Attachment A

MEDICAL STAFF

CREDENTIALING

MANUAL

MCLAREN BAY REGION
MEDICAL STAFF
CREDENTIALING PROCEDURES

BYLAWS ATTACHMENT A

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MEDICAL STAFF BYLAWS – ATTACHMENT A
CREDENTIALING PROCEDURES MANUAL

INTRODUCTION

Credentialing may be defined as "the formal recognition of professional and technical competence." It involves two distinct processes:

(1) Medical Staff Membership
(2) Delineation of Clinical Privileges

Its purpose is to assure that services are provided according to appropriate standards of medical care.

Every practitioner who seeks or enjoys Staff membership must demonstrate to the satisfaction of the Medical Staff and of the Board the following qualifications: licensure, performance, ethics, nondisability, and professional liability insurance. Each member of the Medical Staff shall have certain obligations and responsibilities as provided in Article Three of the Medical Staff Bylaws.

Delineation of clinical privileges refers to the process whereby the Medical Staff evaluates and recommends individuals to provide specific patient care services in the hospital. The process includes three elements: establishing criteria for privileges, evaluating, (on an ongoing basis) an applicant's qualifications, and matching the individual's skills to the needs and resources of the hospital. Delineating clinical privileges is thus a complex selection process involving the individual practitioner, Medical Staff, and the hospital.

It is the intent of the Medical Staff of McLaren Bay Region (MBR) to outline in this manual the process that will be utilized for the credentialing of its members. It is also the intent of the Medical Staff that this manual reflect the accreditation standards established by the Joint Commission.

CATEGORIES FOR STAFF MEMBERSHIP

The following categories for Staff membership shall be utilized as defined in the Medical Staff Bylaws (ARTICLE IV)

A. Provisional
B. Active
C. Consulting
D. Affiliate
E. Emeritus
F. Honorary

DEFINITIONS

The following definitions apply to the provisions of this Credentialing Procedures Manual:

1. PROFESSIONAL AFFAIRS COMMITTEE (PAC) is a committee of the Board and is responsible for taking effective action for the Board. It must report its action to the Board but only under very unusual circumstances should the Board find it necessary to rescind or change a PAC decision.

2. PRACTITIONER means any physician, dentist or podiatrist applying for or exercising clinical privileges or providing other diagnostic, therapeutic, teaching or research services in the hospital.

3. PHYSICIAN means an individual with an M.D. or D.O. degree who is licensed to practice medicine.

4. CLINICAL PRIVILEGES means the right granted to a practitioner to provide those diagnostic, therapeutic, medical, surgical, or dental services specifically delineated to him.

5. PREROGATIVE means a participatory right granted, by virtue of Medical Staff membership category, subject to the conditions and limitations imposed in the Medical Staff Bylaws and in other hospital and Medical Staff policies.

6. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt requested.

7. ADVERSE PAC OR BOARD ACTION: "Adverse action" by the PAC or Board means action to deny Medical Staff appointment, requested Staff category, requested Department assignment, or to deny or restrict requested clinical privileges.

8. HOSPITAL REPRESENTATIVE includes the Board, its directors and committees; the Chief Executive Officer or his designees; the Medical Staff organization and all Medical Staff members, clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his application; and any authorized representative of any of the foregoing.

9. JOINT CONFERENCE COMMITTEE: This committee consists of equal representation of the Board of Directors and Medical Staff and shall function as a forum to:

   (1) discuss matters of administrative and medical policy;
   (2) oversee hospital legal and regulatory compliance; and
   (3) review and act upon PAC recommendations. (If the PAC recommendations conflict with Medical Executive Committee action)

PART I. APPOINTMENT PROCESS

1.1 COMPLETION OF APPLICATION
The applicant must complete the application form for appointment to the Medical Staff in the following manner:

a. all questions on the form must be answered by the applicant;

b. The applicant must attach to the application the following:

1. Postgraduate training, including the name and address of each institution, degrees granted, programs completed, dates attended, and the names of practitioners responsible for the applicant's performance.

2. All currently valid medical, dental or podiatric and other professional licensures or certifications, Drug Enforcement Administration registration, with the date and number of each (in rare circumstances, exceptions may be granted). Each applicant for Emergency or Anesthesia Departments shall document his or her proficiency in CPR. The Educational Commission of Foreign Medical Graduates Certificate (ECFMG) shall serve as primary source verification of medical school completion for graduates of foreign medical schools if the ECFMG directly confirms that an applicant possesses a valid Standard ECFMG Certificate.

3. Specialty or subspecialty board certification, recertification or eligibility.

4. Health impairments, if any, affecting the applicant's ability in terms of skill, attitude, or judgment to adequately perform professional and medical staff duties; and, date of last PPD skin test, or documented history of a positive PPD test, adequate treatment for disease, or adequate preventive therapy for infection.

5. Professional liability insurance coverage, or other evidence of financial responsibility for professional liability, and information regarding malpractice claims history and experience (suits and settlements made, concluded and pending) during the past five (5) years, including the names of present and past insurance carriers. The level of liability insurance coverage shall reflect at least the minimum amount required by the hospital board.

6. The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non- renewal or voluntary relinquishment (by resignation or expiration) of:

   a. license or certificate to practice any profession in the state or country;
   b. Drug Enforcement Administration or other controlled substances registration;

c. membership or fellowship in local, state, or national professional organizations;
d. specialty or subspecialty board certification or eligibility;
e. faculty membership in any medical or other professional schools;
f. staff membership status, prerogatives of clinical privileges at any other hospital, clinic, or health care institutions.

7. Location of offices, names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and locations of any other hospitals, clinics, or health care institutions or organizations where the applicant provides or provided clinical services with the inclusive dates of each affiliation. (Two most recent hospital affiliations required for Affiliate Staff applicants)

8. Department assignment, staff category and specific clinical privileges requested, as defined in the Medical Staff Bylaws.

9. Any current felony criminal charges pending against the applicant and any past charges including their resolution.

10. Any conviction of a criminal offense related to health care. The applicant must describe if he/she has been debarred, excluded or otherwise ineligible for participation in federal health care programs.

    A conviction, exclusion, being debarred or ineligible for participation in federal health care programs are grounds for termination of the application process.

11. The application must include the names and addresses of three (3) physicians who can comment authoritatively regarding his/her professional qualifications; clinical ability, ethical character, and ability to get along with others, and may be contacted by the Professional Functions Committee. One of the references must be Chief of Service, or the Chief of Staff from his/her most recent hospital appointment. (Two professional references required for Affiliate Staff applicants)

12. Signed statements on the application that notify the applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of the Medical Staff Bylaws and this Credentialing Procedures Manual.

1.2 BURDEN ON APPLICANT TO COMPLETE THE APPLICATION PROCESS

The applicant, in completing the application process, has the burden of completing his or her application form and of producing adequate information for proper evaluation of his or her experience, training, demonstrated ability, and health status and of resolving any doubts about the aforementioned or

any of the qualifications required for staff membership or the requested staff category, department or service, assignment, or clinical privileges, and of satisfying any reasonable request for information for clarification (including health examination) made by appropriate staff or Board authorities.

1.3 COMPLETION OF THE APPLICATION PROCESS (Definition)

a. The application process for staff membership shall not be deemed completed until (1) completion of the application form; (2) supplying all of the necessary information reasonably requested; and (3) accomplishment of the collection and verification process pursuant to 1.1-1, Part I of the Credentialing Manual. By way of definition, when items 1, 2 and 3 are accomplished, then the application process for staff membership shall be deemed to be completed.

1.4 REVIEW AND VERIFICATION OF APPLICATION AND INFORMATION

a. All applications shall be submitted by the applicant to the Medical Staff Office and processed.

b. The VPMA shall promptly notify the applicant in writing of any problems concerning (1) the completeness of the application, (2) any problems in obtaining verification information, and (3) the need for additional information and documentation. The VPMA shall set a time limit not to exceed 180 days from the date of said notification in which to complete the application and submit all requested information and documentation.

c. Upon receiving notification from the VPMA of any deficiencies either in the completion of the application, verifying information or supplying additional information and documentation, the applicant shall have the obligation to comply with the request of the VPMA within the time limit set.

d. Only completed applications with all the required information and documentation shall be deemed to be active applications. Only active applications shall be forwarded to the chairperson of each department (or the department's credentialing committee, if one exists) in which the applicant seeks privileges for recommendation to the Professional Functions Committee. This must include primary source verification of:

- The applicant's current licensure, Michigan and all others at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
- The applicant's relevant training
- The applicant's current competence
- National Practitioner Data Bank
- Medicaid/Medicare Sanctions
- Background Check
- Internet Search Engine

and may include primary source verification of:

- Graduation from Medical, Dental or Podiatric School
- Internship and Residency completion from an accredited residency program in the United States or Canada
- Membership on all other hospital staffs, past and present
- Michigan Controlled Substance licensure
- ECFMG status
- Previous practice, including Military Service, locum tenens, clinics, private or group practice, ambulatory surgery center
- AMA/AOA Profiles (if member)

e. In regard to verifying applications received from a teleradiology/ telemedicine group, only those which are Joint Commission-accredited organizations, the Medical Staff Office may utilize the credentialing information from the group as primary source. This utilization would be limited to primary source verifications obtained by the teleradiology/telemedicine group for the following: Professional liability including claims, Board certifications, Education and training including ECFMG, Hospital Affiliations, and other references including previous practices, and Teaching Appointments. The Medical Staff Office would validate credentialing by the teleradiology/telemedicine group and would obtain primary source verification for the following: All State and Pharmacy Licenses, NPDB, AMA/AOA profiles (if member), Medicaid/Medicare Sanctions, Background Check, Internet Search Engine and any other credentialing necessary to complete an application in accordance with Section 1.1-3 of the Medical Staff Credentialing Manual.

f. All applications, which either are incomplete or lack any required information or documentation, shall be deemed to be inactive applications after one (1) year from the date of receipt.

g. Inactive applications shall only be retained for a period of one (1) year from the date of receipt. After such period, the inactive application, without further notice, shall be destroyed by burning, shredding, or other effective method. Destruction of inactive applications shall be made in the ordinary course of business by Medical Staff Office designee. Destruction of the inactive application shall be based on its age as an inactive application.

1.5 EFFECT OF APPLICATION

The applicant must sign the application and in so doing:

a. attests to the correctness and completeness of all information furnished;

b. signifies his willingness to appear for interviews in connection with his application;

c. agrees to abide by the terms of the bylaws, rules, regulations, policies and procedures manuals of the Medical Staff and those of the hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted;

d. agrees to maintain an ethical practice and to provide continuous care to his patients;

e. authorizes and consents to hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence, and consents to their inspecting all records and documents that may be material to evaluation of said qualification and competence;

f. releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status, and other qualifications for Staff appointment and clinical privileges.

1.6 MEDICAL STAFF INPUT

Upon receiving the completed application, the Medical Staff Office will prepare a notice which will indicate the physician's name, qualifications, and Department in which clinical privileges are requested. This notice will be placed in each Active Staff member's mailbox. Any member may then submit, in writing, full details of information pertinent to the applicant's membership and privileges to the Professional Functions Committee. The department and Medical Staff Professional Functions Committee may request the applicant and/or the member who provided the information to appear in person before them.

1.7 REVIEW OF APPLICANT

A. Procedure: For privileges which do not cross Department lines.

(1) Each Department in which the applicant seeks privileges shall review the application and supporting documentation.

(2) Based on specific criteria (Department criteria for granting privileges and membership), this review will be conducted by the Department (or their Credentials Committee if one exists) and such Department shall submit a written evaluation of their findings. The report shall confirm documentation relative to the applicant's training, experience and demonstrated ability. It shall also contain a recommendation as to approval or denial of, and any special limitations on (a) Staff appointment, (b) category of Staff membership and prerogatives, (c) Department affiliation, and (d) the scope of the applicant's clinical privileges.

(3) Once this report has been reviewed and approved by the Department, the report shall be transmitted to the Professional Functions Committee.

(4) The Department may also, at their discretion conduct an interview with the applicant. If the Department requires further information about the applicant, the Department may defer transmitting the report, provided the deferral time is in compliance with the time periods specified in Section 1.1-13. In the event of a deferral, the applicant is notified in writing of the deferral and the reasons upon which the deferral is based.

B. Procedure: For privileges which cross Department lines

(1) In any case where a Department has developed criteria for a certain procedure that is different from another department's criteria for the same procedure, standard criteria should be developed by the departments involved.

1.8 PROFESSIONAL FUNCTIONS COMMITTEE REVIEW

The Professional Functions Committee reviews the application, the supporting documentation, the reports from the Departments, and any other relevant information available to it. The Professional Functions Committee then prepares a report for the Medical Executive Committee, supporting, refuting, or delaying (to collect further information about the applicant) the Department recommendation.

This written report, along with the application and supporting documentation is then transmitted to the Medical Executive Committee. However, if the transmission of this report is delayed, the Professional Functions Committee must notify the applicant, the Chief of Staff and the Chief Executive Officer in writing of the delay and the grounds.

1.9 MEDICAL EXECUTIVE COMMITTEE REVIEW

The Medical Executive Committee (MEC) reviews the application, the supporting documentation, the reports from the Department and the Professional Functions Committee, and any other relevant information available to it. MEC members will be given prior notice of applications for consideration at the next MEC meeting, and shall be expected to review this information prior to the meeting. The Medical Executive Committee then prepares a report for the Professional Affairs Committee supporting, refuting or delaying (to collect further information about the applicant) the Professional Functions Committee recommendation. This written report, along with the application and supporting documentation, is then transmitted to the Professional Affairs Committee. However, if the transmission of this report is delayed, the Medical Executive Committee must notify the applicant, Chief of Staff and the Chief Executive Officer in writing of the delay and the grounds.

Category I Applications may be processed according to the Medical Staff Expedited Credentialing Policy.

1.10 PROFESSIONAL AFFAIRS COMMITTEE ACTION

The Professional Affairs Committee shall have the following three options available in taking action:

A. **On Favorable Staff Recommendation:** The Professional Affairs Committee (PAC) may adopt or reject, in whole or in part, a favorable recommendation from the MEC or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit not to exceed sixty (60) days within which the subsequent recommendation must be made.

B. **Without MEC Recommendation:** If, in its determination, the PAC does not receive an MEC recommendation within a timely manner, it may, after notifying the MEC of its intent including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Staff.

C. **After Procedural Rights:** In the case of an adverse MEC recommendation, the PAC or Board takes final action in the matter as provided in the Fair Hearing Plan.

This report of each individual or group, including the PAC, required to act on an application must state the reason for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Whenever the PAC or Board determines that it will decide a matter contrary to the MEC's recommendation, the matter will be submitted to the Joint Conference Committee for review and recommendation before the PAC or Board, as applicable, makes its final decision.

1.11 NOTIFICATION OF FINAL DECISION

Notice of the PAC's or Board's final decision is given through the Chief Executive Officer to the MEC, to the Chairman of each Department concerned, and to the applicant.

1. In favorable decisions, the notice to appoint shall include the following: the Department to which the applicant is assigned; the clinical privileges he may exercise; any special conditions attached to the appointment; and the length and requirement of his provisional status.

2. In an unfavorable decision, the notice shall include the procedural rights available to the applicant provided in the Fair Hearing Plan. An applicant who has received a final adverse decision regarding appointment, Staff category, Department assignment or clinical privileges is not eligible to reapply to the Medical Staff or for the denied categories, Department or privileges for a period of six (6) months. Any such reapplication is processed as an initial application, and the applicant must submit such additional information as the Staff or the Board may require in demonstration that the basis for the earlier adverse action no longer exists.

1.12 BASIS FOR RECOMMENDATIONS AND ACTIONS

The report for each individual or group, including the PAC, required to act on a reappointment, shall state the reasons for each recommendation made or action taken, with specific reference to the Staff member's credentials file and all other documentation considered. The recommendation/report developed in the process must also include any dissenting views, supported by reasons and references, and transmitted with the complete report.

1.13 TIME PERIOD FOR PROCESSING

Transmittal of the application to a prospective Staff member, and the provision by him of information, is to be carried out in accordance with Section I of this manual. Thereafter, except for good cause, all persons in groups required to act must complete such action so that all appointment reports and recommendations are transmitted to the MEC and in turn to the PAC within ninety (90) days of complete information being available. In the event deferrals prevent the completion of the process within the ninety (90) day time frame, the Chief Executive Officer shall notify the applicant, the Chief of Staff, Chairman of the Professional Functions Committee, and the Chairman of the Department in writing of the delay and the grounds.

The time period specified above in Section I are to guide the acting parties in accomplishing their tasks and to not create any rights for a practitioner to have his application processed within these precise periods. If the provisions of the Fair Hearing Plan are activated, the time requirements provided there govern the continuing processing of the application.

PART II. REAPPOINTMENT PROCESS

2.1 SUBMISSION OF APPLICATION

Submission of application for reappointment to the Medical Staff will be in accordance with the Medical Staff Office policy and procedure #13 for Reappointment Applications for Medical and Allied Health Staff as approved by the Professional Functions Committee, Medical Executive Committee and the Professional Affairs Committee.

2.2 VERIFICATION OF REAPPOINTMENT APPLICATION DATA

The Medical Staff Credentialing Specialist verifies this additional information, and notifies the Staff member of any information inadequacies or verification problems. The Medical Staff Credentialing Specialist will also request any additional information needed to support data submitted on the reappointment application. The Staff member then has the burden of producing adequate information and resolving any doubts about the data.

Clinical activity for a two-year period is obtained from the Quality Management Department. If this data reflects a physician has had fewer than 10 direct clinical encounters within the hospital excluding lab or x-ray, the physician would be required to provide evidence of competence for specific privileges requested from a facility in which he/she regularly sees patients. Evidence of competence could include volume and outcome information from active site, etc. Physicians who have no direct clinical encounters or have low activity at MBR and are not clinically active at another hospital would automatically transfer to Affiliate Staff status with no hospital privileges. This transfer is not a demotion or reportable action.

In addition, the Medical Staff Credentialing Specialist and Quality Management Specialist collects for each Staff member's credentials file, all relevant information regard in the individual's professional and collegial activities, performance and conduct in the hospital. Such information may include, without limitation, the number and types of cases of third party payment denials, patterns of care demonstrated in the findings of quality assurance activities, participation in relevant internal teaching and continuing education activities; timely and accurate completion of medical records as required in Medical Staff Rules and Regulations, and compliance with all applicable Bylaws, policies, rules, regulations and procedures of the hospital and Staff. The completeness and accuracy of this information shall be verified prior to forwarding this information to the Department.

2.3 DEPARTMENT REVIEW

Each Department in which the Staff member requests for, or has Department specific privileges in, shall review the member's file. This review shall be performed using criteria and standards which provide for an assessment of the Staff member's continuing competency as evidenced by outcomes data collected through the Quality Review process. The Department shall submit a written report of the findings from their review. The reports shall include the Department's recommendations and a statement as to whether or not it is known or has been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and Medical Staff duties appropriately and with recommendations for reappointment or non-reappointment and for

Staff category, Department assignment, and clinical privileges. The report shall be reviewed and approved by the Department/Section and then shall be forwarded to the Professional Functions Committee.

2.4 PROFESSIONAL FUNCTIONS COMMITTEE REVIEW

The Professional Functions Committee reviews the member's file, the department reports and all other relevant information available to it and forwards to the Medical Executive Committee a written report with recommendations for reappointment or non-reappointment and for Staff category, department assignment, and clinical privileges.

2.5 MEDICAL EXECUTIVE COMMITTEE REVIEW

The Medical Executive Committee (MEC) reviews the member's file, the department and Professional Functions Committee reports, and any other relevant information available to it and defers action on the reappointment or prepares a written report with recommendations for reappointment or non-reappointment and for Staff category, department assignment, and clinical privileges. This report, along with information reviewed, is submitted to the Professional Affairs Committee (PAC).

2.6 PROFESSIONAL AFFAIRS COMMITTEE ACTION

Processing of reappointments follows the procedures set forth in Section 1.1-11 for purposes of reappointment, an "adverse recommendation" by the MEC and/or "adverse recommendation" by the Professional Affairs Committee (PAC) or Board as used in those Sections means a recommendation to deny reappointment; to deny request of change in, or to change without the Staff member's consent, his Staff category, department assignment; or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in those Sections shall be read respectively, as "Staff member" and "reappointment".

2.7 BASIS FOR RECOMMENDATIONS AND ACTION

The report for each individual or group, including the PAC, required to act on a reappointment shall state the reasons for each recommendation made or action taken, with specific reference to the Staff member's credentials file and all other documentation considered.

2.8 TIME PERIODS FOR PROCESSING

Transmittal of the notice to a Staff member and the provision by him of updated information is to be carried out in accordance with Part II of this manual. Thereafter, and except for good cause, all persons or groups required to act must complete such action so that all reappointment reports and recommendations are transmitted to the MEC and in turn to the PAC prior to the expiration date of Staff membership of the member whose reappointment is being processed.

2.9 REQUEST FOR MODIFICATION IN MEMBERSHIP STATUS OR PRIVILEGES

A Staff member may, either in connection with reappointment or at any other time, request modification of his Staff category, department assignment, or clinical privileges by submitting a written request or the Request for Additional Privileges Form. An application for modification of privileges is processed in the same manner as reappointment using the appropriate form.

PART III. DELINEATION OF PRIVILEGES

3.1 INTRODUCTION

Clinical privileges at McLaren Bay Region will be granted on the basis of criteria developed by the Medical Staff. These criteria shall be established to assess the competence of each member requesting privileges. Through the process outlined in this part, the Medical Staff shall fulfill their responsibility for evaluating and recommending the scope of clinical privileges for individuals who apply for clinical privileges. It will also assure the practitioner that his/her application for privileges will be reviewed fairly by knowledgeable individuals who are experts in his/her clinical area.

3.2 APPROACHES FOR GRANTING PRIVILEGES

The broad criteria for granting clinical privileges are included in the Medical Staff Bylaws (ARTICLE V) and form the basis upon which an applicant's request for clinical privileges is evaluated. The specific criteria to be used in this process shall be developed by each Department of the Medical Staff. The criteria will, therefore, reflect a variety of methods, depending upon what each Department finds most appropriate. The variety of methods shall include a list approach, categorical approach, and a combination approach. Each of these approaches can be briefly described as follows:

a. List approach - establishment of a detailed list of specific procedures in which the practitioner checks those procedures he can perform with competence.
b. Categorical approach - procedures/illness are defined in terms of a hierarchy of levels based either on disease groupings or competence. The practitioner then selects the category he deems most appropriate.
c. Combination approach - combining elements of (a) and (b) above to utilize broad skill or disease categories while specifying specific disease entities or procedures.

3.3 DEPARTMENTAL CRITERIA

The specific criteria to be utilized by each Department shall be documented in each Department's Rules and/or Delineation of Privileges.

3.4 CONSULTATION

There may be attached to any grant of privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws, or in the Rules and Regulations and policies of the Staff, any of its clinical units or the hospital, special requirements for consultation as a condition to the exercise of particular privileges.

3.5 DEPARTMENTAL RESPONSIBILITY

To implement this method for granting clinical privileges, each department must define, in writing, the various criteria for delineating procedures, conditions and problems that fall within its clinical area. These criteria must be approved by the Medical Executive Committee and by the Professional Affairs Committee, must be periodically reviewed and revised, and must form the basis for Department clinical privilege recommendations.

3.6 PROCEDURE FOR DELINEATING PRIVILEGES

3.6-1 REQUEST
Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant or Staff member. Specific request must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

3.6-2 PROCESSING REQUESTS
All requests for clinical privileges will be processed according to the procedures outlined in Parts I and II of this manual, as applicable.

PART IV. CORRECTIVE ACTION PROCEDURES

4.1 ROUTINE CORRECTIVE ACTION

4.1-1 REQUESTS AND NOTICES

All requests for corrective action must be in writing, submitted to the Medical Executive Committee (MEC), and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff promptly notifies the Chief Executive Officer in writing of all requests. See Staff Bylaws ARTICLE 11 (page 44).

4.1-2 INVESTIGATION

After deliberation, the MEC may either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The MEC may conduct such investigation itself or may assign this task to a Medical Staff officer, department, service, other clinical unit, standing or ad hoc committee, or other organizational component. This investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. It may include a consultation with the practitioner involved and with the individual or group making the request and with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is practicable after the assignment to investigate has been made. The MEC may at any time within its discretion, and shall at the request of the Board or Professional Affairs Committee, terminate the investigative process or proceed with action as provided below.

4.1-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as it is practicable after the conclusion of the investigative process, if any, but in any event within 30 days after receipt of the request for corrective action unless deferred, the MEC acts upon such request. Its action may include, without limitation:

(a) recommending rejection of the request for corrective action
(b) recommending a warning or a formal letter of reprimand
(c) recommending a probationary period with retrospective review of cases but without special requirements of prior or concurrent consultation or direct supervision
(d) recommending supervision of membership prerogatives that do not affect clinical privileges
(e) recommending individual requirements of consultation or supervision
(f) recommending reduction, suspension or revocation of clinical privileges
(g) recommending reduction of Staff category or suspension or limitation of any prerogatives directly related to the practitioner's provision of patient care
(h) recommending suspension or revocation of Staff membership.

4.1-4 DEFERRAL
If additional time is needed to complete the investigative process, the MEC may defer action on the request but only upon written consent of the affected practitioner. A subsequent recommendation for any one or more of the actions provided above must be made within the time specified in the consent, and if no time is specified, then within 30 days of the deferral.

4.1-5 PROCEDURAL RIGHTS
An MEC Section 4.1-3 recommendation for individual consultation, decreased privileges, reduced category, diminished or suspended patient care prerogatives, or suspended or revoked membership is deemed adverse and entitles the practitioner to the procedural rights contained in the Fair Hearing Plan.

4.1-6 OTHER ACTION

(a) An MEC Section 4.1-3 recommendation for rejection warning/reprimand, probation with retrospective monitoring, or diminished prerogatives that do not affect clinical privileges is not deemed "adverse" and is transmitted to the Professional Affairs Committee (PAC) together with all supporting documentation. Thereafter, the procedure in Section 1.1-10 of this manual is applicable. However, if the PAC's initial action on any such recommendation represents a substantive change from the MEC's recommendations, the procedure at Section 1.1-10 is applicable. A "favorable recommendation" as used in Section 1.1-10 is any recommended action other than those in Section 4.1-5.

(b) If, in the Board's or Professional Affairs Committee's determination, the MEC fails to act in timely fashion in processing and recommending action on a request for corrective action, the procedure to be followed is as provided in Section 1.1-14.

4.2 SUMMARY SUSPENSION

4.2-1 MEDICAL EXECUTIVE COMMITTEE ACTION
As soon as possible, but in any event within 72 hours, after a summary suspension is imposed, the MEC convenes to review and consider the action taken. The MEC may recommend modification, continuation, or termination of the terms of the suspension.

4.2-2 PROCEDURAL RIGHTS
Unless the MEC recommends immediate termination or modification of the suspension to one of the lesser sanctions provided for in Section 4.1-3(a) through (d), the practitioner is entitled to the procedural rights contained in the Fair Hearing Plan.

4.2-3 OTHER ACTION
An MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting

documentation to the professional Affairs Committee (PAC), and the procedure in Section 4.1-6 is followed. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the PAC or the Board, as applicable.

4.3 AUTOMATIC SUSPENSION

4.3-1 MEDICAL EXECUTIVE COMMITTEE DELIBERATION
As soon as practicable (a) after a practitioner's license is suspended, restricted or placed on probation, or (b) after his controlled substances number is revoked, restricted, suspended or placed on probation, the MEC convenes to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives. Thereafter, the procedure in Section 4.1-5 or 4.1-6, as applicable, is followed.

4.3-2 MEDICAL RECORDS COMPLETION
Refer to Medical Staff Rules and Regulations.

4.3-3 MEDICAL RECORDS PREPARATION
Same as 4.3-3 above.

4.4 DISCIPLINARY SUSPENSION
The Medical Executive Committee (MEC) may, with the approval of the Chief Executive Officer (CEO) and the Board Chair, institute a disciplinary suspension of a member for a period not to exceed 15 consecutive days. The procedures and resultant actions are specified in the Medical Staff Disciplinary Suspension Policy as approved by the Professional Functions Committee, Medical Executive Committee and the Professional Affairs Committee.

PART V. LEAVE OF ABSENCE

5.1 LEAVE STATUS

A Staff member may obtain a voluntary leave of absence by submitting a completed Leave of Absence Request form to the Chief of Staff for transmittal to the applicable department chairman and the Chief Executive Officer. The notice must state (a) the approximate period of time of the leave, which may not exceed two (2) years, and (b) the reason for the requested leave status. Leave status shall not be granted unless based upon the following reasons:

1. government obligations
2. educational obligations
3. military service obligations
4. temporary public service obligations
5. Health reasons, including injury or illness
6. any other appropriate reason as shall be approved by the Board of Directors.

If a member of the Medical Staff requests a Leave of Absence for health reasons, it will be limited to 6 month intervals (not to exceed 2 years) and will be reviewed every 6 months by the appropriate Department, the Professional Functions Committee and the Medical Executive Committee.

5.2 TERMINATION OF LEAVE

The Staff member must, at least 60 days prior to the termination of the leave, or may at any earlier time, request reinstatement by submitting a completed Request for Reinstate4ment from Leave of Absence form to the appropriate medical staff department. The Staff member must submit a written summary of relevant activities during the leave. Verification of this activity and other queries such as state licensure, NPDB, criminal background checks, etc., will be conducted at the discretion of the Vice President Medical Affairs. The department makes a recommendation to the Professional Functions Committee concerning reinstatement, and the procedures in Sections 1.1-7 through 1.1-11 are followed.

When the member's leave has expired and he/she has not requested reinstatement, the Medical Staff Office shall attempt to notify the member by certified letter. If no response is received within 30 days of signed receipt of that certified letter, the member's privileges and Staff status shall automatically terminate.

5.3 EXPIRATION OF LEAVE

If the member has not requested reinstatement, or eligible extension, at least 60 days prior to expiration of the leave, the Medical Staff Office shall attempt to notify the member by certified letter. If no response is received within 30 days of signed receipt of that certified letter, the member's privileges and Staff status shall automatically terminate at expiration date.

PART VI. AMENDMENT

6.1 The Credentials Procedure Manual may be amended or replaced in whole or in part only by the same mechanisms as the Medical Staff Bylaws. This procedure is spelled out in ARTICLE XVI of the Bylaws, and in general terms means that recommendations for change will be processed through the MEC, Medical Staff as a body, PAC, Joint Conference Committee, and Governing Body.

PART VII. ADOPTION

7.1 MEDICAL STAFF

This Credentials Procedures Manual was adopted and recommended to the Professional Affairs Committee by the Medical Executive Committee in accordance with, and subject to, the Medical Staff Bylaws.

ADOPTED by the MEDICAL STAFF on December 13, 1995
Date

7.2 BOARD

This Credentials Procedures Manual was approved and adopted by resolution of the Professional Affairs Committee after considering the Medical Executive Committee's recommendations and in accordance with and subject to the hospital corporate bylaws.

ADOPTED by the PROFESSIONAL AFFAIRS COMMITTEE on

February 5, 1996
Date

Updates:
10/07/96
04/07/97
02/02/98
04/05/99
02/07/00
04/23/01
06/25/01
04/22/02
12/16/02
06/23/03
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02/22/10
04/26/10
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04/27/15
04/25/16
06/20/16

J. D. Abramson, M.D.
Chief of Staff

E. A. Curtis, Chairperson
Professional Affairs Committee