mandatory, and are within the discretion of the Department Chairs and the Peer Review Committee (“PRC”).

2. MEDICAL STAFF OVERSIGHT:

This Policy refers to the records and proceedings of the Medical Staff departments and committees which have the responsibility for evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings that relate to this Policy in any way shall be protected from discovery pursuant to applicable law. Ongoing data review and findings about
practitioner practice and performance are evaluated by the Department Chair and/or Division Chair with the focus on improvement. The findings are used to provide ongoing feedback and provide information to be used at the time of reappointment to the Medical Staff.

3. DEFINITIONS AND GENERAL PRINCIPLES:

A. Professional Practice Evaluation

1. Ongoing Professional Practice Evaluation (OPPE) means the ongoing review and analysis of data to identify issues and professional practice trends that may impact on quality of care and patient safety on an ongoing basis. The program includes:

   a) The evaluation of an individual practitioner’s professional performance and includes opportunities to improve care based on recognized standards.

   b) Use of multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with Hospital policies, Rules and Regulations and the Medical Staff Bylaws, and clinical standards and the use of rates compared against established benchmarks or norms.

   c) Individual feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

2. Focused Professional Practice Evaluation (FPPE) is a process whereby the current competency and professional performance of a practitioner is assessed.

   a) FPPE is used to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at Saint Francis Healthcare.

   b) FPPE is also used when questions arise regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care.

B. Peer: A peer is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.

C. Proctor: A member in good standing of the active Medical Staff of Saint Francis Healthcare, with unrestricted privileges in the appropriate specialty or subspecialty.

D. Proctoring: For purposes of this Policy, proctoring is a type of focused evaluation to confirm an individual practitioner’s competence at the time when he or she requests new privileges, either at initial appointment or as a member of the Medical Staff, or to confirm competence in the case of established practitioners who have been referred for focused review.

E. Time Frames: The time frames specified in this Policy are provided as guidelines. All participants in the process shall use their best efforts to adhere to these guidelines.
F. Conflict of Interest Guidelines: To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest and appearances. Recognizing that peer review involves “peers,” the following conflict of interest guidelines shall be used in determining whether and how an individual can participate in the focused professional practice evaluation process.

1. Immediate Family Members. An immediate family member (spouse, parent, child, sibling or in-law) of the practitioner whose care is being reviewed shall not participate in any aspect of the review process except to provide information.

2. Employment by or Contractual Relationship with the Hospital. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not in and of itself preclude an individual from participating in peer review activities.

3. Actual or Potential Conflicts: With respect to a practitioner whose care is under review, actual or potential conflict situations include, but are not limited to, the following:

   a) membership in the same group practice;
   
   b) having a direct or indirect financial relationship;
   
   c) being a direct competitor;
   
   d) close friendship;
   
   e) a history of personal conflict;
   
   f) personal involvement in the care of a patient which is subject to review;
   
   g) raising a concern that triggered the review; or
   
   h) prior participation in review of the matter at a previous level.

4. Participation in Review Process:

   a) Case Reviewers. Individuals may participate in the review process as case reviewers despite an actual or potential conflict because of the check and balance provided by objective worksheets and the PRC’s subsequent review.

   b) PRC Members. Individuals may participate in the review process as PRC members despite an actual or potential conflict because the PRC does not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the PRC Chair has the discretion to recuse a committee member in a particular situation if the Chair believes that the committee member’s presence could inhibit discussion of the issue before the committee, or the member may recuse himself or herself.
c) MEC Members. When the MEC or the Credentials Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, an individual who has an actual or potential conflict as outlined above may provide information to and answer questions posed by the Committee, but shall not participate in the Committee’s final deliberation or determination and shall be excused from any meeting during that time. This recusal shall be documented in the minutes. However, the member may provide relevant information and may answer any questions concerning the matter before leaving. The member may be assigned to review a case.

d) Any member with knowledge of the existence of a potential conflict of interest on the part of any other member may call the conflict of interest to the attention of the committee or department chair. The Chair will make a final determination as to whether the provisions in this section should be triggered.

e) The fact that a department chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

f) The fact that a department or committee member chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

g) Request for Additional Information or Input. At any point in the process outlined in this Policy, information or input may be requested from the practitioner whose care is being reviewed, or from any other practitioner or Hospital employee with personal knowledge of the matter.

h) No Further Review or Action Required. If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter shall be closed. A report of this determination and the reasons supporting it shall be made to the PRC. If information was sought from the practitioner involved, the practitioner shall be notified of the determination.

i) Findings and Recommendations Supported by Evidence Based Research/Clinical Protocols or Guidelines. Whenever possible, the findings of reviewers and the PRC shall be supported by evidence based research, clinical protocols or guidelines.

j) System Process Issues. Quality of care and patient safety depend on many factors in addition to practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in
this Policy, the issue shall be referred to the appropriate Hospital Department and/or the Clinical Quality Department. The referral shall be reported to the PRC so that it can monitor the successful resolution of these issues.

k) Tracking of Reviews. The Clinical Quality Department shall track the processing and disposition of matters reviewed pursuant to this Policy. The Department Chairs and PRC shall promptly notify the Clinical Quality Department of their determinations, interventions and referrals.

l) Legal Protection for Reviewers and Proctors. It is the intention of the Hospital and the Medical Staff that the professional practice evaluation process outlined in this Policy be considered patient safety, professional review, and peer review activity within the meaning of the federal Health Care Quality Improvement Act of 1986, and Delaware law. In addition to the protections offered to individuals involved in professional review activities under those laws, such individuals shall be covered under the Hospital’s Directors’ and Officers’ Liability insurance and/or will be indemnified by the Hospital when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital. The Hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her acts or omissions in the role of proctor, in accordance with the Saint Francis Healthcare insurance plan.

4. CONFIDENTIALITY PRINCIPLES:

Professional practice evaluation information is privileged and confidential in accordance with Medical Staff Bylaws and applicable laws and regulations pertaining to confidentiality and non-discoverability.

A. The Hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in a secure location. Provider-specific professional evaluation information includes information related to:

1. Performance data for all dimensions of performance measured for that individual practitioner.

2. The individual practitioner’s role in sentinel events, significant incidents, or near misses.

3. Correspondence to the practitioner regarding commendations, comments regarding practice performance, or performance improvement plans.

B. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a Medical Staff leader or a member of a peer review committee. They shall have access to the information only to the extent necessary to carry out their assignment.
C. A physician’s quality reappointment file can only be accessed by the VPMA/CMO, the President of the Medical Staff or designee, Department Chairpersons, and members of the Credentials Committee at the time of reappointment. Physicians can access their own files through their Department Chairperson.

D. All individuals involved in the professional practice evaluation process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

E. Communications among those participating in the professional practice evaluation process, including communications with the individual practitioner involved, shall be conducted in a manner reasonably calculated to protect privacy. Correspondence shall be conspicuously marked with the notation “Confidential, to be Opened Only by Addressee.”

5. METHODS AND PROCEDURES:

A. OPPE

1. Each department will define for each specialty and subspecialty the appropriate data to be collected for practitioners with privileges in that specialty/subspecialty. Each OPPE data set will be approved by the Chairs of the Departments, Peer Review Committee (PRC) and the Credentials Committee. Where appropriate and relevant, the threshold for each data element is included. In determining the data elements to be collected, the available information system capabilities and the type of data that would reasonably be expected to reflect clinically-significant issues for each specialty shall be considered. When possible, the thresholds for data elements shall be based on relevant clinical literature.

2. Semi-Annual Reports. An OPPE report for each practitioner shall be prepared at least every six months. A copy shall be placed in the practitioner’s file and considered in the reappointment process and in the assessment of the practitioner’s competence to exercise the clinical privileges granted. A practitioner’s OPPE report shall include:

   a) performance as measured by the relevant data elements;

   b) the number of cases identified for review and the dispositions of those cases; and

   c) the number of informational letters sent pursuant to this Policy.

3. Review by Clinical Quality Department.

   a) If the OPPE report reveals that the practitioner’s data is within the defined thresholds that have been established and no other issues or concerns are noted, the Clinical Quality Department can provide a copy of the report if requested by the practitioner. This information
is being provided to the practitioner solely for information and for use in his or her patient care activities and that no response and no further review are necessary at that time.

b) If the OPPE report reveals any questions or concerns, the Clinical Quality Department shall provide a copy of the report to the practitioner and indicate that it has been forwarded to the Department Chair for review. The practitioner will also be informed that the Department Chair will contact the practitioner if he or she determines that any response or further review is required.

c) The Department Chair may review the underlying cases that make up the data or other relevant information to determine if the data reflects any clinical pattern or issue that requires further review. If it does, the Department Chair shall notify the Clinical Quality Department and proceed in accordance with this Policy. If it does not, the Department Chair shall document his or her findings and include them in the practitioner’s file along with the OPPE report.

Each OPPE data set may include, but is not limited to, the following types of information:

- Review of operative and other clinical procedures(s) performed and their outcomes;
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay patterns;
- Morbidity and mortality data;
- Practitioner’s use of consultants; and
- Compliance with clinical data.

Methods of data collection may include, but are not limited to:

- Periodic chart review;
- Direct observation;
- Monitoring of diagnostic and treatment techniques;
- Discussion with other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel;
- Practice patterns;
• Aggregated and analyses of resource usage;
• Patient outcomes;
• Reported Concerns from patients or staff; and
• Comparative performance measurements from available databases.

If the data is generated by the Clinical Quality Department from their databases, this data will be sent to the Medical Affairs office for inclusion in the practitioner’s file. The Medical Affairs office will forward the information to the appropriate Department Chair for review.

If the data cannot be obtained from the hospital databases, it will be the responsibility of the individual department/division or their designee to collect the data. This data will be reviewed by the Department Chair and forwarded to the Medical Affairs office for inclusion in the practitioner’s file.

The Department Chair will review the collected data and will complete the attached form (Exhibit A) and send it to the Medical Affairs office for inclusion in the practitioner’s file. This data will be collected two (2) times each year.

Relevant information from the OPPE data sets will be utilized as follows:

• Data shall be reviewed by the Clinical Quality Department and integrated into performance improvement initiatives; and
• Upon determination by the VPMA/CMO, an OPPE data set may result in a focused review of a practitioner under the FPPE process.

The activities of the ongoing professional practice evaluations are considered privileged and confidential. This continuous practice evaluation information will be considered in decisions to revise, revoke, or renew existing privileges in accordance with the applicable provisions of the Credentialing Policy.

B. FPPE for New Privileges

1. Under the direction of the Department Chair, each specialty/subspecialty shall prepare a brief Proctoring Plan for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The Plan will be reviewed and updated as needed and will include the proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source is required. The Medical Affairs office shall maintain copies of all Proctoring Plans.

Proctors may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form.
a) **Prospective proctoring:** Presentation of cases with planned outline of treatment for prospective review of case documentation and proposed treatment orders.

b) **Concurrent proctoring:** Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

c) **Retrospective evaluation:** Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient’s care.

Each of the above methods may include observation of:

a) History and physical;

b) Diagnosis and justification;

c) Proposed treatment or procedure and its indications;

d) Continuity of care provided to the patients;

e) Appropriateness of procedures, tests, and medications prescribed;

f) Appropriate use of consultants;

g) Appropriateness of length of stay;

h) Adequacy of progress notes;

i) Adequacy of operative notes;

j) Discharge summary;

k) Timely completion of medical records;

l) Appropriately signed consents;

m) Technical skills/knowledge (as appropriate);

n) Use of blood and blood products;

o) Punctuality and conduct in OR (as appropriate);

p) Pre- and post-operative care; and

q) Management of complications.

Proctoring data from the above methods can be obtained for all admissions of the practitioner or from a random sample. Data may be individual (i.e., case-specific)
or aggregate “rate” date from multiple cases. Data may be derived from information specially obtained for FPPE or for other purposes. The data obtained by the proctor will be recorded in a FPPE form that has been approved by the Credentials Committee in an effort to structure the proctoring data for consistency and reliability.

Proctoring shall begin with the applicant’s first admission or encounter related to a new privilege which, after approval with proctoring, has been granted by the MEC and the Board. The duration of proctoring shall be a specific period of time or for a specific number of cases as specified in the Plan and may differ based upon the levels of experience described below.

The practitioner’s previous experience may be a factor in determining the approach and extent of proctoring needed to confirm current competence. The practitioner’s experience may fall into one of the following classes:

a) A recent training program graduate (within one year)

b) A practitioner with experience of less than five (5) years on another Medical Staff

c) A practitioner with experience of greater than five (5) years on another Medical Staff

d) A gap in continuity of practice

Practitioners in classes a), b), and d) would be candidates for full proctoring programs. Practitioners in class c) may be candidates for limited proctoring upon recommendation of the Department Chair based upon knowledge of the practitioner.

2. Responsibilities of Proctors:

The proctor shall:

- Personally perform the proctoring methods specified in the Proctoring Plan, obtain source data as specified in the Proctoring Plan and complete the Proctoring forms (see attached form);

- Complete a summary report of the Proctoring forms in a format prescribed by the Department Chair;

- Protect the confidentiality of the proctoring results, forms and summary report;

- Deliver the completed proctoring forms and summary report to the Medical Affairs office within seven (7) days of the conclusion of the proctoring period.

If at any time during the proctoring period the proctor has concerns about the practitioner’s competency related to the specific clinical privileges or care related to a
specific patient(s), the proctor shall promptly notify the Department Chair and provide specific factual information, observation and data to the Chair.

3. **Rights and Responsibilities of Practitioner Being Proctored**:

The practitioner being proctored shall do the following as defined in the Proctoring Plan:

- For prospective and concurrent proctoring, notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as is reasonably possible.

- Provide the proctor with a list of patients, medical record numbers, any clinical information requested including pertinent physical findings; complete medical chart; pertinent x-ray and lab results; the planned course of treatment or management, operative reports, consultations, and discharge summaries. Documentation must be made available timely so as to conform to the method of proctoring.

- Inform the proctor of any unusual incident(s) associated with his or her patients.

The practitioner under review has the right to:

- Request from the Department Chair or VPMA/CMO if the Department Chair is the proctor, a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. Such requests shall not unreasonably be denied.

- Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of Proctoring forms and the summary report to the Department Chair. The proctoring period will automatically extend for 60 days if the summary report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not submitted to the Department Chair at the end of the automatic extension, the provisional privileges subject to proctoring shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

4. **Responsibilities of the Department Chair**:

Each Department Chair shall:

- Establish for each specialty and subspecialty within their Department appropriate proctoring methods, data sources, duration of proctoring or minimum number of cases to be proctored. When there are inter-departmental privileges, the Credentials Committee shall determine the minimum number of cases, procedures or time period to be reviewed if there is a disagreement between Chairs.
• Assign a proctor to each applicant at the time practitioner is recommended to Credentials Committee for approval.

• Review the medical records of the patient(s) treated by the practitioner being proctored and any other information provided, if, at any time during the proctoring period or at the end of the proctoring period, the proctor notifies the Department Chair that he or she has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s). The Department Chair shall interview the practitioner and the Department Chair shall then do one of the following:

  a) Intervene and address a conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient and/or appoint a new proctor;

  b) Refer the case(s) to the PRC for peer review; or

  c) Recommend to the Credentials Committee that additional or revised proctoring requirements be required.

• At the request of the practitioner or the proctor, recommend extension of the evaluation period to the Credentials Committee if the practitioner, through no fault of his/her own, has not presented the minimum number of cases or procedures within the time required by the Plan.

• At the conclusion of the proctoring period, review the Proctoring forms and summary report of the proctor, submit the summary report to the Medical Affairs office, and make a recommendation to the Credentials Committee for approval of privileges, additional proctoring or denial of privileges.

5. Responsibilities of the Medical Affairs Office:

The Medical Affairs office shall do the following:

• Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:

  a) Copy of the privilege form

  b) Name, address and telephone numbers of both the practitioner being proctored and the proctor

  c) Copy of this Policy and the Department’s Specialty Proctoring Plan

  d) Proctoring form to be completed by the sponsor
e) Provide information to appropriate hospital department about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed

f) Periodically submit a report to the Credentials Committee and the MEC of proctorship activity for all practitioners being proctored

g) At the conclusion of the proctoring period, submit the summary report to the Credentials Committee and the MEC.

Responsibilities of the Credentials Committee

The Credentials Committee is charged with monitoring compliance with the proctoring Policy and procedures. It accomplishes this oversight by receiving regular status reports related to the progress of all practitioners required to be proctored, as well as any issues or problems involved in implementing this Policy and procedure. The Department Chair shall be responsible for overseeing the proctoring process for all applicants assigned to their department and seeing that the process is completed within a timely fashion. Based on the evaluation of the practitioner’s current clinical competence, practice behavior and ability to perform the requested privilege, the Credentials Committee shall determine whether to impose additional proctoring requirements and/or extend the proctoring period, and shall recommend to the MEC whether privileges shall be approved at the conclusion of proctoring. The proctored practitioner shall be entitled to request a hearing on a denial of privileges in accordance with the Credentialing Policy.

6. Principle of Proctoring:

The proctor’s role is typically that of an evaluator, not of a consultant or mentor. A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the Medical Center. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.

C. FPPE for Established Practitioners

1. FPPE Triggers. The FPPE process may be triggered by any of the following events:

a) Specialty-Specific Triggers. Each Department shall identify outcomes, clinical occurrences, or complications that will trigger FPPE. The triggers identified by the Departments shall be approved by the PRC.

b) Other Indicators approved by the PRC. The Clinical Effectiveness staff will perform ongoing screening to identify cases.
c) A determination by the VPMA/CMO that a focused review is appropriate, based upon the review of any of the following:

i. Ethics/Hotline calls

ii. Reported concerns from other clinicians or members of the health care team

iii. Root cause analysis following a sentinel event involving an individual practitioner’s professional performance;

iv. Patient complaints referred by the Patient Representative

v. A Department Chair’s determination that OPPE data reveal a practice pattern or trend that warrants further review;

vi. Identification by a Medical Staff committee of a clinical trend or specific case or cases that require further review;

vii. Cases identified as litigation risks that are referred by Risk Management;

viii. Corporate compliance issues (e.g., medical necessity) referred through the Compliance Officer or otherwise; and

ix. A trend of noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols or Core, SCIP, DVT-prevention or other quality measures resulting in more than two informational letters being sent within a six-month period.

2. Physician Review:

a) Cases that fall out of the screening process will be directed to the Department Chair or Leadership Council for initial review.

b) The Department Chair may perform the initial review personally and complete an appropriate review form or shall assign the review to another practitioner in the Department who has the clinical expertise necessary to evaluate the care provided. The initial review shall be completed within 30 days. Following review, the Department Chair may:

i. Determine that no further review or action is required;

ii. Send an educational letter;

iii. Conduct a collegial intervention with the practitioner; or
iv. Refer the matter to the PRC or the MEC.

c) Cases may be referred to the VPMA/CMO if they are administratively complex, which includes those:

i. That require immediate or expedited review;

ii. That involve practitioners from two or more Departments;

iii. That involve a Department Chair;

iv. That involve professional conduct;

v. That may involve a practitioner health issue;

vi. Where a pattern appears to have developed despite prior attempts at collegial intervention/education; or

vii. Where participation in a performance improvement plan does not seem to have addressed identified concerns.

d) Guidelines for External Review. An external review may be arranged by the VPMA/CMO. If a decision is made to seek an external review, the practitioner involved shall be notified of that decision and the cases to be sent for external review.

i. The Department Chair is not a peer or all peers are members of the same group as the physician whose case is being reviewed;

ii. There are ambiguous or conflicting findings by internal reviewers;

iii. The clinical expertise needed to conduct a review is not available on the Medical Staff; or

iv. An outside review is advisable to minimize potential allegations of bias, even if unfounded.

3. Peer Review Committee Review:

a) Review of Prior Determinations. The PRC shall review reports from the Department Chairs for all cases where it was determined that (i) no further review or action was required, or (ii) an educational letter or collegial intervention was appropriate to address the issues presented. If the PRC has concerns about any such determination, it may:
i. Send the matter back to the Department Chair with its questions or concerns and ask that the matter be reconsidered and findings reported back to it within 14 days;

ii. Ask an individual Medical Staff member, another Medical Staff committee or Hospital Department to review the matter and report back to the PRC within 30 days; or

iii. Review the matter itself.

b) Cases Referred to the PRC for Further Review

i. The PRC shall review matters referred to it along with all supporting documentation and determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the PRC may assign review to a practitioner on the Medical Staff with the appropriate clinical expertise or, in consultation with the VPMA/CMO CEO, arrange for an external review.

ii. Cases brought to the PRC may be scheduled for a peer review session.

1. Peers are defined as physicians with similar specialties (i.e., Radiology, Medicine, Orthopedics, etc.);

2. Participants in the peer review process are appointed by each Department Chair;

3. Departmental Peer Review sessions are conducted periodically as required by the volume of cases to be reviewed, but should at least occur within two (2) months of a case requiring review; and

4. Peer Review sessions should have at least two (2) peers to meet along with the Chair.

iii. Peer Review sessions are conducted for the purpose of providing additional, confidential review and feedback.

iv. If this individual fails to respond to a PRC request for information or a personal appearance at a peer review session, within 30 days, the PRC will make a determination without his/her response.

v. The PRC will review all Peer Review Session findings and will make recommendations.

1. As appropriate, the PRC may share aggregate data or provide Grand Round presentations on identified issues of common concern. If a specific case is identified as part of
the focused professional practice evaluation process that would have educational benefit for all members of a particular Department or for members of several Departments, the PRC Chair may direct that the case be presented in an educational session and that members of the relevant Departments be invited to attend the session. The particular practitioner(s) who provided care in the case shall be informed that the case is to be presented in an educational session at least seven days prior to the session. Information identifying the practitioner(s) shall be removed prior to the presentation, unless the practitioner(s) request otherwise. Documentation of the educational session shall be forwarded to the PRC for its review.

2. When review forms are complete and action follow-up has occurred, the review forms will be filed in the physician’s quality reappointment file.

vi. Determinations and Interventions: The PRC may:

1. Determine that no further review or action is required;

2. Send an educational letter;

3. Conduct a collegial intervention with the practitioner;

4. Develop a Performance Improvement Plan; or

5. Refer a matter to the MEC.

vii. Forms. The PRC shall approve forms to implement this Policy. Individuals performing a function pursuant to this Policy shall use the form approved by the PRC for that function.

4. Non-Medical Issues Review:

Any major non-medical issues such as inappropriate management of the medical record or non-compliance with medical staff bylaws and/or rules and regulations will also be referred to the Department Chair for review. Issues involving behavior will be handled pursuant to the Code of Conduct Policy. These issues will be placed in the physician’s quality reappointment file.

5. Reappointment and Trending:

At time of reappointment and any time a trend or pattern becomes apparent between reappointments, the file will be referred to the PRC for review and appropriate action.
6. **Focused Reviews:**

   a) Physicians may be subject to a focused review under the following circumstances:

   i. Physician’s performance raises quality or safety concerns, or

   ii. Three or more individual issues are referred to Risk Management or Clinical Quality Departments during a two-year period, or

   iii. Through screening, the physician is found to have recurring outlier activity, or

   iv. A combination of (ii) and (iii) above is noted.

   b) Once concerns are referred to the PRC, it will determine the appropriate focused review plan. The VPMA/CMO in consultation with the Department Chair and PRC Chair may prepare a Plan specific to the basis for the focused review. The VPMA/CMO shall notify the practitioner of the focused review and provide a copy of the Plan.

   c) The plan may include, but is not limited to, the following:

   i. A Peer Review Session.

   ii. A referral to the Practitioner Health Committee, as outlined in J. Practitioner Health Management Policy.

   iii. A recommendation for an investigation as outlined in the Credentialing Policy.

   d) If an opportunity for improvement is found, then the physician in question will have an opportunity to meet with the PRC.

   e) The time frame for completing the focused review process will be no longer than 120 days.

7. **Medical Executive Committee Review:**

   Issues that are unable to be resolved at the Committee/Department level may be referred to the MEC. The Department Chair (in consultation with the President of the Medical Staff and VPMA/CMO) may refer a matter to the MEC if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, or if the matter involves a very serious incident. In addition, the PRC may refer a matter to the MEC if it determines that a PIP may not be adequate to address the issues identified, or the individual refuses to participate in a PIP developed by the PRC or fails to abide by a PIP. The MEC shall conduct its review in accordance with the Medical Staff Credentials Policy.
8. Non-Compliance with Medical Staff Rules, Regulations and Policies, or Failure to Follow Clinical Protocols:

The PRC shall identify specific situations that are conducive to being addressed with a practitioner through an educational letter. These situations include the following:

a) A practitioner failed to comply with Medical Staff Rules and Regulations or other Hospital or Medical Staff policies; or

b) An adopted protocol or guideline was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol or guideline.

In these situations, the VPMA/CMO shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in doing so. The letter shall be signed by the Department Chair or the Chair of the PRC, a copy shall be placed in the practitioner’s confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner’s competence to exercise the clinical privileges granted. If more than two letters are sent during a six-month period, the matter may then be referred to the PRC.

9. Notice to and Input from Practitioners:

An opportunity for practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

a) Notice. No intervention (informational/educational letter, collegial intervention, or Performance Improvement Plan) shall be implemented until the practitioner is first notified of the specific concerns identified and given an opportunity to provide input. The practitioner shall also be notified when the Department Chair refers a matter to the PRC. The notice to the practitioner shall include a time frame for the practitioner to provide the requested input.

b) Input. The practitioner may provide input through a written description and explanation of the care provided, responding to any specific questions posed by the Department Chair, or PRC, and/or by meeting in person with individuals specified in the notice.

c) Failure to Provide Requested Input.

   (1) If the practitioner fails to provide input requested by the Leadership Council or the Department Chair within the time frame specified, the review shall proceed without the practitioner’s input.

   (2) If the practitioner fails to provide input requested by the PRC within the time frame specified, the practitioner’s clinical privileges shall be considered automatically relinquished until the requested input is provided, in accordance with Credentials Policy.

10. Interventions to Address Identified Concerns:
When concerns regarding a practitioner’s clinical practice are identified, the following interventions may be implemented to address those concerns.

a) Informational Letter. For specific situations that are identified by the PRC (e.g., failure to comply with Medical Staff Rules and Regulations requirements), the VPMA/CMO may prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it. A copy shall be placed in the practitioner’s confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner’s competence to exercise the clinical privileges granted. If more than two letters are sent during a six-month period, the matter shall be subject to more focused review. Informational letters may be signed by the Department Chair or the Chair of the PRC.

b) Educational Letter. An educational letter may be sent to the practitioner involved that describes the opportunities for improvement that were identified in the care reviewed and offer recommendations for future practice. A copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer. Educational letters may be sent by a Department Chair or the PRC. If the letter is sent by the Department Chair, the PRC shall be informed of the substance of the letter.

c) Collegial Intervention. Collegial intervention means a face-to-face discussion between the practitioner and one or more Medical Staff Leaders, followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner’s future practice. A copy of the follow-up letter will be included in the practitioner’s file along with any response that he or she would like to offer. If the collegial intervention is conducted or facilitated by the Department Chair, the PRC shall be informed of the substance of the discussion and the follow-up letter. A collegial intervention may be conducted by the Department Chair or the PRC personally or they may facilitate an appropriate and timely collegial intervention by designees. The Department Chair and PRC shall be informed of the substance of any collegial intervention and the follow-up letter, regardless of who conducts or facilitates it.

d) Performance Improvement Plan (“PIP”). The PRC may determine that it is necessary to develop a Performance Improvement Plan for the practitioner. To the extent possible, a PIP shall be for a defined number of cases. The plan shall specify how the practitioner’s compliance with, and results of, the PIP shall be monitored. The practitioner shall have an opportunity to provide input into the development and implementation of the PIP.

The PIP will be personally discussed with the practitioner and presented in writing, with a copy being placed in the practitioner’s file. The practitioner must agree in writing to participate constructively in the PIP. If the practitioner refuses to do so, the matter shall be referred to the MEC.

Until the PRC has determined that the practitioner has complied with all elements of the PIP and that concerns about the practitioner’s practice have been adequately
addressed, the matter shall remain on the PRC’s agenda and the practitioner’s progress on the PIP shall be monitored.

A PIP may include, but is not limited to, the following:

i. Additional Education/CME, which means that, within a specified period of time, the practitioner must arrange for education or CME of a duration and type specified by the PRC. The educational activity/program may be chosen by the PRC or by the practitioner. If the activity/program is chosen by the practitioner, it must be approved by the PRC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.

ii. Focused Prospective Review, which means that a certain number of the practitioner’s future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the practitioner).

iii. Second Opinions/Consultations, which means that before the practitioner proceeds with a particular treatment plan or procedure, he or she must obtain a second opinion or consultation from a Medical Staff member(s) approved by the PRC. The practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the PRC.

iv. Concurrent Proctoring, which means that a certain number of the practitioner’s future cases of a particular type must be personally proctored by a Medical Staff member(s) approved by the PRC, or by an appropriately credentialed individual from outside of the Medical Staff approved by the PRC. The proctor must be present before the case is started and must remain throughout the duration of the case or must personally assess the patient and be available throughout the course of treatment. Proctor(s) must complete the review form specified by the PRC.

v. Additional Training, which means that, within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the PRC. The training program must be approved by the PRC. The practitioner must execute a release to allow the PRC to communicate information to, and receive information from, the selected program. The practitioner must successfully complete the training within another specified period of time. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the practitioner’s current competence, skill, judgment and technique to the PRC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.
vi. Participation in a Formal Evaluation/Assessment Program, which means that, within a specified period of time, the practitioner must enroll in an assessment program identified by the PRC and must then complete the program within another specified time period. The practitioner must execute a release to allow the PRC to communicate information to, and receive information from, the selected program. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.

vii. Educational Leave of Absence, which means that the practitioner voluntarily agrees to a leave of absence during which time the practitioner completes an education/training program of a duration and type specified by the PRC.

viii. Other elements not specifically listed may be included in a PIP. The PRC has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the practitioner to improve his or her clinical practice and to protect patients.

11. Professional Practice Evaluation Reports:

   a) Practitioner FPPE History Reports. A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past two years and their dispositions shall be generated for each practitioner for consideration and evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process.

   b) Reports to MEC and Board. The Clinical Quality Department shall prepare reports at least quarterly showing the aggregate number of cases reviewed through the PPE process, the timeliness of the reviews, the dispositions of those matters, and, when applicable, the effect of the process on patient outcomes.

   c) Reports on Request. The Clinical Quality Department shall prepare reports as requested by the Department Chairs, PRC, MEC, Hospital management, or the Board.

      i. A practitioner failed to comply with Medical Staff Rules and Regulations or other Hospital or Medical Staff policies; or

      ii. An adopted protocol was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol.

In these situations, the Clinical Quality Department shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it. The letter may be signed by the Department Chair or PRC Chair. A copy shall be placed in the practitioner’s confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner’s competence to exercise the clinical privileges granted. If more than two letters are sent
during the six-month period covered by the OPPE report, the matter shall be reviewed as in 5.C.1(ix).

M. POLICY FOR SUPERVISING RESIDENTS

PURPOSE:

To ensure the safety and quality of care for our patients, residents must be supervised by qualified Medical Staff members.

POLICY:

1. DEFINITIONS:

- Residents are defined as physicians who are part of an organized experience of postgraduate education (residency training) leading to a Board Certification designation who work under an institutional license.
- Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings. All aspects of patient care rendered by resident physicians must receive close supervision.
- The supervisory physician is defined as a member of the Medical Staff who has immediate oversight responsibility of all aspects of patient care rendered by students, interns and residents. In most cases, the supervisory physician is also the attending physician or consultant on the case in all circumstances the supervising physician must have competency in the procedure being supervised.

2. ROLES AND RESPONSIBILITIES:

The Program Director of the Family Practice Residency will be in charge of delineating the roles, responsibilities and patient care activities of all residents. These activities are delineated in Administrative Policy.

The Residency Program Director will communicate with the MEC on a quarterly basis through the Education and House Staff Committee regarding the clinical performance and privileging of the residents. The Residency Director will submit an annual report in June of each year regarding the Family Practice Residency and the advancement of the residents through the training program.

All Supervisors will communicate with the Residency Program Director to determine the level of resident involvement and independence in delivering patient care. All aspects of patient care are ultimately the responsibility of the attending physician and involved consultants. Attending physicians have the right to prohibit resident participation in the care of their patients without penalty. When allowing care of their patients by residents they do not relinquish their right or responsibilities to: examine and interview, admit or discharge their patients; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement and initialing the change. The attending physician and consulting physicians must review all entries by house staff in the medical record on a daily basis and make any necessary corrections in the entries. Attending and consultant physicians must document that they have personally performed the key components of each medical encounter in order to maintain compliance with this policy.
The goal of residency training is to develop resident physicians into independent practitioners by allowing increasing responsibility in the assessment of patients and the development and implementation of therapeutic strategies. However, it remains the responsibility of all participating staff physicians to closely supervise house staff in the care of patients.

When a resident is involved in the care of a patient, it is the resident’s responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis. House staff must always notify the appropriate attending or consultant physicians of any change in a patient’s condition or prior to initiating changes in a patient’s treatment.

3. PRIVILEGES GRANTED TO ALL FAMILY PRACTICE RESIDENTS

Having received admission to the Family Practice Residency, all Family Practice Residents will be permitted to perform the following with supervision as noted.

**Admission History and Physicals/Consultations:**

Residents may perform history and physical examinations, and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. The attending physician must confirm the key portions of the history and physical exam, make additions and corrections in the documented history and physical exam, and co-sign the resident’s documentation.

**Daily Progress Notes:**

Residents may evaluate and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss their findings and treatment plans documented in their progress note with the attending physician on a daily basis, or more often as prescribed above, when a patient’s condition changes, or prior to initiating changes in a patient’s treatment. The attending physician must perform the key portions of the exam and confirm the resident’s documentation in the progress note on a daily basis. All documentation by house staff and attending physicians must be legible to those who use the medical record, including signatures. All entries must be signed, dated and timed.

Attending and consulting physicians must make additions and corrections in the daily progress notes and signify these with initials and a date and time of the additions to the medical record. Corrections should be performed by drawing a single line through items of concern and placing additional notes along the margins of the page or in a new section of the progress note. Initials, dates and time must be placed next to all corrections and additions to the medical record.

**Daily orders:**

Residents may write daily orders on the patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending physician or the consulting physician and upper year resident if a first year resident is writing the orders. Attending, and consulting physicians may write orders in the patient’s chart on all teaching cases. Residents should notify the appropriate nursing or support staff of orders entered into the chart to facilitate timely patient care. Residents are encouraged to evaluate all patients for whom they are
initiating orders. However if it is clinically appropriate, residents are allowed to place "verbal" orders over the phone. All phone orders must be signed, dated and timed within the guidelines set forth in the bylaws.

Occurrence Reports:

If the situation occurs where a resident is called upon to fill out an Occurrence Report on a patient, the resident will not refer to submission of the report in the progress notes, or in any portion of the medical record.

4. SPECIAL PRIVILEGES GRANTED TO FAMILY PRACTICE RESIDENTS:

PGY2 & PGY3 Advancement

After preparation by the Program Director, the Education and House Staff Committee will establish criteria for advancement. Near the end of every academic year, the Education and House Staff Committee will review all residents according to the criteria. Following their evaluation and determination, a recommendation will be made for each resident that will include a determination for advancement to PGY2 or PGY3 status.

Procedural Privileging

Residents should be supervised by the physical presence of the attending physician during all procedures, which are specified by the Residency Program Director. To perform procedures under indirect supervision, the resident must have documented observed competency, which is verified by the Program Director, and approved by the Education and House Staff Committee and MEC.

To establish residency procedural privileging, the Program Director will develop a list of procedures that the residents may be privileged to perform independent of the physical presence of the attending physician (indirect supervision.) This list must be developed in conjunction with the Credentials Committee, so that criteria for providing procedural credentialing are consistent throughout the institution. Once established, these criteria may be applied by the Education and House Staff Committee to allow Residents special procedural privileging. Notification of special privileges would be provided from the Education and House Staff to the MEC. The Residency Program Director will review these lists on an annual basis and report his/her findings at the Education and House Staff Committee.

The resident will keep track of all completed procedures on a form supplied by the Residency Program and submit to the Residency Director on a monthly basis. Once the resident has performed the appropriate number of procedures in a competent fashion, the Program Director will present the resident's documentation to the Education and House Staff for further action.

A “Certification book” will be kept on all nursing stations or in Meditech identifying those residents who are certified to perform procedures. Nurses are instructed to check this book or database each time a resident is requesting to perform one of the specified procedures.

N. POLICY FOR MEDICAL STAFF PRACTICE EVALUATIONS

PURPOSE:

To assure that Saint Francis Healthcare, through the activities of its Medical Staff, assesses the ongoing professional practice and competence of its Medical Staff, conducts professional practice
evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice and care.

**MEDICAL STAFF OVERSIGHT:**
This policy refers to the records and proceedings of the Medical Staff, which has the responsibility for evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings of the Medical Staff that relate to this policy in any way shall be protected from discovery pursuant to applicable law. Ongoing data review and findings about practitioner practice and performance are evaluated by the Department Chair and/or Division Chief with the focus on improvement. The findings are used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff.

**DEFINITIONS:**

**A. Professional Practice Evaluation**

1. **Ongoing Professional Practice Evaluation (OPPE)** is a program that allows the Medical Staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis. The program includes:
   a) The evaluation of an individual practitioner’s professional performance and includes opportunities to improve care based on recognized standards.
   b) Use of multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with Hospital policies, Rules and Regulations and the Medical Staff Bylaws, and clinical standards and the use of rates compared against established benchmarks or norms.
   c) Individual evaluation based on generally recognized standards of care. This process provided practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

2. **Focused Professional Practice Evaluation (FPPE)** is a process whereby the Medical Staff evaluates the competency and professional performance of a practitioner.
   a) FPPE is used to evaluate the privilege-specific competence of a practitioner that does not have documented evidence of competently performing the requested privilege at Saint Francis Healthcare.
   b) FPPE is also used when questions arise regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care.

**B. Peer:** A peer is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.

**C. Proctor:** A member in good standing of the active Medical Staff of Saint Francis Healthcare, with unrestricted privileges in the appropriate specialty or subspecialty.

**D. Proctoring:** For purposes of this policy, proctoring is a focused evaluation to confirm an individual practitioner’s competence at the time when he or she requests new privileges, either at initial appointment or as a member of the Medical Staff, or to confirm competence in the case of established practitioners who have been referred for focused review.

**E. Conflict of Interest**

1. A member of the Medical Staff assigned to perform a professional practice evaluation may have a conflict of interest if he or she might not be able to render an unbiased opinion due to either involvement in the patient’s care or a relationship with the practitioner involved as direct competitor or partner.
2. It is the individual reviewer’s obligation to disclose the potential conflict to the Department Chair or VPMA/CMO.
3. It the responsibility of the Department Chair and VPMA/CMO to determine whether the conflict would prevent the individual from participating, and the extent of that participation if allowed.

PRINCIPLES:
Professional practice evaluation information is privileged and confidential in accordance with Medical Staff Bylaws, state and federal laws and regulations, and regulations pertaining to confidentiality and non-discoverability.

1. The Hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in a secure location. Provider-specific professional evaluation information includes information related to:
   a. Performance data for all dimensions of performance measured for that individual practitioner.
   b. The individual practitioner’s role in sentinel events, significant incidents, or near misses.
   c. Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.

2. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a Medical Staff leader or a member of a peer review committee. They shall have access to the information only to the extent necessary to carry out their assignment.

METHODS AND PROCEDURES:
1. OPPE: Each department will define for each specialty and subspecialty the appropriate data to be collected for practitioners with privileges in that specialty/subspecialty. Each OPPE data set will be approved by the Chair of the Department and the Credentials Committee.

Each OPPE data set may include, but is not limited to, the following types of information:
- Review of operative and other clinical procedures(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner’s use of consultants
- Compliance with clinical data

Methods of data collection may include, but are not limited to:
- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel
- Practice patterns
- Aggregated and analyses of resource usage
- Patient outcomes
- Complaints from patients or staff
- Comparative performance measurements from available databases
If the data is generated by the Clinical Quality Department from their databases, this data will be sent to the Medical Affairs office for inclusion in the practitioner’s file. The Medical Affairs office will forward the information to the appropriate Department Chair for review.

If the data cannot be obtained from the hospital databases, it will be the responsibility of the individual department/division to collect the data. This data will be reviewed by the Department Chair and forwarded to the Medical Affairs office for inclusion in the practitioner’s file.

The Department Chair will review the collected data and will complete the attached form (Exhibit A) and send it to the Medical Affairs office for inclusion in the practitioner’s file. OPPE required on an ongoing basis within the 2 year reappointment period.

Relevant information from the OPPE data sets will be utilized as follows:
- Data shall be reviewed by the Clinical Quality Department and integrated into performance improvement initiatives
- Upon determination by the VPMA/CVO, an OPPE data set may result in a focused review of a practitioner under the FPPE process;
- Data shall be used to determine whether to continue, limit or revoke any existing privileges(s) and shall be placed in the practitioner’s file for consideration at the time of reappointment.

The activities of the ongoing professional practice evaluations are considered privileged and confidential. This continuous practice evaluation information will be considered in decisions to revise, revoke, or renew existing privileges in accordance with the reappointment provisions of the Credentialing Manual.

2. **FPPE for Established Practitioners**

   Focused review may be utilized to obtain sufficient information regarding competence of an established practitioner under the following circumstances:

   A determination by the VPMA/CVO or designee that a focused review is appropriate, based upon the review of any of the following:

   a) Ethics/Hotline calls
   b) Complaints from other clinicians or members of the health care team
   c) Root cause analysis
   d) Performance improvement data indicating unfavorable trend associated with practitioner
   e) Patient complaints
   f) OPPE results

   The VPMA/CVO shall prepare a Plan for focused review, which shall contain all of the elements of a Performance Improvement Plan under this policy, but shall be specific to the basis for the focused review. The VPMA/CVO shall notify the practitioner of the focused review and provide a copy of the Plan. The VPMA/CVO may perform the focused review or appoint a proctor. At the conclusion of the focused review, the VPMA/CVO shall evaluate the results of the focused review and if he/she determines further investigation is required, the VPMA/CVO may submit a request for a corrective action to the President of the Medical Staff pursuant to the process outlined in the Credentialing Manual. At the conclusion of the
focused review, the proctor shall return the proctoring forms or summary report to the Credentials Committee.

3. FPPE for New Privileges

4. Under the direction of the Department Chair, each specialty/subspecialty shall require a minimum of 3 Focused Professional Practice evaluations be completed. For Surgeons higher risk procedures will be used for the FPPE. This will be required for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source may be required, shall be identified on a case by case basis by the department chairman.

Proctor may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form (Exhibit B).

a) **Prospective proctoring**: Presentation of cases with planned outline of treatment for prospective review of case documentation and proposed treatment orders.

b) **Concurrent proctoring**: Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

c) **Retrospective evaluation**: Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient’s care.

Each of the above methods may include observation of:

a) History and physical

b) Diagnosis and justification

c) Proposed treatment or procedure and its indications

d) Continuity of care provided to the patients

e) Appropriateness of procedures, tests, and medications prescribed

f) Appropriate use of consultants

g) Appropriateness of length of stay

h) Adequacy of progress notes

i) Adequacy of operative notes

j) Discharge summary

k) Timely completion of medical records

l) Appropriately signed consents

m) Technical skills/knowledge (as appropriate)

n) Use of blood and blood products

o) Punctuality and conduct in OR (as appropriate)

p) Pre and post-operative care

q) Management of complications

Proctoring data from the above methods can be obtained for all admissions of the practitioner or from a random sample. Data may be individual (i.e. case specific) or aggregate “rate” data from multiple cases. Data may be derived from information specially obtained for FPPE or for other purposes. The data obtained by the proctor will be recorded in a FPPE form that has been approved by the Credentials Committee in an effort to structure the proctoring data for consistency and reliability.
Proctoring shall begin with the applicant’s first admission or encounter related to a new privilege which, after approval with proctoring has been granted by the MEC and the Board. The duration of proctoring shall be a specific period of time or for a specific number of cases as specified in the Plan and may differ based upon the levels of experience described below.

The practitioner’s previous experience may be a factor in determining the approach and extent of proctoring needed to confirm current competence. The practitioner’s experience may fall into one of the following classes:

a) A recent training program graduate (within one year)
b) A practitioner with experience of less than five (5) years on another Medical Staff
c) A practitioner with experience of greater than five (5) years on another Medical Staff
d) A gap in continuity of practice

Practitioners in classes a), b), and d) would be candidates for full proctoring programs. Practitioners in class c) may be candidates for limited proctoring upon recommendation of the Department Chair based upon knowledge of the practitioner.

RESPONSIBILITIES:

A. Responsibilities of Proctors
The proctor shall:

- Personally perform the proctoring methods specified in the Proctoring Plan, obtain source data as specified in the Proctoring Plan and complete the Proctoring forms;
- Complete a summary report of the Proctoring forms in a format prescribed by the Department Chair;
- Ensure the confidentiality of the proctoring results, forms and summary report;
- Deliver the completed proctoring forms and summary report to the Medical Affairs office within seven (7) days of the conclusion of the proctoring period.

If at any time during the proctoring period the proctor has concerns about the practitioner’s competency related to the specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the Department Chair and provide specific factual information, observation and data to the Chair.

B. Rights and Responsibilities of Practitioner being Proctored
The practitioner being proctored shall do the following as defined in the Proctoring Plan:

- For prospective and concurrent proctoring, notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as is reasonably possible.
- Provide the proctor with list of patients, medical record numbers, any clinical information requested including pertinent physical findings; complete medical chart; pertinent x-ray and lab results; the planned course of treatment or management, operative reports, consultations, and discharge summaries. Documentation must be made available timely so as to conform to the method of proctoring.
- Inform the proctor of any unusual incident(s) associated with his or her patients.

The practitioner under review has the right to:
• Request from the Department Chair or VPMA/CMO if the Department Chair is the proctor, a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. Such requests shall not unreasonably be denied.

• Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of Proctoring forms and the summary report to the Department Chair. The proctoring period will automatically extend for 60 days if the summary report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not submitted to the Department Chair at the end of the automatic extension, the provisional privileges subject to proctoring shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

C. Responsibilities of the Department Chair

Each Department Chair shall:

• Establish for each specialty and subspecialty within their Department appropriate proctoring methods, data sources, duration of proctoring or minimum number of cases to be proctored. When there are inter-departmental privileges, the Credentials Committee shall determine the minimum number of cases, procedures or time period to be reviewed if there is a disagreement between Chairs.

• Assign a proctor to each applicant at the time practitioner is recommended to Credentials Committee for approval.

• Review the medical records of the patient(s) treated by the practitioner being proctored and any other information provided, if, at any time during the proctoring period or at the end of the proctoring period, the proctor notifies the Department Chair that he or she has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s). The Department Chair shall interview the practitioner and the Department Chair shall then do one of the following:
  a) Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient and/or appoint a new proctor;
  b) Refer the case(s) to the Credentials Committee for peer review;
  c) Recommend to the Credentials Committee that additional or revised proctoring requirements be required; or
  d) Submit a request for a Fair Hearing to the President of the Medical Staff or designee pursuant to the process outlined in the Credentialing Manual.

• At the request of the practitioner or the proctor, recommend extension of the evaluation period to the Credentials Committee if the practitioner, through no fault of his/her own, has not presented the minimum number of cases or procedures within the time required by the Plan.

• At the conclusion of the proctoring period, review the Proctoring forms and summary report of the proctor, submit the summary report to the Medical Affairs office, and make a recommendation to the Credentials Committee for approval of privileges, additional proctoring or denial of privileges.

Responsibilities of the Medical Affairs Office

The Medical Affairs office shall do the following:

• Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:
  a) Copy of the privilege form
  b) Name, address and telephone numbers of both the practitioner being proctored and the proctor
c) Copy of this PPE policy and the Department’s Specialty Proctoring Plan
d) Proctoring form to be completed by the sponsor
e) Provide information to appropriate hospital department about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed
f) Periodically submit a report to the Credentials Committee and the MEC of proctorship activity for all practitioners being proctored
g) At the conclusion of the proctoring period, submit the summary report to the Credentials Committee and the MEC.

D. Responsibilities of the Credentials Committee
The Credentials Committee is charged with monitoring compliance with the proctoring policy and procedures. It accomplishes this oversight by receiving regular status reports related to the progress of all practitioners required to be proctored, as well as, any issues or problems involved in implementing this policy and procedure. The Department Chair shall be responsible for overseeing the proctoring process for all applicants assigned to their department and assuring that the process is completed within a timely fashion. Based on the evaluation of the practitioner’s current clinical competence, practice behavior and ability to perform the requested privilege, the Credentials Committee shall determine whether to impose additional proctoring requirements and/or extend the proctoring period, and shall recommend to the MEC whether privileges shall be approved at the conclusion of proctoring. The proctored practitioner shall be entitled to appeal a denial of privileges after proctoring in accordance with the process outlined in the Credentialing Manual.

PRINCIPLE OF PROCTORING:
The proctor’s role is typically that of an evaluator, not of a consultant or mentor. A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the Medical Center. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have not duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.

The Hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her good faith, acts of omissions in the role of proctor, in accordance with the Saint Francis Healthcare insurance plan.

O. AMENDMENTS, ADDITIONS, DELETIONS

The Rules and Regulations may be changed after a recommended change is approved by the Bylaws Committee, the MEC, and the Board of Directors.
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ARTICLE I.
APPOINTMENT TO THE MEDICAL STAFF

1.1. QUALIFICATIONS FOR APPOINTMENT

1.1.1. General

A. Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this Policy and in such policies as are adopted from time to time by the Medical Staff and the Board of Directors of Saint Francis Healthcare. All individuals practicing medicine, dentistry, podiatry, or psychology at Saint Francis Healthcare, unless accepted by specific provisions of this Policy, must have been appointed to the Medical Staff.

B. All procedures described in this Policy shall be subject to the confidentiality provisions described in Section 4.4 of this Policy.

1.1.2. Specific Qualifications

Only physicians, dentists, podiatrists, and psychologists who continuously satisfy the following conditions shall be qualified for membership on the Medical Staff:

1. Have a current unrestricted license to practice in the State of Delaware (except members of the Emeritus Staff);

2. Are located (office and residence) close enough to the Hospital to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital, in accordance with those specific requirements that are recommended by the MEC and approved by the Board of Directors (except members of the Emeritus and Community Staff);

3. Possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Board of Directors, in compliance with the laws of the State of Delaware, and adequate to provide coverage of the privileges requested or granted. (Physicians admitting or attending patients at Saint Francis Healthcare shall be required to carry professional liability coverage of $1 million per person/$3 million per occurrence);

4. If a physician attending patients at Saint Francis Healthcare, be currently registered at both the state and federal levels to prescribe all medications typically used by practitioners in the same field, which in appropriate circumstances, includes controlled substance classes II-IV.

5. Be able to perform the essential functions of his/her profession for which he/she is seeking privileges, with or without reasonable accommodation;

6. Can demonstrate to the satisfaction of the Board their:
a. Background, experience, training and documented competence;

b. Adherence to the ethics of their profession;

c. Good reputation and character, including the applicant's physical health and mental and emotional stability; and

d. Ability to work harmoniously with others sufficiently that all patients treated by them at the Hospital will receive quality care and the Hospital and Medical Staff will be able to operate in an orderly manner;

7. Physicians, Podiatrists, Psychologists and Oral Surgeons must be board certified in their primary area of practice at Saint Francis Healthcare by the appropriate specialty board of the American Board of Medical Specialties, The American Osteopathic Association, The Council on Podiatric Medical Education, The American Board of Professional Psychology or The American Board of Oral and Maxillofacial surgery, and they must maintain said certification.

Those applicants who are not board certified at the time of application but who by virtue of completing their residency or fellowship training within the last five years are board eligible in their primary specialty, shall be eligible for Medical Staff appointment. However in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the completion of their residency or fellowship training.

Practitioners who have been members of the Medical Staff continuously since January 1, 1999 shall be excluded from the board certification requirement, with the exception that if as of June 28, 2011 they are board certified in their primary area of practice at St. Francis, or ever become certified in their primary area of practice, they must maintain said certification.

Once board certified, individuals whose boards require it must participate in a maintenance of certification program. Individuals who lose certification as a result of failure of a recertification exam must remain eligible for recertification according to the requirements of their board, continue the recertification process and must recertify within three (3) years to remain eligible for medical staff membership.

8. Electronic Medical Records

All physicians, dentist, oral surgeons, podiatrists, psychologists and all other independent practitioners on the Medical Staff must participate in the training for Saint Francis Hospital’s electronic medical records system (EMR) at such time as the EMR training becomes available. Additionally, all listed providers must agree to use the EMR system. Failure to complete such training will result in temporary suspension of all clinical privileges until the training is complete. Only Emeritus and Community Staff categories are exempt from participation but are permitted to apply for appropriate EMR training and access.
All new physicians, dentists, oral surgeons, podiatrists and psychologists and all other independent practitioners joining the Medical Staff will be required to successfully complete the EMR training at such time as EMR training becomes available before being allowed to treat patients. Only those practitioners applying for Emeritus and Community staff categories are exempt from participation but they are permitted to complete appropriate EMR training if requested.

**Waiver of Criteria**

Only under extreme and rare circumstances may an individual who does not satisfy the eligibility criteria outlined above request that it be waived. The individual requesting the waiver bears the burden of demonstrating the circumstances, and/or that their qualifications are equivalent to, or exceed, the requirement in question.

A request for waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may, at its discretion, consider the specific qualifications of the individual, input from the Department Chair, the application form and other information supplied by the applicant, and the best interests of the communities served by Saint Francis Healthcare. The waiver may take the form of an extension of a specific amount of time to complete board certification, a complete waiver of the requirement for certification for practitioners whose breadth of experience or other qualifications warrant it, or other form of waiver depending on the circumstances. The Credentials Committee’s recommendation and the basis for it shall be forwarded to the Medical Executive Committee. The Medical Executive Committee shall review the Credentials Committee action and submit a recommendation and the basis for it to the Board regarding whether to grant or deny the request for a waiver.

An application for appointment that does not satisfy an eligibility criterion will not be considered complete for processing until the Board has determined that a waiver should be granted. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. The Board may not act to grant an individual a waiver absent a recommendation from the Medical Executive Committee. A determination that an individual is not entitled to a waiver is not deemed a denial of appointment or clinical privileges. The granting of a waiver in a particular case is not intended to set a precedent of eligibility criteria for any other individual or group.

8. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership;

9. Each member must abide by the Corporate Responsibility program, and the CHE Standards of Conduct. Failure to do so shall be grounds for corrective action;

10. Practitioners who diagnose or treat patients via telemedicine link are subject to the usual credentialing and privileging processes of the Medical Staff.
1.1.3. No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges at Saint Francis Healthcare merely by virtue of the fact that such individual:

1. Is licensed to practice a profession in this or any other state;
2. Is a member of any particular professional organization;
3. In the past had or currently has Medical Staff appointment or privileges at any hospital;
4. Resides in the geographic service area of the Hospital;
5. Is affiliated with a particular Medical Staff member or a practice; or
6. For any other reason.

1.1.4. Nondiscrimination Policy

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criterion unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

1.1.5. Ethical and Religious Directives

All Medical Staff appointees exercising clinical privileges at the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated from time to time by the National Conference of Catholic Bishops with respect to their practice at the Hospital.

1.2. RESPONSIBILITIES AND REQUIREMENTS FOR APPLICANTS AND APPOINTEES

1.2.1. Basic Responsibilities and Requirements for Applicants and Appointees

As a condition for consideration of an application for Medical Staff appointment or reappointment, and as a condition for continued Medical Staff appointment, if granted, every applicant and appointee specifically agrees to the following:

1. To provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual practitioner has responsibility;
2. To abide by this Policy and all Bylaws, other policies, and rules and regulations of the Medical Staff and Hospital as shall be in force during the time the individual is an applicant or appointed to the Medical Staff;
3. To accept committee assignments and such other reasonable Medical Staff duties and responsibilities as assigned;
4. To provide, with or without request, new or updated information to the Credentials Committee, as it occurs, that is pertinent to any question on the application forms for appointment or reappointment. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

5. To attest that the applicant has had an opportunity to read a copy of this Policy and the Bylaws and rules and regulations of the Medical Staff that are in force at the time of application and to agree to be bound by the terms thereof in all matters relating to consideration of the application, without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

6. To appear, if requested, for personal interviews with regard to the application;

7. To agree that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute grounds for the Hospital to stop processing the application. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to result in automatic relinquishment of Medical Staff appointment and privileges. In either situation, the individual shall not be entitled to a hearing. (The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the MEC. The MEC will recommend to the Board whether the application should be processed further.);

8. To use the Hospital and its facilities sufficiently to enable appropriate Medical Staff committees and Department Chairpersons and the Hospital to evaluate in a continuing manner the current competence of the appointee;

9. To refrain from illegal fee splitting or other illegal inducements relating to patient referral;

10. To comply with any and all Hospital Compliance Plans relating to billing and reimbursement matters;

11. To refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

12. To refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

13. To seek consultation whenever necessary;
14. To promptly notify the VPMA/CMO, and the President of the Medical Staff or designee, of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

15. To abide by generally recognized ethical principles applicable to the applicant's or appointee's profession;

16. To participate in the quality improvement and assessment activities of clinical departments;

17. To complete in a timely manner the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, this Policy and other applicable policies of the Medical Staff and Hospital;

18. To work cooperatively and professionally with Medical Staff appointees, Medical Staff leadership, Hospital management, other practitioners and Hospital personnel;

19. To promptly pay any applicable Medical Staff dues and assessments annually by March 31st. Medical Staff members, other than Emeritus, who fail to pay their dues by September 30th will be considered to have voluntarily resigned from the Medical Staff;

20. To participate in education programs at the Hospital (both for the appointee's own benefit and for the benefit of other professionals and Hospital personnel);

21. To appropriately satisfy the medical education requirements for Medical Staff appointees;

22. To authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

23. To abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services as provided in Section 1.1-5 above; and

24. To promptly notify the VPMA/CMO immediately upon notice of any proposed or actual exclusion from any federally funded health care program and disclose to the hospital President, by telephone call and in writing, any notice to the member or his or her representative of proposed or actual exclusion and/or any pending investigation of the member from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

1.2.2. Burden of Providing Information

A. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

B. The applicant shall have the burden of providing evidence to the satisfaction of the Credentials Committee that all the statements made and information given on the pre-application, application and other hospital documents are true and correct.
C. Until the applicant has provided all information requested by the Hospital, the application for appointment or reappointment shall be deemed incomplete and will not be further processed. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credential's Committee's review and assessment.

1.2.3. Effect of Application

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

1. Whether or not appointment or clinical privileges are granted;

2. Throughout the term of any appointment or reappointment period and thereafter and as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.
   a. Immunity:

   To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

   b. Authorization to Obtain Information from Third Parties:

   The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

   c. Authorization to Release Information to Third Parties:

   The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and
their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

d. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

e. Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

For purposes of this Section, the term "Hospital Representative" includes the Board, its Directors and committees; the Hospital Chief Executive Officer, and his or her designee, the VPMA/CMO, the Medical Staff organization and all Medical Staff members, Departments, Sections, Committees, and their Chairpersons who have responsibility for collecting or evaluating the applicant's credentials and acting upon his/her application, and any authorized representative of any of the foregoing individuals or bodies.

1.3. PROCEDURE FOR INITIAL APPOINTMENT

1.3.1. Submission of Application

A. The application for Medical Staff appointment shall be submitted to the VPMA/CMO. It must be accompanied by payment of such processing fees as may be required by the Hospital. After reviewing the application to determine that all information has been provided, and that any questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with primary sources, the VPMA/CMO shall transmit the complete application and all supporting materials to the appropriate department chairperson.

B. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information at any time during the evaluation process. An incomplete application will not be further processed. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references.

C. Any current Medical Staff member shall have the right to appear in person before the Credentials Committee to discuss in private and confidence any concerns the Medical Staff member may have about the applicant.
D. New applicants to the Medical Staff who are currently excluded from any health care program funded, in whole or in part, by the federal government shall be notified that their applications will not be processed because they do not meet the basic qualifications for membership. They shall further be notified that they have no right to a hearing pursuant to this Article regarding the matter.

1.3.2. Factors to be Considered

A. Each recommendation concerning appointment of a practitioner shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the treatment of patients, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

2. Participation in Staff duties;

3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;

4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;

5. Utilization of Hospital resources;

6. Utilization patterns (e.g., length of patient stays);

7. Current physical and mental health status and ability to perform the privileges requested competently and safely;

8. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications, such as ongoing professional practice evaluation (OPPE) and/or focused professional practice evaluation (FPPE);

9. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;

10. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

11. Current status of professional licenses, including currently pending challenges to any license or registration;

12. Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
13. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and

14. Other reasonable indicators of continuing qualifications.

1.3.3. **Review by the Department Chairperson and/or Section Director**

A. The appropriate department chairperson(s) or section director(s) shall review the application and all supporting materials and shall provide the Credentials Committee with a written report concerning the applicant's qualifications for appointment and requested clinical privileges.

B. As part of his/her evaluation, the department chairperson and/or any section director has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chairperson and/or any section director shall evaluate the applicant's education, training, experience and make inquiries with respect to the same to the applicant's past or current department chiefs, residency training director and any other individuals who may have knowledge about the applicant's education, training, experience and ability to work with others.

C. The department chair and/or section director shall be available to the Credentials Committee to answer any questions that may be raised with respect to his/her report and findings.

1.3.4. **Credentials Committee Review**

A. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in the references given by the applicant, and from other sources available to the Committee, including the report and findings from the chairperson of each clinical department and/or section in which privileges are sought, whether the applicant has satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

B. As part of the process of making its recommendation, the Credentials Committee shall have the right to meet with the applicant to discuss the applicant's application, qualifications, and clinical privileges requested.

C. The Credentials Committee may use the expertise of the Department Chairperson, the Section Director, the VPMA/CMO, any member of the Department or Committee, or an outside consultant, if additional information is required regarding the applicant's qualifications.

D. If, after considering the report of the Department Chairperson or Section Director concerned, the Credentials Committee's recommendation is favorable, the Credentials Committee shall recommend provisional department appointment. All recommendations to appoint, including provisional department appointment, must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the Credentials Committee.
E. If the recommendation of the Credentials Committee is delayed longer than ninety (90) days after receipt of the Department Chairperson's or Section Director's report, the Chairperson shall send a letter to the applicant, with a copy to the MEC, the VPMA/CMO and the Chief Executive Officer, explaining the delay.

1.3.5. Credentials Committee Report

A. Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof, to the MEC, unless such recommendation is delayed and notice of the same is provided as required under Section 1.3-5(E) above. The completed application and all supporting documentation shall accompany the Credentials Committee recommendation and findings. The Credentials Committee report shall contain one of the following recommendations:

1. That the applicant be appointed to the Medical Staff;

2. That the applicant be deferred for further consideration; or

3. That the application be rejected for Medical Staff.

B. When the Credentials Committee recommends appointment to the Medical Staff, it shall also make a specific recommendation regarding the clinical privileges to be granted, and any limitations or conditions on the appointment of the privileges.

C. The Chairperson of the Credentials Committee shall be available to the MEC to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

1.3.6. Medical Executive Committee Review

A. At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall prepare a report. The report shall:

1. Adopt the findings and recommendation of the Credentials Committee;

2. Refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the MEC prior to its final recommendation;

3. Set forth the reasons and any supporting documentation, for its disagreement with the Credentials Committee's recommendation; or

4. May request evaluations of the practitioner where there is doubt about an applicant's ability to perform the privileges requested.

This report shall be forwarded, along with the Credentials Committee's report, through the Chief Executive Officer to the Board of Directors.
B. If the recommendation of the MEC is favorable to the applicant, it shall transmit its recommendation through the Chief Executive Officer to the Board of Directors, including the findings and recommendation of the Credentials Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions related to such clinical privileges.

C. If the recommendation of the MEC would entitle the applicant to request a hearing pursuant to the Fair Hearing Plan, it shall be forwarded to the Chief Executive Officer or his/her designee, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Chief Executive Officer or his/her designee shall then hold the application until after the applicant has exercised or waived the right to a hearing as provided in the Fair Hearing Plan, after which the Chief Executive Officer or his/her designee shall forward the recommendation of the MEC, together with the complete application and all supporting documentation, for further consideration to the Board of Directors.

D. Upon receipt of a favorable recommendation from the MEC that an applicant be granted appointment and the requested clinical privileges, the Board of Directors may:

1. Appoint the applicant and grant clinical privileges as recommended;

2. Refer the matter back to the MEC or to another source inside or outside the Hospital for additional research or information; or

3. Reject the recommendation. If the Board of Directors decides to reject a favorable recommendation, it shall send its decision and the reasons therefore to the Chief Executive Officer and/or designee who shall promptly notify the applicant in writing, certified mail, return receipt requested. If the applicant is entitled to a hearing or appeal, as outlined in the Fair Hearing Plan, the Board of Directors shall not make a final decision until the applicant has exercised or waived his/her rights under the Fair Hearing Plan.

E. The time frame for processing a complete application for initial appointment will be no later than 120 days from the date the application is deemed complete until final approval by the Board of Directors. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

1.4. CLINICAL PRIVILEGES

1.4.1. General

A. Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at the Hospital.

B. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board of Directors.
C. The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including emergency service and other rotation obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) and/or other applicable requirements or standards.

D. Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of patient care obligations.

E. The clinical privileges recommended to the Board of Directors shall be based upon consideration of the following:

   1. The applicant's education, training, experience, demonstrated current competence and judgment, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

   2. Appropriateness of utilization patterns;

   3. Ability to perform the privileges requested competently and safely;

   4. Information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

   5. The applicant's ability to meet all current criteria for the requested clinical privileges;

   6. Availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

   7. Adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

   8. The Hospital's available resources and personnel;

   9. Any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

   10. Any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility; and

   11. Other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which such privileges are sought.

F. The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.
The report(s) of the appropriate department chairperson(s) shall be forwarded to the Credentials Committee and processed as part of the initial application for staff appointment.

1.4.2. Clinical Privileges for Dentists, Oral Surgeons, and Podiatrists

A. The scope and extent of surgical procedures that a dentist, oral surgeon or podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

B. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by an allopathic or osteopathic physician or oral surgeon who holds an appointment to the Medical Staff before dental or podiatric surgery shall be scheduled for performance, and a designated allopathic or osteopathic physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

C. The dentist, oral surgeon or podiatrist shall be responsible for the dental or foot care of the patient, including the dental or podiatric history and physical examination as well as all appropriate elements of the patient's record. Dentists, oral surgeons and podiatrists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with the Medical Staff Bylaws and this Policy.

1.4.3. Clinical Privileges for New Procedures

Whenever a Medical Staff member requests clinical privileges to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

A. The matter shall first be referred to the Department Chairperson who shall investigate the service or procedure and make a recommendation including the following issues (1) whether the new procedure or service is desirable in view of the resources and facilities of Saint Francis Healthcare; (2) the minimum education, training and experience necessary to perform the procedure or provide the service in question in accordance with generally accepted standards of quality; and (3) the extent of monitoring and supervision that should be required.

B. The Department Chairperson shall submit his/her report and recommendation to the Credentials Committee, which shall review the matter and shall forward its recommendation along with the Department Chairperson's report to the MEC.

C. The MEC shall review the matter, prepare its own recommendation and shall forward all reports to the Board of Directors for final action.

D. The Board, after reviewing the Medical Staff's recommendations on the matter, shall make a final decision regarding whether the new procedure or service is one that may be offered to patients. The Board may consider numerous factors, including, without limitation, the
Hospital's capability to perform the procedure in question, the Hospital's needs and mission, and community's need for the procedure or service.

E. Should the Hospital decide to offer the new procedure or service, the Credentials Committee shall investigate the procedure or service and develop criteria to determine the qualifications required for the grant of clinical privileges to perform the new procedure or service.

1.4.4. Clinical Privileges that Cross Specialty Lines

A. Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

B. The Credentials Committee will conduct research and consult with experts, including those on the Medical Staff (e.g., Department Chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

C. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

1. the minimum education, training, and experience necessary to perform the clinical privileges in question;

2. the clinical indications for when the procedure is appropriate;

3. the extent of monitoring and supervision that should occur if privileges would be granted;

4. the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and

5. the impact, if any, on emergency call responsibilities.

The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

1.5. TEMPORARY CLINICAL PRIVILEGES

1.5.1. Circumstances

Upon the written concurrence of the Chairperson of the department where the privileges will be exercised and of the President of the Medical Staff or designee the Chief Executive Officer may grant temporary clinical privileges in the following circumstances:
A. Pendency of Application: After receipt of a completed application for Staff appointment, including a request for specific temporary clinical privileges, and after an interview with the Chairperson of each Department in which privileges have been requested, and after Credentials Committee approval, an appropriately licensed applicant may be granted temporary privileges for a period of up to 120 days. In exercising such privileges, the applicant shall act under the supervision of the Chairperson of the Department to which he/she is assigned and in accordance with the conditions specified in Section 1.5-2 below.

B. To fulfill an important patient care need upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is not an applicant for membership may be granted temporary privileges on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice. Such privileges shall be exercised in accordance with the conditions specified in Section 1.5-2 below and shall be restricted to a period of 120 days, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

1.5.2. Conditions

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested and only after the practitioner has satisfied the requirements regarding professional liability insurance. Special requirements of consultation and reporting may be imposed by the Director of the Department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received (or has been given access to) and read the Medical Staff Bylaws, rules and regulations and policies and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

1.5.3. Termination

A. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital and any or all may be terminated if a question or concern arises regarding the individual's clinical performance or professional conduct.

B. Under such circumstances, the President of the Medical Staff or designee, or the Chief Executive Officer may, after consultation with the pertinent Department Chairperson, terminate any or all of such practitioner's temporary privileges. If the life or well-being of a patient or other person may be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose a summary suspension.

C. In the event of such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the pertinent Department Chairperson. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

1.5.4. Rights of the Practitioner
A practitioner shall not be entitled to the procedural rights (hearing or appellate review) because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated, suspended or otherwise restricted.

1.6. EMERGENCY CLINICAL PRIVILEGES

A. In an emergency, any practitioner who is not currently appointed to the Medical Staff may be permitted by the Chief Executive Officer and/or his/her designee to exercise clinical privileges to the extent permitted by his/her license. Similarly, in an emergency, a physician currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to the extent permitted by his/her license, regardless of that individual's Department status or specific grant of clinical privileges.

B. When the emergency situation no longer exists, the patient shall be assigned by the President of the Medical Staff or designee, to an appropriate Medical Staff member with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

1.7. DISASTER CREDENTIALING

A. Purpose: When the Emergency Management Plan has been activated for Saint Francis Healthcare, the Hospital may be unable to handle the immediate and emergent patient care needs. At that time, it may become necessary to grant disaster privileges, temporarily, to external physicians to help care for an unusually high number of critically ill patients.

B. Policy: During the disaster in which the Emergency Management Plan has been activated, the Chief Executive Officer, VPMA/CMO shall grant disaster privileges to individuals deemed qualified and competent, for the duration of the disaster situation. Granting of these privileges will be handled on a case-by-case basis and is not a "right" of the requesting provider.

C. Procedure:

1. Hospital Administration will inform Medical Staff Office that the Emergency Management Plan has been activated and that disaster privileging will be required.

2. A Disaster Privileging Form will be given to any licensed independent practitioner wishing to request these privileges. The form must be completed to the extent possible and signed by the requesting licensed independent practitioner prior to approval of disaster privileges. The form must be accompanied by his or her valid government-issued photo identification (a driver’s license or passport), and at least one of the following:

   • Current hospital photo ID card.
   • Current medical license with valid photo ID issued by a State, Federal, or regulatory agency.
   • Identification that certifies the physician is a member of a State or Federal disaster medical assistance team.
• Identification that certifies the physician has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies.
• Presentation by a current Hospital or Medical Staff member who can vouch for the physician's identity.

3. As soon as the immediate situation is under control, the Medical Staff Office personnel will complete within 72 hours the primary source verification of the medical license of the physician. In addition, the DEA certification and the malpractice insurance carrier will be verified to the extent possible.

4. A signed Disaster Privileges Request Form, which binds the practitioner to follow the Bylaws of the Medical Staff and related hospital policies, and any supporting documents will be forwarded to the Chief Executive Officer, VPMA/CMO for final approval.

5. Once approved, the physician will be notified that he/she may begin working. A photo ID will be provided to the physician.

6. The practitioner shall be paired with a currently credentialed Medical Staff member and should act under the direct supervision of a Medical Staff member. Any observed concerns should be reported to the VPMA/CMO or Department Chair, as soon as possible.

7. As soon as possible after the initial implementation of the Emergency Management Plan, Medical Staff Office personnel will verify additional information on all physicians who have requested disaster privileges such as:
   a. Current competence;
   b. NPDB query;
   c. Medicare sanction information.

8. If any adverse information is uncovered during this verification process, this information will be brought to the attention of the Chief Executive Officer, VPMA/CMO, who granted the privileges. A determination will be made at that time whether or not to immediately terminate the disaster privileges for that physician.

9. The CEO or VPMA/CMO must approve the continuation of disaster privileges within 72 hours.

10. When the Hospital has deemed that the Emergency Management Plan is no longer needed, all disaster privileges will immediately terminate.

1.8. CONTRACT PRACTITIONERS

The Medical Staff appointment and clinical privileges of any staff member who has an exclusive contractual relationship with the Hospital or who is either an employee of, principal of, or partner in an entity that has an exclusive contractual relationship with the Hospital shall be governed by
the provisions of the pertinent contract. Unless otherwise provided in the contract, the contract practitioner shall not be entitled to procedural rights (including a fair hearing and appellate review) based upon the termination of Medical Staff membership or clinical privileges occurring as a result of the expiration or termination of the contract.

1.9. **TELEMEDICINE**

A. **Definition:** Telemedicine is the electronic transmission of images and other health information from one facility to another facility for the purposes of clinical interpretation and/or consultation.

B. **Credentialing:** Physicians performing clinical services via telemedicine will follow the same procedure for appointment and clinical privileges as all other physician applicants.

C. **Active Status:** Will not be eligible to hold office or vote at medical staff meetings.

1.10. **VOLUNTARY RELINQUISHMENT OF PRIVILEGES**

A. A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the Department Chairperson specifying the clinical privilege(s) to be relinquished and the reasons for the request. The Department Chairperson will make a recommendation to the MEC.

B. The Department Chairperson will report to the MEC as to whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call rotation. The MEC may request a meeting with the member involved. The MEC will make a recommendation to the Board.

C. The Board will make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply with applicable regulatory requirements, including EMTALA. The Board's decision will be reported in writing by the CEO to the member, the Executive Committee, and the applicable department chairperson. If the Board permits the relinquishment of privileges, it will specify the effective date of the relinquishment.

D. Failure of a member to request relinquishment of clinical privileges as set forth above will result in the member being maintained on the call schedule without any change to his or her call responsibilities.

E. Members must maintain competency for the core privileges in their specialty. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage OR to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.
1.11. CORE PRIVILEGES

A. Application Process Requirements

Individuals requesting clinical privileges at the Hospital are required to apply for core privileges in their specialties as may be defined by each clinical department. The scope of core privileges for each clinical department shall be recommended by the department chairperson and must be approved by the Credentials Committee, MEC, and Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the department chairperson and approved by the Credentials Committee, MEC and Board.

B. Rules Governing Exercise of Core Privileges

Individuals who have been granted core privileges shall be required to do the following:

1. provide emergency call coverage for patients requiring emergency care within the scope of their core privileges; and

2. provide consultations for patients requiring consults within the scope of their core privileges.

C. Exemption from Core Privileges

1. Any individual who wishes to be exempt from a particular privilege(s) within the core for a specialty must apply for an exemption in writing, documenting the good cause basis for the request.

2. After considering the recommendations from the relevant department chairperson and the Credentials Committee, the MEC shall make a recommendation in support of or against such exemption. The following factors may be considered by the Medical Staff leadership in their review of the request:

   a. the Hospital's mission and its obligation to serve the health care needs of the community by providing timely, quality health care on a local basis;

   b. fairness to the individual requesting the exemption, including past service and the other demands placed upon the individual;

   c. fairness to the other Medical Staff members who serve on the call roster in that specialty, including the effect that the removal would have upon them;

   d. any gaps in call coverage that might/would result from a Medical Staff member's removal from the call roster for the specific privilege and the feasibility and safety of transferring patients to other facilities in that situation;

   e. the expectations of other members of the Medical Staff who are in different specialties but who routinely rely on the specialty in question in the care of the patients who present to the emergency department;
f. the perceived inequities in exemptions being available to some; and

g. how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including EMTALA.

3. If the MEC recommends against granting an exemption, the individual shall be entitled to appear before the Executive Committee before the Executive Committee makes a final recommendation to the Board.

4. If the MEC recommends in favor of granting the exemption, the recommendation shall be forwarded to the Board for its review and action.

5. The Board shall make a final decision on the exemption request based upon consideration of the factors set forth in (a) above. The Board's decision shall be reported in writing by the President of the Medical Staff to the member, the MEC, and the applicable department chairperson, and shall specify the effective date of the exemption.

6. No individual is entitled to an exemption or to a hearing if the Board determines not to grant an exemption. A denial of a request for exemption does not entitle an individual to request a hearing.

D. Special Privileges Beyond the Core

Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis, as may be requested.

ARTICLE II.
REAPPOINTMENT

2.1. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

2.2. APPLICATION

A. Each current Medical Staff member who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form.

B. The reappointment application shall be furnished to the Medical Staff member at least four (4) months prior to the expiration of the member's current appointment period. The completed reappointment application shall be submitted to the VPMA/CMO at least three (3) months prior to the expiration of the member's current appointment period. Failure to submit an application by that time will result in automatic expiration of the member's appointment and clinical privileges at the end of the then current term of appointment unless good cause is shown for the delay.
C. Reappointment, if granted, shall be for a period of not more than two (2) years.

D. Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges will expire at the end of the then current term of appointment. Subsequent Board action may be needed to grant reappointment and renewal of clinical privileges.

E. In those situations where the Board has not acted on a pending application for reappointment, and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the CEO will have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO will consult with the chairperson of the applicable department, the Chair of the Credentials Committee, or the President of the Medical Staff or designee. The temporary clinical privileges will be only for a period not to exceed 120 days.

F. In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

2.3. FACTORS TO BE CONSIDERED

A. Each recommendation concerning reappointment of a practitioner currently appointed to the Medical Staff shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the treatment of patients, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

2. Participation in Staff duties;

3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;

4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;

5. Utilization of Hospital resources;

6. Utilization patterns (e.g., length of patient stays);

7. Current physical and mental health status, including ability to perform the privileges requested competently and safely;
8. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications, including ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

9. Any focused professional practice evaluations;

10. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;

11. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

12. Current status of professional licenses, including currently pending challenges to any license or registration;

13. Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

14. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and

15. Other reasonable indicators of continuing qualifications.

B. To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments or therapies in the previous appointment term to enable the appropriate department chairperson and the Credentials Committee to assess the applicant's current clinical competence for the privileges requested.

2.4. PROCEDURE FOR REAPPOINTMENT

2.4.1. Review by the Department Chairperson

A. No later than three (3) months prior to the end of the current appointment period, the VPMA/CMO, shall send to the Chairperson of each Department a current list of all practitioners who have clinical privileges in that Department, together with a description of the clinical privileges that each holds, accompanied by copies of their applications for reappointment.

B. Each Department Chairperson shall provide the Credentials Committee with a written report concerning each practitioner seeking reappointment. The Chairperson shall include in each written report, when applicable, the reasons for any recommended changes in staff category or clinical privileges or the reasons for a recommendation of non-reappointment. The Department Chairpersons shall be available to the Credentials Committee to answer any questions that may be raised with respect to any practitioner.
2.4.2. Credentials Committee Review

A. The Credentials Committee, after receiving the reports from each department chairperson, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and Hospital, for the purpose of determining its recommendations regarding staff reappointment, clinical privileges and staff category for the ensuing appointment period.

B. As part of the process of making its recommendation, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee, either as part of the reappointment process or at any time during the appointment period to aid the Committee in determining whether it should recommend that clinical privileges be granted or continued. The results of such examination shall be made available for the Credentials Committee's consideration. Failure of a practitioner to undergo such examination within a reasonable time of being requested to do so in writing by the Credentials Committee shall constitute a voluntarily relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

C. The Credentials Committee shall have the right to require the practitioner seeking reappointment to meet with the Committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

D. The Credentials Committee may use the expertise of the Department Chairperson, any member of the Medical Staff, or an outside consultant, if it decides additional information is needed regarding a practitioner's qualifications for reappointment.

E. After considering all the available information regarding a practitioner, the Credentials Committee shall prepare a report recommending reappointment or non-reappointment, specific clinical privileges, and any restrictions or other conditions regarding reappointment or clinical privileges. When non-reappointment, non-promotion, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated. The Credentials Committee shall forward its written findings and recommendations, as well as the completed application for reappointment and supporting documentation, to the MEC in time for that Committee to consider the practitioner's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period.

F. The Chairperson of the Credentials Committee shall be available to the MEC (or to the Board of Directors) to answer any questions that may be raised with respect to its report or recommendations.

2.4.3. Medical Executive Committee Review

A. The MEC shall review the written findings and recommendations of the Credentials Committee and shall:

1. Adopt the findings and recommendations of the Credentials Committee;
2. Refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the MEC prior to its final recommendation; or

3. Set forth in its report and recommendation the reasons, along with supporting documentation, for its disagreement with the Credentials Committee's recommendation.

B. If the recommendation of the MEC is favorable, it shall transmit its recommendation, as well as the report of the Credentials Committee, through the Chief Executive Officer, or his/her designee, to the Board of Directors. All recommendations to reappoint must also specifically recommend the clinical privileges to be granted.

C. Any recommendation by the MEC that would entitle the affected individual to the procedural rights (hearing and appellate review) in the Fair Hearing Plan, shall be forwarded to the Chief Executive Officer, or his/her designee, who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer, or his/her designee, shall then hold the recommendation until after the individual practitioner has exercised or waived the right to a hearing as provided in the Fair Hearing Plan. After such time, the Chief Executive Officer, or his/her designee, shall forward the recommendation of the MEC, together with all supporting documentation, to the Board of Directors. The Chairperson of the MEC shall be available to the Board of Directors to answer any questions that may be raised regarding the practitioner.

D. In the event the Board of Directors decides to consider modification of the action of the MEC and such modification would entitle the practitioner to a hearing in accordance with the Fair Hearing Plan, it shall notify the affected practitioner through the Chief Executive Officer and shall take no final action until the practitioner has exercised or waived the procedural rights provided in the Fair Hearing Plan.

E. The time frame for processing a complete application for reappointment will be no later than 120 days from the date the application is deemed complete until final approval by the Board of Directors. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

2.4.4. Conditional Reappointments

A. Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). The imposition of such conditions does not entitle an individual to request a hearing.

B. In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to request a hearing.
2.5. PROCEDURES FOR REQUESTING AN INCREASE IN CLINICAL PRIVILEGES

2.5.1. Application for Additional Clinical Privileges

Whenever, during the term of appointment, additional clinical privileges are desired, a practitioner may submit a written request for increased clinical privileges to the VPMA/CMO. The request shall state in detail the specific clinical privileges desired and the practitioner's relevant recent training and experience that justify the additional privileges. This request shall be transmitted to the appropriate Department Chairperson. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.

2.5.2. Factors to Be Considered

A. Recommendations for additional clinical privileges shall be based upon the following factors:

1. Relevant recent training;
2. Observation of patient care provided;
3. Review of the records of patients treated in this or other hospitals;
4. Results of the Hospital's quality improvement activities;
5. The applicant's ability to meet the qualifications and criteria for the clinical privileges requested; and
6. Other reasonable indicators of the practitioner's continuing qualifications for the privileges in question.

B. The granting of such increased privileges may be accompanied by requirements for supervision, consultation or other conditions or restrictions.

ARTICLE III.
LEAVE OF ABSENCE

3.1. PROCEDURE FOR LEAVE OF ABSENCE

A. Medical Staff members may, for good cause, be granted leave of absence by the Board of Directors for a definite period of time, not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation from Medical Staff membership and clinical privileges unless an exception is made by the Board of Directors upon the recommendation of the MEC.

B. A practitioner must submit his/her request for a leave of absence to the President of the Medical Staff or designee and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff or designee shall transmit the request, together
with a recommendation, to the Chief Executive Officer for action by the Board of Directors.

3.2. TERMINATION OF LEAVE OF ABSENCE

A. At the conclusion of the stated time period for the leave of absence, the Medical Staff member shall submit a request for reinstatement to the President of the Medical Staff or designee. The request shall include a summary of all professional activities undertaken during the period of the leave. If requested by the President of the Medical Staff or designee, the Medical Staff member shall provide further information relating to the practitioner's professional qualifications, current competence, and/or ethical conduct. A Medical Staff member who fails to timely submit a request for reinstatement shall be deemed to have voluntarily resigned from the Staff.

B. If the leave of absence was for medical reasons, then the Medical Staff member must submit a report from his or her attending physician indicating that the member is physically or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The Medical Staff member shall also provide any other information requested by the President of the Medical Staff or designee, the Credentials Committee, the MEC, or the Board of Directors. At the request of the MEC, the Medical Staff member shall undergo a physical or mental examination by a physician chosen by the Committee.

C. The request and all supporting documentation and information shall be transmitted to the Credentials Committee, which shall forward to the MEC a recommendation regarding the practitioner's reinstatement. The MEC thereafter shall consider all the information and transmit its recommendation and the reasons therefore, to the Board of Directors for final action.

D. If the Board of Directors grants reinstatement, it may modify the practitioner's staff category and/or clinical privileges, or impose conditions (such as supervision, observation, consultation, or probation) on the exercise of clinical privileges.

ARTICLE IV.
PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

4.1. COLLEGIAL INTERVENTION

A. This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

B. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.
C. Collegial intervention efforts involve reviewing and following up on questions raised about
the clinical practice and/or conduct of staff members and pursuing counseling, education,
and related steps, such as the following:

1. advising colleagues of all applicable policies, such as policies regarding appropriate
behavior, emergency call obligations, and the timely and adequate completion of
medical records;

2. proctoring, monitoring, consultation, and letters of guidance; and

3. sharing comparative quality, utilization, and other relevant information, including
any variations from clinical protocols or guidelines, in order to assist individuals to
conform their practices to appropriate norms.

D. The relevant Medical Staff leader(s) (Officers, applicable Committee and Department
Chairpersons and the VPMA/CMO) will determine whether it is appropriate to include
documentation of collegial intervention efforts in an individual's confidential file. If
documentation of collegial efforts is included in an individual's file, the individual will have
an opportunity to review it and respond in writing. The response will be maintained in
that individual's file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and will be within
the discretion of the appropriate Medical Staff leaders and Hospital management.

F. The relevant Medical Staff leader(s), in conjunction with the CEO, will determine whether
to direct that a matter be handled in accordance with another policy (e.g., code of conduct
policy; practitioner health policy; peer review policy). Medical Staff leaders may also
direct these matters to the MEC for further action.

4.1.1. Investigation Procedure

A. Whenever a concern or question has been raised regarding the conduct or activities of a
Medical Staff member, or where collegial efforts have not resolved an issue, regarding:
the President of the Medical Staff or designee, appropriate department chairperson, or
Chief Executive Officer (or designee) shall make sufficient inquiry to ascertain that the
concern or question is credible, after which a report of such conduct or activity shall be
submitted in writing to the MEC. If any of the inquiring individuals set forth in this
provision believe it to be in the best interest of the Hospital and the Medical Staff member
involved, he/she may, but are not required to, discuss the matter with the affected Medical
Staff member.

B. The MEC shall consider all reports submitted to it and determine whether to discuss the
matter with the practitioner concerned and/or to begin an investigation.

C. The President of the Medical Staff or designee shall promptly notify the Chief Executive
Officer in writing of all requests for corrective action and all investigations and shall keep
the Chief Executive Officer fully informed of all actions taken in connection with such
matters.
D. If the concern contains sufficient information to warrant a recommendation, the MEC, at its discretion, may make such a recommendation with or without a personal interview with the individual being investigated.

E. If the concern does not contain sufficient information to warrant a recommendation, the MEC shall immediately appoint an ad hoc Investigation Committee consisting of up to three (3) members of the MEC or other Medical Staff members to investigate the matter. This Investigation Committee shall not include any individual who previously participated in the recommendation, had any direct involvement in the matter, or any direct competitors, partners, associates, or relatives of the person being investigated.

F. The Investigation Committee shall have the cooperation of the Hospital and Medical Staff. With the approval of the Chief Executive Officer, the Investigation Committee may obtain information from outside consultants. The Investigation Committee may also require the involved practitioner to submit to a physical or mental examination by a physician satisfactory to the Committee and may require that the results of such examination be made available for the committee's consideration.

G. The investigated practitioner shall have an opportunity to meet with the MEC or the Investigation Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it), the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain or refute the information. This interview shall not constitute a hearing and none of the procedural rules provided in the Fair Hearing Plan shall apply. A summary of such interview shall be made by the Investigation Committee and included in the report to the MEC.

H. The MEC may accept, modify, or reject the recommendation it receives from the investigation committee.

4.1.2. Corrective Recommendations and Action

A. In acting after the investigation, the MEC may:

1. Determine that no action is justified;

2. Issue a letter of counsel, education or guidance;

3. Issue a written warning;

4. Issue a letter of reprimand;

5. Impose conditions for continued practice;

6. Impose a requirement for non-binding consultation;

7. Recommend modification of clinical privileges (e.g., reduction, suspension, or restrictions);

8. Recommend permanent revocation of Medical Staff appointment;
9. Make such other recommendations as it deems necessary or appropriate.

B. If the action of the MEC is not of the kind that entitles the individual to a hearing, the action shall take effect immediately without action of the Board of Directors and without the right of appeal to the Board of Directors. A report of the action taken and the reasons therefore shall be made to the Board of Directors through the Chief Executive Officer or designee, and the action shall stand unless modified by the Board of Directors.

C. Any recommendation by the MEC that would entitle the affected practitioner to a hearing under the Fair Hearing Plan shall be forwarded to the Chief Executive Officer or designee who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer or designee shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in the Fair Hearing Plan, after which the Chief Executive Officer or designee shall forward the recommendation of the MEC, together with all other information, to the Board of Directors. The Chairperson of the MEC shall be available to the Board of Directors to answer any questions that may be raised with respect to the recommendation.

D. In the event the Board of Directors determines to consider modification of the action or recommendation of the MEC and such modification would entitle the individual to a hearing in accordance with the Fair Hearing Plan, the Chief Executive Officer or designee shall notify the affected practitioner and no final action will be taken until the individual has exercised or waived his or her rights to a hearing.

4.2. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

4.2.1. Criteria for Initiation and Initial Procedure

A. The Chair of the Board of Directors, the Chief Executive Officer or designee, the VPMA/CMO, and the Department Chairpersons shall each have the authority to suspend or restrict all or any portion of the clinical privileges of a Medical Staff member or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any patient or other individual. Such precautionary suspension or restriction shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the matter that precipitated the suspension or restriction. The individual may be afforded an opportunity to voluntarily refrain from exercising privileges pending an investigation.

B. The individual imposing the precautionary suspension shall immediately report the suspension in writing to the Chief Executive Officer and the President of the Medical Staff or designee.

C. The Chief Executive Officer shall provide immediate notice to the affected practitioner and shall promptly thereafter provide written notice to the practitioner.
D. A precautionary suspension shall become effective immediately upon imposition. A precautionary suspension shall remain in effect, unless earlier terminated by the Chief Executive Officer or his/her designee.

E. Immediately upon the imposition of a precautionary suspension or restriction, the appropriate department chairperson or, if that individual is unavailable, the President of the Medical Staff or designee, shall assign to another practitioner with appropriate clinical privileges, the responsibility for care of the suspended practitioner's patients still in the Hospital. The wishes of the patient shall be considered in the selection of the substitute practitioner.

F. A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.

4.2.2. Medical Executive Committee Procedure

A. The MEC will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

B. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

C. There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

4.3. AUTOMATIC RELINQUISHMENT

4.3.1. Failure to Complete Medical Records

The admitting and clinical privileges of any Medical Staff appointee shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable rules and regulations governing the same, after notification of the Medical Records Department of such delinquency. Such relinquishment shall continue until all records of the Medical Staff member are no longer delinquent.

4.3.2. Action by State Licensure Agency

The medical staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished in the event that the appropriate state licensing board terminates or revokes a Medical Staff member's professional license for any reason. If a Staff member's license
is suspended, his or her clinical privileges shall also be relinquished until such matter is resolved, and an application for reinstatement of privileges has been approved by the Credentials Committee and the Board of Directors. In the event the Medical Staff member's license is only partially restricted, the clinical privileges affected by the license restriction will be similarly restricted.

4.3.3. Controlled Substance Registration

The Medical Staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished in the event that the appropriate governmental agency revokes, suspends or restricts the member's controlled substance registration.

4.3.4. Failure to be Adequately Insured

The admitting and clinical privileges of any Medical Staff member shall be automatically relinquished if, at any time, such Staff member fails to maintain the required levels and scope of professional liability insurance coverage. Such relinquishment shall remain in effect until adequate professional liability insurance coverage is obtained.

4.3.5. Failure to Provide Requested Information or Correct Information

A. The Medical Staff membership and clinical privileges of any Medical Staff member shall be automatically relinquished if, at any time, the appointee fails to provide required information pursuant to a formal request by the Credentials Committee, the MEC, or the Chief Executive Officer. Such relinquishment shall remain in effect until the required information is provided to the satisfaction of the requesting party.

B. The Medical Staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished if it is determined that the Medical Staff member knowingly provided erroneous information on any official Medical Staff documents or provided incorrect or inaccurate information to any Hospital or Medical Staff representative.

4.3.6. Medicare and Medicaid Violations

The Medical Staff membership and clinical privileges of a Medical Staff member who is excluded from participation in the Medicare and/or Medicaid program shall be automatically relinquished. The relinquishment shall be effective as of the date of the termination, exclusion or preclusion. A Staff member who is sanctioned, but not excluded from the Medicare and/or Medicaid Program, shall be automatically deemed to be ineligible for reappointment if the sanctions are not resolved, and the Staff member fully reinstated by the expiration of the member's then current reappointment term. It shall be the duty of all Medical Staff members to promptly inform the Hospital of any action taken by either such program.

4.3.7. Criminal Activity

The Medical Staff membership and clinical privileges of any Medical Staff member shall be automatically relinquished if such Medical Staff member is convicted or pleads guilty or nolo contendere to any felony crime.
4.3.8. Effect of Automatic Action

Any physician whose Medical Staff membership, admitting or clinical privileges, for any reason, are deemed to be automatically relinquished or who is deemed automatically ineligible for reappointment, shall not be entitled to procedural rights (a hearing or appellate review) under the Fair Hearing Plan.

4.4. CONFIDENTIALITY AND REPORTING

A. Actions taken and recommendations made pursuant to this Policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Medical Staff or the Hospital. In addition, reports of actions taken or recommendations made pursuant to this Policy shall be treated as confidential. Nevertheless, the Chief Executive Officer or designee may provide such documents and information to governmental agencies or as otherwise may be required by law.

B. All records and other information generated in connection with and/or as a result of professional review activities shall be confidential and each Medical Staff member or Committee member participating in such review activities shall agree to make no disclosures of any such information except as authorized in writing by the Chief Executive Officer or designee or by legal counsel for the Hospital. Any breach of confidentiality by a Medical Staff member or Committee member may result in professional review action and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

ARTICLE V.
RENSIGNATIONS

5.1. RESIGNATIONS FROM MEDICAL STAFF

Medical Staff members desiring to resign from the Medical Staff must submit a letter of resignation to activate the termination process.

No resignation will be effective until at least 90 days following receipt of a resignation letter unless otherwise determined by the MEC.

ARTICLE VI.
ADOPTION AND AMENDMENT OF CREDENTIALING POLICY

6.1. AMENDMENTS TO CREDENTIALING POLICY

This policy is incorporated by reference in the Medical Staff Bylaws of Saint Francis Healthcare and therefore may only be amended in accordance with the procedure set forth in Section 8.2 of the Medical Staff Bylaws.
6.2. ADOPTION OF CREDENTIALING POLICY

This Policy is adopted and made effective upon approval of the Board of Directors, and supersedes and replaces any and all other previous Medical Staff Bylaws, rules and regulations, or Policies pertaining to the subject matter of this Policy. All activities and actions of the Medical Staff and each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements and provisions of this Policy.

ARTICLE VII.
ALLIED HEALTH PROFESSIONALS CREDENTIALING POLICY

7.1. POLICY

It is the policy of the Saint Francis Healthcare to grant permission to physicians, podiatrists and dentists who are members of the Medical Staff (Active, Associate to use qualified employed assistants or licensed independent practitioners for certain activities in the hospital care of patients of the employer/physician. In addition, licensed independent practitioners may be granted clinical privileges if they are employees of a physician, podiatrist, dentist, hospital, or contracted vendor of the hospital.

7.2. DEFINITIONS

A. Active/Associate Physician, Podiatrist, Dentist

An Active/Associate physician, podiatrist or dentist is one who maintains staff privileges in accordance with Article III, Section 3.1 and Section 3.2 of the Bylaws of the Medical Staff.

B. Allied Health Professional (AHP)

An employee of an Active/Associate physician, podiatrist, dentist, hospital, or contracted vendor of the hospital, qualified by academic and clinical training and experience to function in a medical support role in the provision of medical care under the direction, supervision, and responsibility of the employer/physician.

C. Board

All references to the "Board" shall be interpreted to refer to The Board of Directors of Saint Francis Healthcare, Inc.

D. Direct Supervision

Supervision, which includes physical presence with the ability to directly observe the assistant in the performance of an approved procedure, evaluation or consultation.

E. Employer/Physician

Physician who employs an AHP and who request permission to use the services of the AHP in providing care to hospital patients.
F. Indirect Supervision

Supervision which includes physical presence on the premises or ready availability by an electronic device with the ability to become physically present within 30 minutes of notification if the situation so warrants.

G. Definition of Licensed Independent Practitioner

Any individual permitted by law and by the organization to provide care, treatment, and services, without direct supervision.

7.3. PROCEDURE

7.3.1. Application Process

1. The applicant must:
   a. Complete the application form which provides sufficient information about the education, training and experience of the AHP to permit the hospital to determine the scope of activities the AHP is qualified to perform in the hospital. The form must be signed by the AHP and submitted to the office of the VPMA/CMO.
   b. Procure and maintain professional liability insurance for the AHP that covers all activities in the hospital. Insurance coverage must be within minimum limits as established by the Board and CHE. Proof of such insurance shall be furnished to the Hospital. The AHP may act in the hospital only while such coverage is in effect.
   c. All Allied Health Professionals on the Medical Staff must participate in the training for Saint Francis Healthcare’s electronic medical records system (EMR) at such time as EMR training becomes available. Additionally, all Allied Health Professionals must agree to use the EMR system.

   All new Allied Health Professionals joining the Medical Staff will be required to successfully complete the EMR training at such time as EMR training becomes available before being allowed to treat patients.

2. If the applicant is an employee of a physician, podiatrist or dentist, the physician must co-sign the application and agree to indemnify the hospital for any claims, losses or payments resulting from injuries or damage to a patient or property due to an act or omission of the AHP.

3. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for clinical privileges. In the event that such exclusion occurs following completion of application and/or while AHP is exercising Hospital privileges, the AHP must immediately notify VPMA/CMO office.

4. Each applicant must abide by the hospital's Standards of Conduct. Failure to do so shall be grounds for corrective action.
7.3.2. Factors to Be Considered

Each recommendation concerning the granting of clinical privileges for an AHP shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the care of patients;
2. Participation in Staff duties;
3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;
4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;
5. Utilization of Hospital resources;
6. Current physical and mental health status;
7. Capacity to satisfactorily perform his/her duties as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications;
8. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;
9. Current professional liability insurance status, claims history, and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;
10. Current status of professional licenses, including currently pending challenges to any license or registration;
11. Voluntary or involuntary termination of Staff appointments or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
12. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and
13. Other reasonable indicators of competency.

7.3.3. Review Process

1. Upon receipt of a completed application, the VPMA/CMO will verify the information provided by the physician and the AHP, seek recommendations from previous employers and listed references and obtain other necessary and pertinent information. All information will then be forwarded to the following, in succession, for review and recommendation:
2. Completed application and recommendations will be forwarded to the Board of Directors for final action.

7.3.4. Delineation of the Scope of Activities

1. In granting permission to a physician, podiatrist or dentist to use an AHP, the Board will delineate the scope of activities each AHP is permitted to undertake in the hospital. The qualifications of the employing physician and his/her ability to provide supervision for the AHP for which he/she is responsible should be considered.

2. The delineation will permit the AHP to engage in direct patient care activities at the specific level for which permission was granted. Patient care provided by the AHP will be in collaboration with all other health professionals and hospital personnel. All AHP's, regardless of level of function, will assist in the development and implementation of Care Plans of the patients of their respective employer/physician, and assess the results of such care with the employer/physician and appropriate hospital staff members.

3. In the event the Credentials Committee is of the opinion that a requested scope of activities or any part thereof is not supported by the submitted application and materials, the physician requesting use of an AHP in the hospital and the AHP may be given an opportunity to appear before the Credentials Committee and discuss the proposed delineation before any final action is taken by the MEC.

4. The AHP may act in the Hospital pursuant to the approved delineation only so long as he/she maintains any required licensure, remains an employee of the physician who requested permission to use the AHP, and so long as the employer/physician remains an Active/Associate member of the Medical Staff.

5. Under the new direction of the Department Chairperson, each specialty/subspecialty shall prepare a brief Proctoring Plan for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The Plan will be reviewed and updated as needed and will include the proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source is required. The Medical Staff office shall maintain copies of all Proctoring Plans.

6. Proctoring may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form.
a. **Prospective proctoring:** Presentation of cases with planned outline of treatment for prospective review of cases documentation and proposed treatment orders.

b. **Concurrent proctoring:** Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

c. **Retrospective evaluation:** Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient’s care.

Each of the above methods may include observation of:

a. History and physical
b. Diagnosis and justification
c. Proposed treatment of procedure and its indications
d. Continuity of care provided to the patient
e. Appropriateness of procedures, tests, and medications prescribed
f. Appropriateness of length of stay
g. Adequacy of progress notes
h. Adequacy of operative notes
i. Discharge summary
j. Timely completion of medical records
k. Technical skills/knowledge (as appropriate)
l. Punctuality and conduct in OR (as appropriate)
m. Pre and post-operative care

5. Permission to use the AHP may be summarily suspended by the President of the Medical Staff or designee, Departmental Chairperson or the CEO or their designee whenever the activities or professional conduct of the AHP are, or are reasonably likely to be, detrimental to patient safety or the delivery of quality patient care; are disruptive to Hospital operations, or are in contravention of the policies and directives of the Hospital or the Medical Staff. Such suspension will be effective until the next regular meeting of the Credentials Committee, at which time the Credentials Committee will give the physician requesting permission to use the Assistant an opportunity to appear and discuss, explain or refute the concerns leading to the suspension. The Credentials Committee may confirm, modify or
reject the summary suspension. A suspension confirmed or modified by the Credentials Committee will remain in effect as specified by the Credentials Committee unless rejected or modified by the MEC at its next regular meeting, at which time the Credentials Committee will give a report of the matter to the MEC. The MEC may confirm, modify or reject the action of the Credentials Committee.

7.4. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

A. Non-Licensed Physician's Employee

B. Registered Nurse or Licensed Practical Nurse

C. Nurse Practitioner or Physician Assistant

D. Certified Registered Nurse Anesthetist

E. Nurse Midwives

7.4.1. Authorized Activities are as follows:

A. Non-Licensed Physician's Employee

1. May visit patients independently;

2. May examine patient limited to area of specialty or expertise;

3. May perform limited non-invasive procedures, as specified on the approved application;

4. May make adjustments to patient care equipment, previously approved;

5. Performance of procedures in the presence of and under the direct supervision of the physician/employer, to include operating room, ambulatory care, emergency room or other location;

6. May perform dressing changes and cultures of wounds after the physician/employer initiates care of each separate wound.

B. Registered Nurse or Licensed Practical Nurse (A professional license issued by the State of Delaware is required)

1. May perform all activities as defined in Category A above;

2. May visit patients independently and record progress notes on charts;

3. May assist in and perform all duties within the scope of practice of his/her employer, which are normally delegated to hospital staff, excluding administration of medications;
4. May dictate, for the employer/physician, the discharge summary, which may only be signed by the employer/physician.

Progress notes documented by the AHP in this category while under direct or indirect supervision must be countersigned by the employer/physician within 24 hours. Orders must be countersigned before they are accepted.

C. Nurse Practitioner or Physician Assistant (A professional license issued by the State of Delaware is required)

1. May perform all activities as defined in Category A&B above without direct supervision;

2. Initial and ongoing assessment of patient's medical, physical and psychosocial status including: dictation H & P, rounding, recording progress notes, and recording admission and discharge summaries;

3. Implement physician directed and initiated treatment plans recorded as verbal orders to be countersigned;

4. Diagnose and determine the appropriate medical management and treatment of patient being seen for initial evaluation;

5. Provide follow-up medical management and treatment of previously diagnosed conditions;

6. Must report to the physician/employer medical regimens they have ordered while the physician was not physically present. The physician/employer must countersign the recording of medical regimen on the patient's chart within 24 hours;

7. Prescribe and dispense a drug (non-narcotics) for a patient who is under the care of physician/employer (if authorized by the collaborative agreement between the physician and the NP or PA);

8. Interpret and analyze patient data to determine patient status, patient management and treatment;

9. Educate patients and/or families to promote wellness, prevent health problems, maintain current health and intervene appropriate in acute/chronic illness;

10. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac shock, hemorrhage, convulsions, poisoning and allergic reactions;

11. The Nurse Practitioner or Physician Assistant may also be considered for additional privileges based on appropriate training, experience, and demonstration of current competence, and in conjunction with the State of Delaware Board of Nursing and Board of Medical Practice regulations.
Privileges for the following list of specific procedures, which is not all inclusive, may be requested:

a. Placement of Central Venous Catheter;

b. Endotracheal intubation;

c. Arthrocentesis;

d. Lumbar puncture;

e. Chest tube thoracostomy;

f. Debridement, irrigation, suturing, and routine care of superficial wounds;

g. Treatment of minor superficial burns;

h. Removal of superficial foreign bodies;

i. Incision and drainage of abscesses, wound irrigation and packing;

j. Evacuation of hematomas;

k. Nail removal;

l. Control of external hemorrhage;

m. Subcutaneous local and digital anesthesia;

n. Anterior nasal packing for epistaxis;

o. Splitting of sprains and fractures;

p. Cast removal;

q. Initial x-ray interpretation and subsequent physician interpretation;

12. If so certified by the Correspondence Regulatory Council of the Board of Medical Practice, may initiate prescription medications within the scope of the Nurse Practitioner or Physician Assistant practice. (Verification of prescription authority registration is required.)

D. Certified Registered Nurse Anesthetist (CRNA) (A professional license as issued by the State of Delaware is required)

Performs the following duties under the direct and/or indirect supervision of an anesthesiologist:

1. Obtain a health history including psychosocial and biophysical;

2. Conduct physical screening assessment;

3. Prescribe approved medications;
4. Select and administer pre-anesthetic medication;
5. Request and evaluate pertinent laboratory studies;
6. Utilize current techniques in monitoring;
7. Select and administer anesthetic techniques, medications and adjunctive drugs;
8. Perform tracheal intubation and extubation;
9. Identify and manage emergency situations including assessment of adequacy of recovery; antagonism of muscle relaxants; narcotics and other agents; implement appropriate management techniques;
10. Discharge patient from the Recovery Room;
11. Post-anesthesia follow-up and evaluation;
12. Initiate cardiopulmonary resuscitation;
13. Participate in cardiopulmonary resuscitation in absence of a physician;
14. Insert intravenous catheters including central venous pressure catheters by basilic vein and external jugular vein;
15. Internal jugular vein catheterization;
16. The following privileges are required to be under Direct Supervision of an anesthesiologist:
   Insert Swan-Ganz catheters;
   Insert arterial lines;
   Perform regional anesthetics:
   A. Spinal
   B. Epidural
   C. Bier Block

E. Nurse Midwives (A Professional License as issued by the State of Delaware is required)

May perform all activities in accordance with the Protocol for Certified Nurse Midwifery, a supplement to the Allied Health Professional policy.

1. Applicants may seek approval for additional or more specific activities at the time of initial appointment or at any time by letter to the Vice President for Medical
Management. Approval of such additional activities will follow the same process as the approval of the initial appointment.

7.5. TERM

The term of appointment and reappointment shall be for a period of not more than two (2) years.

7.6. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. Clinical performance data or one (1) professional reference will be reviewed prior to reappointment.

7.7. IDENTIFICATION

Allied Health Professionals are to dress in a professional manner. A lab coat over street clothes is acceptable. An identification badge noting the assistant's name and professional status is required to be worn at all times.

7.8. ORIENTATION

The Vice President of Patient Care Services will conduct an orientation, which all AHP's must attend prior to engaging in direct patient care activities.

7.9. INTERACTION WITH HOSPITAL STAFF

If a nurse has a question regarding the clinical competence or authority of an AHP, either to act or to issue instructions outside the physical presence of the employer/physician in a particular instance, the nurse has the right and the duty to require the supervising physician to validate the order of the AHP. No order or instruction transmitted by the AHP shall be carried out if the nurse has reason to doubt that the act is within the scope of the appointed AHP’s delineation of activities.

7.10. RESPONSIBILITY

The office of the President of Medical Staff or designee is responsible for the implementation and monitoring of this Policy. All questions regarding this Policy should be referred to that office.
# FAIR HEARING PLAN

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FAIR HEARING PLAN

DEFINITIONS

The following definitions, in addition to those stated in other provisions of the Medical Staff Bylaws, shall apply to the provisions of this Fair Hearing Plan:

Day means calendar days, unless otherwise specified.

Board means the Board of Directors of Saint Francis Healthcare.

Parties means the practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse recommendation or action a hearing or appellate review request is predicated.

Practitioner means an applicant or Staff member with respect to whom an adverse action has been recommended or taken.

Special Notice means official written notification sent by certified or registered mail, return receipt requested.

ARTICLE I.
INITIATION OF HEARING

1.1. RECOMMENDATIONS OR ACTIONS

The following recommendations or actions, if deemed adverse pursuant to Section 1.2 below, shall entitle the practitioner affected thereby to a hearing upon a timely and proper request:

1. denial of initial Staff membership;
2. denial of reappointment;
3. suspension of staff membership; (other than Precautionary Suspension);
4. revocation of staff membership;
5. reduction of staff category;
6. restriction of admitting prerogatives;
7. denial of requested clinical privileges, and
8. reduction, restriction, suspension or revocation of clinical privileges.
1.2. WHEN DEEMED ADVERSE

A recommendation or action listed in Section 1.1 shall be deemed adverse action only when it is:

1. recommended by the MEC; or
2. taken by the Board under circumstances where no prior right to a hearing existed;

1.3. EXCEPTIONS

The following recommendations and/or actions, even if deemed adverse pursuant to Section 1.1 and 1.2 of the Fair Hearing Plan shall not give rise to any right to a hearing or appellate review:

1. the issuance of a letter of warning, guidance, counsel, admonition, or reprimand;
2. imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
3. imposition of a requirement for additional training or continuing education;
4. precautionary suspension;
5. denial of a request for leave of absence or for an extension of a leave;
6. determination that an application is incomplete;
7. determination that an application will not be processed due to a misstatement or omission;
8. determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract;
9. imposition of a term of probation;
10. the denial, restriction or termination of temporary privileges;
11. the denial, restriction, or termination of Staff membership or Staff category of a member of the Emeritus or Community Staff;
12. any relinquishment or other action imposed automatically;
13. current members of the Medical Staff who are excluded from a Federally funded health care program shall also not have the right to a hearing under this Article regarding the resulting termination of their staff membership and privileges. However, if the member immediately notifies the Hospital President of the exclusion of any proposed or actual exclusion from any Federally funded health care program as required by these Bylaws,
a simultaneous request in writing by the member for a meeting with the Hospital President and the VPMA/CMO, to contest the fact of the exclusion and present relevant information shall be granted;

if requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The Hospital President and the VPMA/CMO shall determine within ten (10) business days following the meeting, and after such follow-up investigation as they deem appropriate, whether the exclusion had in fact occurred, and whether the member’s staff membership and privileges shall be immediately terminated. The determination of the Hospital President and the VPMA/CMO regarding the matter shall be final, and the member shall have no further procedural rights within the Hospital or its Medical Staff. The member shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination;

a current member who does not immediately notify the Hospital President of the exclusion of any proposed or actual exclusion from any Federally funded health care program as required by these Bylaws shall have his or her staff membership and privileges terminated, effective immediately, at such time as the Hospital President or his or her designee receives reliable information of the member’s exclusion. The member shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination;

whenever a member’s membership and privileges are terminated pursuant to this Section, the VPMA/CMO and the Member’s Department Chairperson shall take all necessary steps to ensure that any patients currently under the member’s care in the Hospital shall immediately be brought under the care of another appropriate practitioner;

no report of any action taken based on a practitioner’s exclusion from a health care program funded, in whole or in part, by the Federal government shall be reported to the State Medical Board or the NPDB, whether that action involves a decision to not process an application or to terminate a practitioner’s membership and privileges, because the action taken is based on the practitioner’s failure to meet a basic qualification of membership, and

14. any other actions not specified in Sections 1.1 and 1.2 of this Fair Hearing Plan.

1.4. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A practitioner with respect to whom adverse action has been recommended or taken pursuant to Section 1.1 and 1.2 shall promptly be given Special Notice of such action by the Chief Executive Officer. The Notice shall state:

1. that an adverse action has been proposed to be taken involving the practitioner;
2. a general description of the proposed action and the reasons for the proposed action;

3. that the practitioner has the right to request a hearing on the proposed adverse action in accordance with the Medical Staff Bylaws and this Fair Hearing Plan;

4. that the practitioner has thirty (30) days after receiving the Notice within which to request a hearing;

5. a copy of this Fair Hearing Plan;

6. that, after receipt of his hearing request, the practitioner will be notified of the date, time and place for the hearing; and

7. that failure to request a hearing within the specified time period shall constitute a waiver of his or her rights to a hearing and to an appellate review on the matter.

1.5. REQUEST FOR HEARING

A practitioner shall have thirty (30) days following his receipt of a notice pursuant to Section 1.4 to file a written request for a hearing. Such request shall be deemed to have been made when received by the Chief Executive Officer. The request for a hearing shall state whether the practitioner wishes to be represented by an attorney at the hearing.

1.6. FAIR HEARING PROCESS FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals may request a fair hearing by submitting a request in writing to the Chief Executive Officer within thirty (30) days following receipt of a notice.

The procedures will be the same as for members of the medical staff as specified in this Plan, with the following exceptions:

In Section 2.3.A. By the Medical Staff – The Hearing Committee shall be composed of two impartial peers and be chaired by an impartial member of the Active Staff (a physician);

In Section 2.3.B. By the Board – The Hearing Committee shall include an impartial peer among its members instead of the requirement for at least one (1) member of the Active Staff.

1.7. WAIVER BY FAILURE TO REQUEST A HEARING

A. A practitioner who fails to request a hearing within the time specified in Section 1.5 waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled. Such waiver applies only to the matters that were the basis for the adverse recommendation or action triggering the Special Notice.

B. Effect of a Waiver: Such a waiver in connection with:
1. An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

2. An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC’s recommendations at its next regular meeting following the waiver. In its deliberations, the Board shall review all the information and material considered by the MEC and may consider additional relevant information received from any source. The Board is not bound by the adverse recommendation or action that the practitioner has accepted by the waiver but may take any action, whether more or less severe, it deems warranted by the circumstances.

C. The Chief Executive Officer shall promptly send the practitioner Special Notice informing him of each action taken and also shall inform the President of the Staff.

ARTICLE II.
HEARING PREREQUISITES

2.1. SCHEDULING OF THE HEARING

A. Upon receipt of a timely request for hearing, the Chief Executive Officer shall deliver such request to the President of the Medical Staff or to the Chairman of the Board, depending on whose recommendation or action prompted the request for hearing. The Chief Executive Officer in consultation with the President of the Staff or the Chairman of the Board, as applicable, shall promptly schedule and arrange for a hearing.

B. The date for commencement of the hearing shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing. Requests for postponement or rescheduling of a hearing shall be granted by the presiding officer only upon a showing of good cause and only if the request is made as soon as reasonably practical.

2.2. NOTICE OF HEARING

At least twenty (20) days prior to the hearing, the Chief Executive Officer shall send the practitioner Special Notice of the time, place, and date of the hearing. The Notice shall also contain the following information:

1. a concise statement of the reasons;

2. a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing;

3. a list of witnesses expected to testify on behalf of the Executive Committee or Board at the hearing;
4. a list of the members of the Hearing Committee (if any);

5. the name of the Hearing Officer or Hearing Examiner (if any);

6. the name of the person representing the MEC or Board;

7. a statement notifying the practitioner that he or she is required to provide to the Chief Executive Officer no later than ten (10) days prior to the hearing date a list of witnesses (if any) expected to testify and a list of documents and other materials expected to be introduced at the hearing on behalf of the practitioner; and

8. a statement advising that the practitioner will forfeit his or her rights to a hearing and appellate review if the practitioner fails, without good cause, to provide the list of witnesses and documents or to appear at the hearing.

2.3. APPOINTMENT OF HEARING COMMITTEE

A. **By MEC** – A hearing occasioned by a MEC recommendation or action shall be conducted by a Hearing Committee appointed by the Hospital Chief Executive Officer in consultation with the President of the Medical Staff or designee. The Hearing Committee shall be composed of at least three (3) members of the Active Staff who are qualified to serve. One of the members so appointed shall be designated as Chairperson. In the event it is not possible to appoint a fully qualified Hearing Committee from the Active Staff, qualified physicians from other categories of the Staff may serve on the Hearing Committee.

B. **By Board** - A hearing occasioned by an adverse action of the Board shall be conducted by a Hearing Committee appointed by the Chairman of the Board and composed of at least three (3) persons who are qualified to serve. At least one (1) Active Staff member chosen shall be included on this Committee when the issues concern professional competence or performance. One of the members so appointed shall be designated as Chairperson.

C. **Service on Hearing Committee** - To be qualified to serve on a Hearing Committee, a Medical Staff member or a Board member shall not have actively participated in formulating the adverse recommendation or action that occasioned the hearing, or in initiating or investigating the underlying matter at issue at any earlier stage of the proceedings. A Staff or Board member shall not be disqualified from serving on the Hearing Committee merely because he or she heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be, or because he or she is a party to a contract or is employed by the Hospital or an affiliate. None of the members of the Hearing Committee or the Hearing Officer shall be in direct economic competition with the practitioner. All members of the Hearing Committee shall be required to consider and decide the case with good faith objectivity.

2.4. APPOINTMENT OF A HEARING OFFICER OR HEARING EXAMINER

A hearing may be conducted by a Hearing Officer or Hearing Examiner and such persons shall be appointed as follows:
A. **Hearing Officer**: The use and appointment of a Hearing Officer to preside at an evidentiary hearing and assist the hearing committee shall be determined by the Chief Executive Officer after consultation with the President of the Medical Staff or designee (for hearings based upon the actions of the Executive Committee) or with the Chairman of the Board (for hearings based upon the actions of the Board). The Hearing Officer shall act in an impartial manner as the Presiding Officer of the hearing. The Hearing Officer may not participate in the deliberations of the hearing committee and is not entitled to vote.

B. **Hearing Examiner**: The use and appointment of a Hearing Examiner in lieu of a Hearing Committee shall be determined by the Chief Executive Officer after consultation with the President of the Medical Staff or designee (for hearings based upon the actions of the Executive Committee) or with the Chairman of the Board (for hearings based upon the actions of the Board). The Hearing Examiner shall exercise all authority and responsibility otherwise granted to a Hearing Committee and its Chairperson.

C. A Hearing Officer or Examiner may, but need not be, an attorney, but shall be experienced in conducting hearings. The Hearing Examiner may not be a practitioner in economic competition with or having any interest adverse to the subject practitioner. The Hearing Officer or Examiner may not have participated in any previous investigation or consideration of the matter. A Hearing Officer or Examiner shall not be disqualified from serving merely because he or she has heard of the matter or has knowledge of the facts involved. The Hearing Officer or Examiner, however, must consider and decide the case with good faith objectivity.

2.5. **PRE-HEARING PROCEDURES**

A. The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

B. Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

C. Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with the following:

1. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

2. reports of experts relied upon by the MEC;

3. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
4. copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

D. The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners.

E. Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

F. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

G. Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

H. The Presiding Officer will require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half (7 1/2) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

I. The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

J. The following documents will be provided to the Hearing Committee in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.
ARTICLE III.
HEARING PROCEDURE

3.1. PERSONAL PRESENCE

The personal presence of the practitioner who requested the hearing is required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section 1.6.

3.2. PRESIDING OFFICER

The Hearing Officer or Examiner, if one is appointed pursuant to Section 2.4, or the Chairperson of the Hearing Committee shall serve as the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer shall require and supervise the liberal exchange of evidence prior to the hearing. The Presiding Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3.3. REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical staff in good standing, or by a member of his or her local professional society. The Executive Committee or the Board, depending upon whose recommendation has prompted the hearing, shall appoint an individual (an attorney, Staff member or Board member) to represent it at the hearing, to present the facts in support of its adverse recommendation or action, to introduce exhibits, and to examine witnesses. Attorneys may provide advice and counsel but not examine or cross-examine witnesses unless agreed upon by the parties at the Pre-Hearing Conference.

3.4. RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

1. call and examine the witnesses;
2. introduce evidence, including exhibits determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;
3. cross-examine any witness on any matter relevant to the issues;
4. impeach any witness;
5. rebut any evidence;
6. submit a written statement at the close of the hearing; and,
7. obtain a copy or transcript of the hearing record.

If the practitioner who requested the hearing does not testify on his/her own behalf, he may be called and examined as if under cross-examination.

3.5. PROCEDURE AND EVIDENCE

The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Evidence will not be excluded merely because it is hearsay. Each party, prior to or during the hearing, shall be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The Presiding Officer may require one or both parties to prepare and submit to the committee, written statements of their position on the issues, prior to, during, or after, the hearing. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation.

3.6. EVIDENTIARY NOTICE

In reaching a decision, the hearing committee (or hearing examiner) may take note, for evidentiary purposes, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Delaware. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information that can be considered, pursuant to the Medical Staff bylaws, in connection with applications for appointment or reappointment to the staff and for clinical privileges.

3.7. BURDEN OF PROOF

It shall be the obligation of the Committee or Board representative to go forward and present evidence in support of the adverse recommendation or decision. The affected practitioner shall thereafter be responsible for presenting evidence in support of his/her challenge to the adverse recommendation or decision. The affected petitioner shall be responsible for supporting the challenge to the adverse recommendation or decision by showing by a preponderance of the evidence that the recommended action lacks basis, or that such basis or action based thereon is either arbitrary, unreasonable, or capricious.

3.8. RECORD OF HEARING

A record of hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a
recommendation or decision in the matter. The Presiding Officer shall select the method to be used for making the record, such as court reporter, electronic recording unit, or detailed transcription. A copy of the record may be obtained by the practitioner upon payment of reasonable charges associated with its preparation.

3.9. RECESSES AND ADJOURNMENT

The Presiding Officer may recess the hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The Presiding Officer shall reconvene the hearing within a reasonable time period depending upon the availability of the participants.

Upon conclusion of the presentation of oral or written evidence, the hearing shall be closed. The hearing committee (or hearing examiner) shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

3.10. PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

A majority of the Hearing Committee must be present throughout the hearing and deliberations. Any committee member who is absent from any part of the proceedings may not participate in the deliberations or the decision, without the agreement of all parties.

ARTICLE IV.
HEARING COMMITTEE REPORT AND FURTHER ACTION

4.1. HEARING COMMITTEE REPORT

Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee or hearing examiner shall prepare a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and other documentation considered, to the body whose adverse recommendation or action occasioned the hearing. All findings shall be supported by reference to the hearing record and other evidence considered. A copy of the report shall also be forwarded to the practitioner.

4.2. ACTION ON HEARING COMMITTEE REPORT

Within fourteen (14) days after receipt of the hearing report, the MEC or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. It shall transmit its decision, together with the hearing record, the hearing report and all other documentation considered, to the Chief Executive Officer.

4.3. NOTICE OF DECISION

The Chief Executive Officer shall promptly send a copy of the decision to the practitioner by Special Notice, to the President of the Medical Staff or designee, the MEC and the Board.
4.4. EFFECT OF FAVORABLE RESULT

A. Adopted by the Board: If the Board’s decision is favorable to the practitioner, it shall become the final decision of the Board and the matter shall be considered closed.

B. Adopted by the MEC: If the MEC’s decision is favorable to the practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC’s result in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The Chief Executive Officer shall promptly send the practitioner Special Notice of each action taken. Favorable action shall become the final decision of the Board, and the matter shall be considered closed.

4.5. EFFECT OF ADVERSE RESULT

If, subsequent to the hearing, initiated by the MEC or the Board, the decision of the MEC or of the Board is adverse to the practitioner in any of the respects listed in Section 1.1, the practitioner shall be entitled to appellate review by the Board. The Chief Executive Officer shall promptly send the practitioner a Special Notice informing the practitioner of his or her right to appellate review.

ARTICLE V.
INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.1. REQUEST FOR APPELLATE REVIEW

A practitioner shall have fourteen (14) days following receipt of a Special Notice pursuant to Section 4.5 to submit a written request for an appellate review. Such request shall be deemed to have been made when received by the Chief Executive Officer. The request may include a request for a copy of the report and hearing record and all other material, favorable or unfavorable, if not previously forwarded, that was considered in making adverse action or result. The practitioner may be represented by an attorney or other appropriate person with regard to appellate review and at any appellate review appearance that may be granted under Section 6.4.

5.2. WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 5.1 waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 1.6.

5.3. NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW
Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Chairman of the Board. The Board shall promptly schedule and arrange for an appellate review, which shall be not less than thirty (30) days nor more than forty-five (45) days from the date of receipt of the appellate review request; provided, however, that an expedited appellate review shall be offered to a practitioner who is under a suspension then in effect, which shall be held as soon as the arrangements for it may reasonably be made, but not later than thirty (30) days from the date of receipt of the request for appellate review. The Chief Executive Officer shall promptly send the practitioner Special Notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body upon request of the parties for good cause if the request is made as soon as is reasonably practical.

5.4. APPELLATE REVIEW BODY

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of at least three (3) members of the Board (who did not serve on the hearing committee) appointed by the Chairman of the Board. If a Committee is appointed, one of its members shall be designated as Chairperson.

ARTICLE VI.
APPELLATE REVIEW PROCEDURE

6.1. NATURE OF PROCEEDINGS

The proceedings by the appellate review body shall be in the nature of an appellate review based upon the Report of the Hearing Committee or Examiner, the hearing record and other evidence admitted at the hearing, all subsequent results and actions, any written statements, and any other materials or oral statements as may be presented and accepted under Sections 6.4 and 6.5.

6.2. WRITTEN STATEMENTS

The practitioner seeking the review shall submit a written statement detailing the findings of facts, conclusions and procedural matters with which he or she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body through the Chief Executive Officer at least fifteen (15) days (seven (7) days for expedited appellate review) prior to the scheduled date of the appellate review, except if the time limit is waived by the review body. A written statement in reply may be submitted by the Executive Committee or by the Board and, if submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least seven (7) days (four (4) days for an expedited review) prior to the scheduled date of the appellate review.

6.3. PRESIDING OFFICER

The Chairperson of the appellate review body shall be the Presiding Officer. The Presiding Officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
6.4. ORAL STATEMENT

The appellate review body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

6.5. CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only at the discretion of the review body and, as the review body deems appropriate, only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the Chief Executive Officer, a written substantive description of the matter or evidence to the appellate review body and the other party at least seven (7) days prior to the scheduled date of the review.

6.6. POWERS

The appellate review body shall have all power granted to a hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

6.7. PRESENCE OF MEMBERS AND VOTE

A majority of the members of the appellate review body must be present throughout the review and deliberations. If a member of the review body is absent from any part of the proceedings, that member may not be permitted to participate in the deliberations or the decision without the agreement of the parties.

6.8. RECESSES AND ADJOURNMENT

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

6.9. ACTION TAKEN

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the MEC or by the Board, or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within fourteen (14)
days and in accordance with its instructions. Within fourteen (14) days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board.

ARTICLE VII.
FINAL DECISION OF THE BOARD

7.1. BOARD ACTION

Within thirty (30) days after the conclusion of the appellate review, the Board shall render its final decision in the matter in writing and the Chief Executive Officer shall send Special Notice thereof to the practitioner and to the Executive Committee. If this decision is in accord with the MEC’s last recommendation in the matter, if any, it shall be immediately effective and final. If the Board’s action has the effect of changing the MEC’s last such recommendation, if any, the Board shall refer the matter to the Joint Conference Committee comprised of the officers of the Medical Staff and the officers of the Board.

7.2. JOINT CONFERENCE COMMITTEE REVIEW

Within fourteen (14) days of its receipt of a matter referred to it by the Board pursuant to the provisions of this Plan, the Joint Conference Committee shall submit its recommendation to the Board. The Board’s action on the matter shall be immediately effective and final.

ARTICLE VIII.
GENERAL PROVISIONS

8.1. NUMBER OF REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or of this Fair Hearing Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right.

8.2. EXTENSIONS

Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in this Fair Hearing Plan may be extended upon the agreement of the parties, and, when necessary, the Presiding Officer.

8.3. RELEASE

By requesting a hearing or appellate review under this plan, a practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability in all matters related thereto.

ARTICLE IX.
ADOPTION AND AMENDMENT
9.1. AMENDMENT

This Fair Hearing Plan may be amended or repealed, in whole or in part, in accordance with the procedure set forth in the Medical Staff Bylaws.

9.2. ADOPTION

This Fair Hearing Plan is adopted and made effective upon approval of the Board of Directors, superseding and replacing any previous Fair Hearing Plans of Saint Francis Healthcare.

Recommended by the Medical Staff Executive Committee this

________________________________________________________________________
President of the Medical Staff

Approved by the Board of Saint Francis Healthcare this

________________________________________________________________________
Chairman of the Board

________________________________________________________________________
Secretary of the Board