CREDENTIALING POLICY AND PROCEDURES MANUAL OF THE MEDICAL STAFF OF ADVENTIST HINSDALE HOSPITAL AND ADVENTIST LA GRANGE MEMORIAL HOSPITAL
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ARTICLE 1.
COMPOSITION OF CREDENTIALS COMMITTEE (amended: 12/07/00, 03/28/02)

The credentials committee shall be appointed by the medical staff president, subject to the approval of the medical executive committee, and consist of six or more medical staff members who have served as chair of medical staff committees or departments and the CMO or designee. Each member will serve a four-year term of office, with the exception of the initial committee of which one-half of the members shall serve a two-year term of office. The chair shall be appointed by the medical staff president. The senior presiding medical staff officer will serve as Vice Chair.

ARTICLE 2.
APPOINTMENT PROCEDURES

SECTION 2.1 APPLICATION

Requests for an application shall be in writing and addressed to the medical staff services department and shall contain the name, home address and medical specialty of the applicant. The CMO, at his/her discretion, may require a meeting with the practitioner for the purpose of a preliminary interview prior to providing the practitioner with an application. The CMO shall advise a practitioner desiring to apply if the medical staff department, specialty or category of privileges desired by the practitioner has been closed by the board to additional membership and, on that basis, may refuse to issue a pre-application or an application to the practitioner. The CMO, after consultation with the chair of the appropriate department, may advise a practitioner that he does not meet the prerequisites necessary for eligibility for consideration for membership, and the CMO shall refuse to issue an application on that basis. Refusals to provide application for these reasons shall create no right to a hearing or appeal under the fair hearing plan. Generally, unless otherwise stated in the medical executive committee or board policy, prerequisites necessary for eligibility consideration are as listed in this document, the medical staff bylaws and policies of the medical staff and hospital. To obtain medical staff membership and clinical privileges at the hospital, a practitioner shall file a pre-application and, if invited to do so by the medical staff an application for membership and privileges. The practitioner shall contact the medical staff services department to obtain a pre-application form. The pre-application and application shall be in writing and on such forms as designated by the medical executive committee and approved by the board. Prior to the application being submitted, the applicant shall be provided access to a copy of the hospital corporate bylaws, the medical staff bylaws and its accompanying manuals, the rules and regulations of the staff and its departments, and summaries of other hospital and staff policies and resolutions relating to clinical practice in the hospital.

SECTION 2.2 NO ENTITLEMENT TO APPOINTMENT

No individual shall be entitled to appointment or reappointment to the medical staff or to the grant or renewal of particular clinical privileges merely by the virtue of the fact that such individual:

2.1.1. Is licensed to practice a profession in this or any other state,

2.1.2. Is a member of any particular professional organization,

2.1.3. Has had in the past, or currently has, medical staff appointment or privileges at any hospital,
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2.1.4. Resides in the geographic service area of the hospital,

2.1.5. Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity, or

2.1.6. Is in a group with an exclusive contract with the hospital.

SECTION 2.3 APPLICATION CONTENT. (amended 12/22/04)

Every applicant must furnish a photo and all of the information and, where appropriate, confirming certificates or transcripts as may be required by the application forms adopted by the staff and board from time to time. The medical staff shall utilize the Uniform Hospital Credentials Form (as required by Illinois law [410 ILCS 517/15(e)]) and such additional forms as the medical staff may from time to time require and the board approve, which forms collectively shall include provisions necessary to secure information useful for evaluation of the pre-applicant or applicant.

SECTION 2.4 REFERENCES.

The application shall include the names of at least three professionals in the health care field, not currently business associates or partners with the applicant in professional practice or related to him or her, who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the hospital or medical staff authorities. The named individuals shall have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time, and at least one must have had organizational responsibility for supervision of his/her performance (e.g., department chair, service chief, training program director).

SECTION 2.5 EFFECT OF APPLICATION.

By applying for medical staff membership, a practitioner:

2.5.1 Attests to the correctness and completeness of all information furnished;

2.5.2 Signifies his/her willingness to appear for interviews in connection with the application;

2.5.3 Agrees to abide by the terms of the bylaws, rules, regulations, policies and procedure manuals of the medical staff and those of the hospital if granted membership, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not staff membership and/or privileges are granted;

2.5.4 Agrees to abide by the ethical standards of his/her profession and to provide continuous care to his/her patients;

2.5.5 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 and copying all records and documents that may be material to evaluation of those qualifications and competence;
2.5.6 Releases from any liability to the maximum extent permitted by laws all hospital representatives and its medical staff for their acts performed in connection with evaluating the applicant and his/her credentials;

2.5.7 Releases from all liability to the maximum extent permitted by law all individuals and organizations who provide information, including otherwise privileged or confidential information, to hospital representatives concerning the applicant’s ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;

2.5.8 Waives voluntarily, in the case of a rejected initial applicant, any right to file a court action based on state law claims challenging the rejection upon penalty of paying the hospital all of its costs and expenses, including attorney fees, if this waiver is dishonored;

2.5.9 Consents to mental, physical or toxicological examination by person(s) appointed by the medical staff president if requested to do so and to produce full reports thereof;

2.5.10 Waives voluntarily the provisions of Section 412(b) of the Health Care Quality Improvement Act of 1986 (Act) [42 U.S.C. 11112(b)], which waiver is expressly permitted by Section 412(b). This waiver means that no variance between these bylaws and Section 412(b) concerning notice and hearing rights may be asserted by a practitioner to defeat the peer review immunity provisions in Section 411(a) of the Act [42 U.S.C. 11111(a)];

2.5.11 Signifies his/her willingness to appear for interviews in regard to his/her application, if requested to do so; and

2.5.12 Agrees to sign a statement which acknowledges that he/she is fully informed of the scope and extent of the authorizations, releases, consents and provisions stated above and that he/she is fully informed of and agrees to be bound by the immunity provisions contained in Article 8 of the medical staff bylaws.

2.5.13 For purposes of this Section, the term “hospital representative” includes the board, its members and committees; the president of the hospital; the CMO; the medical staff organization; all staff members, departments, clinical units and committees and hospital and staff officers, employees and agents that have responsibility, directly or indirectly, for collecting or evaluating the applicant’s credentials or acting upon applications; and any authorized representative of any of the foregoing.

SECTION 2.6 PROCESSING THE PRE-APPLICATION (amended 3/27/03; 7/26/07)

2.6.1 Pre-applicant Status. A practitioner who submits an application for membership on the medical staff shall be considered a pre-applicant until he/she completes the pre-application review. The practitioner shall become an applicant to the medical staff when his/her pre-application review is complete and the CMO or his/her designee determined that the application may be considered by the medical staff.

2.6.2 Pre-application review. Before an individual may be considered an applicant, the following information must be verified:
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a. that an individual is eligible for appointment to the medical staff because he/she meets the threshold criteria for appointment set forth in Section 1.3 of the Medical Staff Bylaws;

b. that the individual meets the threshold criteria for the requested clinical privileges at the hospital;

c. that the individual desires to provide care and treatment to patients for conditions and diseases for which the hospital has facilities and personnel;

d. that the individual indicates an intention to utilize the hospital as required by the staff category to which he/she desires appointment;

e. that the individual is not seeking clinical privileges that are currently subject to an exclusive contract; and

f. that the individual is applying for privileges in a specialty area where the hospital is accepting applications per the hospital’s Medical Staff Development Plan (if applicable).

2.6.3 Additional Criteria for Applicant Status. The Medical Staff Services Department shall verify the information and forward the application to the Credentials Committee, which shall determine whether a pre-applicant is eligible to become an applicant. The Credentials Committee may request additional information or may request that the pre-applicant meet with the Department Chair or the Credentials Committee prior to making its determination. It shall be the pre-applicant’s responsibility to provide all information required by the Credentials Committee, and failure to provide such information or to comply with a request to meet with the Department Chair or the Credentials Committee shall constitute a withdrawal of the pre-applicant’s application. To become an applicant, the practitioner shall have

2.6.3.1 Substantially completed and submitted the application forms to the Medical Staff Services Department;

2.6.3.2 Demonstrated by virtue of the information contained in the application forms that no reason is immediately apparent to disqualify him/her for medical staff privileges under the requirements set forth in this manual and the medical staff bylaws; and

2.6.3.3 Received from the Medical Staff Services Department written notice of the successful completion of the pre-application review and a copy of the medical staff bylaws and related materials described in Section 2.1 of this manual.

2.6.4 Failure to Obtain Applicant Status. If the practitioner does not meet the criteria for applicant status, the Medical Staff Services Department shall notify him/her by special notice and shall return the application forms to the practitioner. A determination that a pre-applicant fails to meet the criteria for applicant status shall not entitle the pre-applicant to a hearing or appellate review.

SECTION 2.7 PROCESSING THE APPLICATION (amended: 1/19/06)

2.7.1 Applicant's Burden. The applicant shall have the burden of producing all information, and verification thereof, necessary for (a) a proper substantive evaluation of his/her experience, training, demonstrated ability, and health status for appointment to the medical staff and the
exercise of clinical privileges, (b) resolving any doubts about these or any of the qualifications required for staff membership or the requested staff category, department assignment, or clinical privileges, and (c) satisfying any reasonable requests for information or clarification (including health examinations) made by the appropriate staff or board authorities. Failure of the applicant to meet the burden required herein shall constitute voluntary withdrawal of the application, and the application will not be processed. Such withdrawal shall create no rights to a hearing and appeal under the fair hearing act.

2.7.2 Verification of Information; Time Limit to Complete. The application shall be submitted to the Medical Staff Services Department, which shall then collect or verify the references, licensure and other qualification evidence submitted and promptly notify the applicant of any problems in obtaining the information required. Upon such notification, it is the applicant's obligation to obtain the required information. Upon receipt of the application, a request for information regarding the applicant shall be submitted to the Illinois Department of Professional Regulation and to the National Practitioners Data Bank to obtain information concerning the licensure status and any disciplinary action taken against the applicant's license. When collection and verification is accomplished, the application and all supporting materials shall be transmitted to the chair of each department in which the applicant seeks privileges, to the chair of the credentials committee, and to the CEO. Collection and/or verification of credentialing information for medical staff members who provide telemedicine services may, at the discretion of the Medical Staff or Hospital, be performed by another JCAHO-accredited organization, pursuant to an agreement between such organization and the Hospital.

If the application cannot be declared complete within 90 days of its submission, the CEO (or designee) shall send special notice thereof to the applicant, specifying the needed information required to process the application. If the application cannot be declared complete within 120 days of its submission, the application shall be deemed to be withdrawn, and the CMO shall send special notice thereof to the applicant. Falsification, withholding or material omissions of information, whenever discovered, shall be grounds for disciplinary action, including revocation of clinical privileges and medical staff membership.

2.7.3 Medical Staff Input. After the application is complete, the name of the applicant shall be posted on the appropriate staff bulletin boards. Any member of the staff may submit to the CEO, in writing and with full details, information relevant to the applicant's qualifications for staff membership and privileges. Such information is forwarded to the credentials committee. Any staff member may request, in writing with reasons, or may be requested by the credentials committee, to appear before the credentials committee in person to discuss the application. The credentials committee, in its sole discretion, shall determine whether to grant such requests.

2.7.4 Department Action. The chair of each department in which the applicant seeks privileges shall review the application and its supporting documentation and, within a reasonable time frame of receipt of the complete application forward to the credentials committee a written report as required by Section 2.7.8.2 (Content of Reports and Bases for Recommendations and Actions) evaluating the evidence of the applicant's training, experience and demonstrated ability and stating how the applicant's skills are expected to contribute to the activities of the department. Prior to completion of such report, a department chair or his/her designee will conduct a formal interview with the applicant. If a department chair requires further information, he/she may defer transmitting his/her report after receipt of the complete
application from the Medical Staff Services Department. In the case of a deferral, the applicable chair shall notify the chair of the credentials committee of the deferral. The CEO (or his/her designee) shall give the applicant special notice of the deferral and, if the applicant is to provide additional information, the special notice must so state and include a request for the specific data/explanation required.

2.7.5 **Credentials Committee Action.** (amended: 8/3/06) After it receives all department reports, the credentials committee shall review the application, the supporting documentation, the reports from the department chairs, and any other relevant information available to it. The credentials committee shall interview the applicant and then transmit to the medical executive committee, the credentials committee's written report and recommendations as required by Section 2.7.8.2 (Content of Reports and Bases for Recommendations and Actions). If the credentials committee requires further information, it may defer transmitting its report, but for no more than a reasonable time frame after its receipt of the application. The CEO shall give special notice of the deferral to the applicant and notify the medical executive committee of, and the reasons for, the deferral. If the applicant is to provide the additional information, the special notice to him/her shall so state and shall include a request for the specific data/explanation required to process the application.

2.7.6 **Medical Executive Committee Action.** (amended: 8/3/06) The medical executive committee, at its next regular meeting after receipt of the credentials committee report (or the following meeting if the report was received later than ten days prior to the next regular meeting), shall review the application, the supporting documentation, the reports and recommendations from the department chairs, and credentials committee, and any other relevant information available to it, or request at its option, a personal interview with the applicant. The medical executive committee shall prepare a written report with recommendations as required by Section 2.7.8.2 (Content of Reports and Bases for Recommendations and Actions) or shall defer action on the application. If there is a deferral, the medical executive committee shall give notice thereof to the CEO. The CEO (or designee) shall promptly give the applicant special notice of an action to defer, including a request for the specific data/explanation, if any, required from the applicant.

2.7.7 **Effect of Medical Executive Committee Recommendation.**

2.7.7.1 **Deferral.** Action by the medical executive committee to defer the application for further consideration shall be followed up no later than within 60 days of the deferral with its report and recommendations.

2.7.7.2 **Favorable or Adverse Recommendation.** The medical executive committee shall give its recommendation on the application to the CMO in a timely manner. Whether the medical executive committee's recommendation is favorable or adverse to the applicant, the CMO shall promptly forward it to the quality council of the board. For an adverse recommendation, a summary of the application and its accompanying information, the reports and recommendations of the departments, the credentials committee and the medical executive committee, comments from staff members given pursuant to Section 2.7.2 (Verification of Information; Time Limit to Complete), and dissenting views shall be forwarded to the quality council of the board. An adverse recommendation by the medical executive committee does not entitle the applicant to the procedural rights afforded by the fair hearing plan.
2.7.3 **Quality Council of the Board.** The quality council may revise the medical executive committee recommendation before referring the recommendation to the board of directors for final action. If the quality council disagrees with the medical executive committee recommendation, it shall refer the matter back to the medical executive committee for further consideration, which should be done at the next regular meeting of the medical executive committee. After receiving the report of the medical executive committee's reconsideration, the quality council shall make its final determination on the matter and forward a report to the board of directors for final action.

2.7.4 **Withdrawal of Application.** Prior to action on the application by the board, an applicant may, by special notice to the CEO, request that his/her application be withdrawn. Such request shall be honored, and no further action shall be taken on the application. A request to withdraw an application from a practitioner who has received an adverse action by the board of directors shall not be honored.

2.7.8 **Board Action**

2.7.8.1 **On Favorable or Adverse Quality Council Recommendation.** The board may adopt or reject, in whole or in part, a favorable or adverse recommendation of the quality council or refer the recommendation back to the quality council and medical executive committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the board shall be effective as its final action. If the board's action is adverse to the applicant in any respect, the CMO shall promptly so inform the applicant by special notice.

2.7.8.2 **Content of Reports and Bases for Recommendations and Actions.** The report of each individual or group required to act on an application, including the board, shall include recommendations as to approval or denial of, and any special limitations on, staff appointment, category of staff membership and prerogatives, department affiliation, and scope of clinical privileges. The reasons for each recommendation or action taken must be stated and specifically address how the applicant's appointment satisfies the requirement of Section 1.3 of the medical staff bylaws. The report shall explain the reasons for any adverse decision (including all reasons based in whole or in part on the applicant’s medical qualifications or any other basis, including economic factors). Any dissenting views at any point in the process shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

2.7.8.3 **Notice of Final Action.** Notice of the board's final action shall be given to the medical executive committee, to the chair of each department concerned, and to the applicant by special notice from the CEO (or designee). Notice of a final adverse board action, including the basis for that action, regarding staff appointment shall be given to the applicant by special notice from the CEO (or designee). The board's action and notice to appoint shall include: (a) the staff category to which the applicant is appointed; (b) the department to which the applicant is assigned; (c) the clinical privileges the applicant may exercise; and (d) any special conditions attached to the staff appointment.
2.7.8.4 **Time Periods for Processing.** All individuals and groups required to act on an application for staff appointment shall do so in a timely manner and in good faith. References to the processing of an application by medical executive committee and the board at the next regular meeting shall be deemed to be guidelines and not directives and they shall create no rights for an applicant to have an application processed within these precise periods.

**SECTION 2.8 REAPPLICATION BY APPLICANT AFTER FINAL ADVERSE ACTION.**

An applicant who has received a final adverse board action regarding staff appointment, any aspect of staff membership status, including staff category or department assignment, or clinical privileges shall not be eligible to reapply for staff membership or for the denied category, department, other status or prerogatives, or privileges for a period of 24 months after such final adverse board action, provided, however, that the board may waive this provision at its discretion. Any such reapplication shall be processed as an initial application, and the applicant shall 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. Failure to provide such additional information satisfactory to the board and applicable staff authorities shall constitute voluntary withdrawal of the reapplication, and the application shall not be processed.

**ARTICLE 3 REAPPOINTMENT PROCEDURES**

**SECTION 3.1 TERM OF APPOINTMENT.**

Except for new appointees, appointments to the medical staff shall be for a maximum of two years, except as defined in Section 3.2 below.

**SECTION 3.2 REAPPOINTMENT PERIOD.** (amended: 12/22/04)

Reappointments to the staff shall be for a maximum of two years. Approximately half of the staff shall be considered for reappointment each year, thus staggering the reappointment process.

**SECTION 3.3 REAPPOINTMENT APPLICATION, INFORMATION COLLECTION, AND VERIFICATION.** (amended 11/21/02)

3.3.1 **From Staff Member.** On or before five months prior to the date of expiration of a medical staff member's appointment, the Medical Staff Services Department shall give the staff member special notice of the date of expiration and a copy of the required reappointment form. The reappointment application shall be considered incomplete and shall not be processed unless the applicant is current with respect to the payment of medical staff dues and assessments. At least 90 days prior to the expiration date, the staff member shall furnish, in writing on the reappointment form to the CMO:

3.3.1.1 Complete information to update his/her file on the items referred to in Section 2.3 (Application Content);
3.3.1.2 Continuing training and education external to the hospital during the current appointment period;

3.3.1.3 Specific requests for the clinical privileges sought on reappointment, with any basis for changes; and

3.3.1.4 Requests for changes in staff category for department assignments.

Failure, without good cause, to submit the completed reappointment form by the date required shall be deemed a voluntary resignation from the staff and shall result in automatic termination of staff membership at the expiration of the current appointment. A member of the staff whose staff membership is terminated for failure to submit a reappointment form by the required date shall not be entitled to the procedural rights provided in the fair hearing plan.

3.3.2 Verification. The Medical Staff Services Department shall verify the additional information on the reappointment form, and notify the staff member by special notice of any information inadequacies, verification problems, or a request for evidence of current health status and the date by which such additional information must be supplied or verified. The staff member then shall have the burden of producing adequate information and resolving any doubts about the data, including if requested, submitting reasonable evidence of current health status in accordance with Section 1.8 of the medical staff bylaws. The staff member shall sign an acknowledgement that the Illinois Department of Professional Regulation and National Practitioner Data Bank (organized in accordance with the Health Care Quality Improvement Act of 1986) will be contacted as part of the reappointment process to obtain information concerning the licensure status and any disciplinary action taken against the staff member’s license.

3.3.3 From Internal Sources. The Medical Staff Services Department shall collect for each staff member's credentials file all relevant information regarding the individual’s professional and collegial activities and performance and conduct in the hospital. Such information shall include, without limitation, any relevant information considered for a member’s initial application, demonstrated competence, as well as deficiencies; patterns of care as demonstrated in the findings of quality assurance activities; reports of inappropriate admissions or procedures and length of stay; participation in relevant internal teaching and continuing education activities; level/amount of clinical activity (patient care contacts) at the hospital; sanctions imposed or pending and other disciplinary action; claims, lawsuits, settlements and judgments involving the member; health status; attendance at required medical staff and department meetings; participation as a staff official, committee member/chair and proctor and in specialty coverage for the emergency rooms; timely and accurate completion of medical records; and compliance with all applicable bylaws, policies, rules, regulations and procedures of the hospital and staff. Recommendations concerning reappointment shall also be based on maintenance of professional liability insurance in accordance with the medical staff bylaws and current physical and mental health status as they may pertain to the clinical privileges requested and required medical staff functions.

SECTION 3.4 DEPARTMENT ACTION.

The Medical Staff Services Department shall give the chair of each department, in which the staff member requests, or has exercised, privileges, notice of the processing of the member’s reappointment. Each department chair or his/her designee shall review the staff member's file and
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forward it to the credentials committee, a written report of the chair's recommendations regarding reappointment and clinical privileges. This report shall include the reasons for any recommended changes in the staff member's membership or privilege status. The department chair may take into consideration any and all information coming to his/her attention in arriving at a determination. In performing his/her review, a department chair may call upon the member for an interview. There shall be no right to the procedural protections under the fair hearing plan regarding the findings and recommendations of the department chair.

SECTION 3.5 CREDENTIALS COMMITTEE ACTION.

The credentials committee shall review the staff member's file, the department reports and all other relevant information available to it and send to the medical executive committee a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category, department assignment, or clinical privileges. The credentials committee may call upon the member for an interview before making its recommendations. There shall be no right to the procedural protections under the fair hearing plan regarding its findings and recommendations of the credentials committee.

SECTION 3.6 MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION.

At its next regularly scheduled meeting after receipt of the credentials committee report (or the following meeting if the report were received later than ten days prior to the next regular meeting), the medical executive committee shall review the staff member's file, the departments and credentials committee reports, and any other relevant information available to it and may call upon the member for an interview, and either defer action on the reappointment or prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category, department assignment, and clinical privileges, which it shall forward to the CMO, who shall forward it to the quality council, which acts in accordance with Section 2.7.7.3 (Quality Council of the Board).

3.6.1 Deferral. A decision by the medical executive committee to defer the reappointment for further consideration shall be followed up within 60 days with its report and recommendations. The CEO (or designee) shall promptly give the staff member special notice of a decision to defer, including a request for the specific data/explanation, if any, required from the staff member and the date by which it must be provided to the medical executive committee.

SECTION 3.7 FINAL PROCESSING AND BOARD ACTION.

3.7.1 Effect of Medical Executive Committee Recommendation.

3.7.1.1 Favorable Recommendation. When the medical executive committee's recommendation is favorable to the staff member in all respects, the CMO shall promptly forward it, together with all supporting documentation, to the quality council, which acts in accordance with Section 2.7.7.3 (Quality Council of the Board).

3.7.1.2 Adverse Recommendation. When the medical executive committee's recommendation is adverse to the staff member in any respect, the CMO shall so inform the staff member by special notice, and he/she shall be entitled to the
procedural rights as provided in the fair hearing plan, and further processing of the reappointment shall proceed as set forth therein.

3.7.2 **Resignation.** A resignation by a staff member who has received an adverse medical executive committee reappointment recommendation or board action shall be honored.

3.7.3 **Board Action.** In the case of a favorable medical executive committee recommendation or the absence of a timely recommendation, final board action shall follow the procedures set forth in Section 2.7.8.1 (On Favorable or Adverse Quality Council Recommendation). In the case of an adverse medical executive committee recommendation or an adverse board action after a favorable medical executive committee recommendation, the board shall take final action in the matter as provided in the fair hearing plan. For purposes of reappointment, the terms "applicant" and "appointment" as used in Sections 2.7.8 (Board Action), 2.7.8.2 (Content of Reports and Bases for Recommendations and Actions), and 2.7.8.3 (Notice of Final Action) shall be read respectively as "staff member" and "reappointment". Except for suspensions imposed under Article 6, the membership and privileges of the affected member shall continue until final action by the board or until the member’s procedural rights under the fair hearing plan have been waived or unless otherwise terminated.

**SECTION 3.8 CONTENT OF REPORTS AND BASES FOR RECOMMENDATIONS AND ACTIONS.**

The report of each individual or group, including the board, 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 and how the reappointment satisfies the requirement of Section 1.3 of the medical staff bylaws. Any dissenting views at any point in the process shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

**SECTION 3.9 TIME PERIODS FOR PROCESSING.**

Except for good cause, all persons and groups required to act on a reappointment shall complete such action so that all reappointment reports and recommendations can be transmitted to the medical executive committee and in turn to the board prior to the expiration date of staff membership or the staff member whose reappointment is being processed. The time periods specified shall be to guide the acting parties in accomplishing their tasks. If delay is attributable to the staff member's failure to provide information required by Section 3.3.1 (From Staff Member), his/her staff membership terminates on the expiration date as provided in Section 3.3.1 (From Staff Member), unless an extension is given as provided therein. An extension shall create no right of automatic reappointment for the coming term.

**SECTION 3.10 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES.**

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, or clinical privileges by submitting a written request to the president of the medical staff, provided that the staff member is not in the provisional period when making such a request. Such request for modification shall be processed in substantially the same manner as provided for reappointment.
SECTION 3.11 RESIGNATION. (amended 12/4/03)

3.11.1 Voluntary Resignation. Resignations shall be in good standing if all medical records are complete and/or any pending disciplinary actions have been resolved. Resignations shall not be in good standing if medical records are incomplete and/or disciplinary actions have not been resolved. See Section 8.3 regarding a medical staff member’s status if delinquent medical records are not completed when a leave of absence turns into a resignation.

3.11.2 Automatic Resignation.

3.11.2.1 Failure to Pay Dues. A staff member’s failure to pay dues and assessments after receipt of two notices shall constitute an automatic resignation from the staff.

3.11.2.2 Termination of Affiliation with Practice Under Exclusive Contract. If a staff member is employed or under other contract with a group that holds an exclusive agreement to provide professional services to the hospital and his/her relationship with the group is terminated for any reason, the member will be deemed to have automatically resigned from the medical staff.

ARTICLE 4
SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES

SECTION 4.1 DEPARTMENT RESPONSIBILITY.

Each department shall define, in writing, the clinical procedures, conditions and problems that fall within its clinical area, including different levels of severity or complexity when appropriate. These definitions shall be coordinated by the credentials committee and shall be approved by the medical executive committee and the board. These definitions shall also be periodically reviewed and revised. These definitions form the basis for delineating privileges within the department. Special procedures (i.e., biopsies, aspirations, endoscopies, dialysis, ventilator management, Swan-Ganz insertion, etc.) that may be performed at the hospital shall also be defined and privileges specifically requested and delineated for them.

SECTION 4.2 CONSULTATION AND OTHER CONDITIONS.

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, regulations and policies of the staff or any clinical units of the hospital, special requirements for consultation as a condition to the exercise of particular privileges. As part of his/her request for clinical privileges, each practitioner pledges, in dealing with cases outside his/her training and usual area of practice, that he/she will seek appropriate consultation with or refer to a practitioner who has expertise in such cases, and the practitioner acknowledges that his/her grant of privileges is circumscribed by hospital medical staff policies concerning the management of patients in intensive care units and by such other special policies as may from time to time be adopted.
SECTION 4.3 EXERCISE OF PRIVILEGES.

Privileges generally shall be granted for a period of two years, except that a more frequent reappraisal period may be set for the exercise of particular privileges that are new to the hospital or represent new or still developing techniques or modalities in the field of practice or for individual practitioners as recommended by the applicable department chair and the medical executive committee and approved by the board of directors.

SECTION 4.4 PROCEDURE FOR DELINEATING PRIVILEGES.

4.4.1 Requests. Each application for appointment and reappointment to the medical staff shall contain a request for the specific clinical privileges desired by the applicant or staff member. Specific requests shall also be submitted for temporary privileges and for modifications of privileges between reappraisals.

4.4.2 Processing Requests. All requests for clinical privileges shall be processed according to the procedures outlined in Articles 2 and 3, as applicable.

4.4.3 Clinical Privileges for New Procedures. Whenever a medical staff member requests clinical privileges to perform a procedure or service not currently being performed at the hospital, or to utilize a significantly new technique to perform an existing procedure, the following process shall be followed:

4.4.3.1 The member shall first be informed by the CMO that his/her request will not be processed until (1) a determination has been made regarding whether the procedure or service will be offered by the hospital and, if so, until (2) minimum threshold criteria for the requested service or procedure have been established.

4.4.3.2 Upon request by the CMO, the credentials committee shall make a preliminary recommendation as to whether the new procedure, service, or technique is one that should be offered to patients. One factor to be considered in reaching this determination shall be whether the hospital has the capabilities, including support services, to perform the procedure or service in question. If the preliminary recommendation is favorable, the credentials committee shall then develop threshold credentialing criteria. In developing the criteria, the credentials committee may consult with experts – both those on the hospital’s medical staff and those outside the hospital. The minimum threshold criteria shall include (1) the minimum education, training, and experience necessary to perform the procedure or service, (2) the extent of monitoring and supervision that should occur if the privileges are granted, and (3) when appropriate, the criteria and/or indications for the procedure or service. The credentials committee shall forward its recommendations to the medical executive committee, which shall review the matter and forward its recommendations to the board for final action.

4.4.3.3 After receiving recommendations from the medical executive and credentials committees, the board shall make a determination as to whether the new procedure, service or technique is one that will be offered to patients. If the board determines to offer the procedure, service or technique, the board shall then establish the minimum threshold qualifications that an individual must possess in order to be eligible to request the clinical privileges in question.
4.4.3.4 Once the foregoing steps are completed, specific requests from eligible medical staff members who wish to perform the procedure or service shall be handled as set forth above.

4.4.4 Term of Privileges. The term of new privileges granted a member during the term of his/her current staff membership shall be coterminous with his/her staff membership.

SECTION 4.5 TEMPORARY PRIVILEGES. (amended: 12/07/00; 3/25/04; 4/7/05)

4.5.1 Conditions. Temporary privileges may be granted after the following requirements have been met and only under the circumstances described in Section 4.5.2 (Circumstances). Temporary privileges may be granted only to an appropriately licensed practitioner, when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. The practitioner shall provide the hospital with: (a) a completed application confirming all educational training, past and current hospital affiliations, claims history and information from the National Practitioner Database; (b) evidence of Illinois state licensure, controlled substance and Federal DEA; (c) evidence of professional liability insurance; (d) no negative references; (e) favorable recommendations for temporary privileges by the department chair, (f) favorable recommendations for temporary privileges by the Chair of the Credentials Committee, (g) favorable recommendation for temporary privileges by the medical staff president and the CEO or designee. Special requirements of consultation and reporting may be imposed by the chair of the department responsible for supervision. Under usual circumstances, the practitioner requesting temporary privileges should agree in writing to abide by the bylaws, rules, regulations and policies of the staff and hospital in all matters relating to his/her temporary privileges. In the absence of such written agreement, the practitioner will be presumed to have so agreed.

4.5.2 Circumstances and Additional Requirements. If the requirements of Section 4.5.1 and any additional requirements listed below are met, the CEO or designee may grant temporary privileges in the following circumstances:

4.5.2.1 Pendency of Application: After receipt of an application for staff appointment including a request for specific temporary privileges for an initial period of 120 days, with subsequent renewals not to exceed the pendency of the application. Such renewals may be made only when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges, and may not be made if the application is still pending as the result of the applicant's failure to respond in a satisfactory manner to a request for clarification of a matter or for additional information.

The applicant must interview with the appropriate department chair and receive a favorable recommendation.

4.5.2.2 Care of Specific Patients: Upon the receipt of a written request for specific temporary privileges for the care of one or more specific patients from a practitioner who is not an applicant for staff membership. Such privileges shall be restricted to the treatment of not more than four cases in any 12-month period after which such practitioner shall be required to apply for appointment to the medical staff before being allowed to attend additional patients.
4.5.2.3 **Locum Tenens:**

4.5.2.3.1 The CEO may grant a practitioner serving as a locum tenens for the hospital or for a member of the medical staff temporary admitting and clinical privileges to attend patients of that member for an initial period not to exceed six months but not to exceed his/her services as a locum tenens.

The applicant must be interviewed by the appropriate department chair and receive a favorable recommendation. The Credentials Committee shall review the applicant’s credentials at its next meeting and make a favorable recommendation.

4.5.2.4 **Teleradiologists:** Applicants must receive a favorable recommendation from the Credentials Committee.

4.5.3 **Residents and Fellows:** Upon receipt of a written request, an appropriately licensed physician who is serving his residency or fellowship may, without applying for appointment to the Medical Staff, be granted temporary privileges for an initial period of 365 days. Such privileges may be renewed for successive periods of 365 days but not to exceed the practitioner’s services as a resident or fellow. All procedures performed by such physician shall be under the general supervision of the Chairman of the Department in which the privileges are granted or his/her designee. (amended: 12/07/00)

Residents and Fellows must also provide the following documents to the Medical Staff Office:

a. A letter from the primary training institution affirming that the proposed rotation at Adventist Hinsdale Hospital/Adventist La Grange Memorial Hospital is approved by that institution as a part of training and affirming that the individual is in good standing at the primary institution.

b. Proof of malpractice coverage with dollar limits

c. For residents: Proof of Illinois medical license (a statement from the primary training institution will suffice)

d. The mechanisms of supervision of the trainee by the attending staff and names of medical staff members who will be responsible for the supervision.

4.5.4 **Termination.** The CEO or the president of the staff shall, on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications or his/her ability to exercise any or all of the temporary privileges granted, and may at any other time after consultation with the chair responsible for supervision, terminate any or all of a practitioner's temporary privileges, provided that where the life or well-being of any person is determined to be endangered, the termination may be effected by any person entitled to impose suspensions under Section 6.2.1 (Grounds for Precautionary Suspension). In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the chair responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
4.5.5 Rights of the Practitioner. Neither the rejection of a request for temporary privileges nor the suspension or termination of all or any portion of his/her temporary privileges shall entitle the practitioner to the procedural rights afforded by the bylaws and the fair hearing plan.

SECTION 4.6 SPECIAL CONDITIONS FOR ORAL AND MAXILLOFACIAL SURGEONS AND DENTISTS.

Requests for clinical privileges from oral and maxillofacial surgeons and dentists shall be processed in the manner specified in this Section. Surgical procedures performed by oral and maxillofacial surgeons and dentists shall be under the overall supervision of the chair of surgery. An oral and maxillofacial surgeon with the requisite qualifications may be granted the privilege of performing the admission history and physical examination and assessing the medical risks of the proposed procedure to the patient, but only if the patient has no known medical problems. Otherwise, oral and maxillofacial surgery and dental patients shall receive a basic medical appraisal by a physician member of the medical staff. A physician member of the medical staff shall also be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization and shall determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When significant medical abnormality is present, the final decision on whether to proceed with the surgery shall be agreed upon by the oral and maxillofacial surgeon or dentist and the physician consultant. The chair of the department of surgery (or the president of the staff if the chair of surgery is a consulting physician in the matter) shall decide the issue in case of dispute.

SECTION 4.7 CLINICAL PRIVILEGES FOR PODIATRISTS.

The scope and extent of surgical procedures that a podiatrist may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges and in accordance with such policies governing podiatrists as may be adopted by the board from time to time. Surgical procedures performed by podiatrists shall be under the overall supervision of the chair of the department of surgery.

SECTION 4.8 EMERGENCY PRIVILEGES.

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any medical staff member is authorized and shall be assisted in efforts to save the patient's life or to save the patient from serious harm, to the degree permitted by the member's license but regardless of department affiliation, staff category or privileges. A physician exercising emergency privileges shall promptly summon and arrange all consultative assistance he/she considers necessary and shall arrange for appropriate follow-up care.

SECTION 4.9 SPECIAL CONDITIONS FOR PART-TIME PHYSICIANS UNDER CONTRACT WITH HOSPITAL.

Requests for clinical privileges for part-time physicians under contract with Hospital shall be processed in the manner specified in Articles 2 and 3 of the Credentialing Policy and Procedures Manual. All procedures performed by such physicians shall be under the overall supervision of the department chair or designee in which privileges are granted. Such physicians are not eligible for appointment to the Medical Staff and have no rights under the Fair Hearing Plan. (amended: 12/07/00)
SECTION 4.10 DISASTER PRIVILEGES (new section added: 3/25/04; amended: 8/3/06; 3/27/08)

4.10.1 Disaster privileges may be granted to licensed independent practitioners who are not members of the Adventist Hinsdale Hospital/Adventist La Grange Memorial Hospital medical staff, in accordance with this Section, when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs.

Any practitioner providing patient care must be granted emergency privileges prior to providing patient care.

4.10.2 Disaster privileges may be granted to licensed independent practitioners as outlined below:

a. Hospital staff shall obtain the information outlined on the Emergency Privileges Application Form, which includes obtaining the following items at the time that emergency privileges are requested:
   • Copy of current professional license to practice medicine/dentistry/podiatry in the state of Illinois
   • Copy of photo identification (current driver’s license, hospital ID)
   • Names of current hospital affiliations where practitioner holds active privileges

b. The Credentialing Verification Service/Medical Staff Office shall query the National Practitioner Data Bank and the Office of Inspector General in addition to trying to obtain a certificate of the physician’s malpractice insurance. Primary source verification of licensure shall begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it shall be done as soon as possible. Primary source verification of licensure will not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges. The organization shall make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

A record of this information shall be retained in the Medical Staff Office.

4.10.3 The option to grant disaster privileges/scope of practice to volunteer practitioners is made on a case-by-case basis in accordance with the needs of this organization and its patients, and on the qualifications of volunteer practitioners. The practitioner being granted disaster privileges may, in the CEO’s or Medical Staff President’s (or either of their designee’s) discretion, be paired with a currently credentialed medical staff member who oversees the professional performance of volunteer practitioners via direct observation, mentoring, and/or a clinical record review. All non-staff members granted disaster privileges shall act only under the oversight of the Medical Staff President or his designee. Names badges shall be given to individuals granted disaster privileges so that hospital staff can identify them.
4.10.4 Disaster privileges may be granted by the chief executive officer (or his/her designee) or the medical staff president (or his/her designee), in such individual’s discretion, upon receipt and review of the items outlined in #1a through 1c above.

4.10.5 The CEO or Medical Staff President (or either’s designee) shall have the discretion to terminate any practitioner’s disaster privileges at any time. Otherwise, any disaster privileges granted hereunder shall automatically terminate when the emergency situation no longer exists. No practitioner shall be entitled to hearing or appellate review rights regarding termination of disaster privileges.

ARTICLE 5
PROVISIONAL PERIOD

SECTION 5.1 APPLICABILITY AND DURATION.

New appointees shall be reviewed annually. All new appointments to the staff and all grants of clinical privileges to new appointees shall be provisional for a period of one year, which may be extended for another year as provided in Section 5.6.

SECTION 5.2 EFFECT ON MEMBERSHIP OR EXERCISE OF PRIVILEGES.

During the provisional period, a practitioner shall demonstrate all of the qualifications, may exercise all of the prerogatives, and shall fulfill all of the obligations described in the medical staff bylaws; and he/she may exercise all of the clinical privileges granted to him/her. During the provisional period, a practitioner may not vote or hold office, and he may sit on committees only under special circumstances as determined by the MEC.

SECTION 5.3 OBSERVATION AND EVALUATION.

During his/her provisional period, a practitioner's performance will be specifically observed and evaluated by the chair of the department with which he/she has his/her primary affiliation and by the chair of each other department in which he/she exercises his/her privileges, or by other active staff members specifically delegated these tasks by such chairs. Such observation and evaluation may include without limitation retrospective chart review and/or the appointment of a member from the department to which a provisional appointee is assigned to serve as a proctor to supervise and review the practitioner’s performance. The purpose of the observation period shall be to judge the quality of medical care that the practitioner delivers. As a condition of appointment, the new member shall agree that any proctor appointed by the department chair shall be empowered to assume responsibility for a patient whenever, in the sole judgment of the proctor or department chair, such action appears necessary to safeguard patients’ lives, health or well-being.

SECTION 5.4 DEPARTMENT REVIEW.

Termination of the provisional period shall require the following action by the applicable departments, in addition to any other requirements of the bylaws:

5.4.1 The applicable department chair (or his/her designee) in which his/her appointment was made, shall attest that, by observed performance, the practitioner has demonstrated his/her
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qualifications for staff membership and for his/her staff category, that he/she has not abused his/her prerogatives, and that he/she has discharged his/her membership obligations; and

5.4.2 The applicable department chair (or designee) in which he/she was granted clinical privileges, shall attest that he/she has satisfactorily demonstrated his/her ability to exercise those privileges.

SECTION 5.5 ACTION REQUIRED.

The credentials committee shall consider all requests for termination or extension of the provisional period.

SECTION 5.6 EXTENSION.

If an initial staff appointee case load at the hospital was inadequate to demonstrate ability to exercise that privilege, he/she may submit to the credentials committee, a statement to such effect, describing his/her case load at another facility and signed by the chair of the applicable department, and a request for an extension. The credentials committee shall consider such request and make a recommendation thereon to the CMO, who shall forward it to the medical executive committee. Further processing of such request for an extension shall follow the procedures set forth in Sections 3.6 through 3.9 as if it were a reappointment application. Only one such extension shall be permitted.

SECTION 5.7 PROCEDURAL RIGHTS.

If the provisional period ends and the practitioner is not advanced to the staff category for which he/she applied or if a requested extension is denied, the CMO shall provide him/her special notice of the adverse result and of his/her entitlement to the procedural rights provided in the fair hearing plan, and further processing of the extension shall proceed as set forth therein.

ARTICLE 6
PEER REVIEW (amended 05/24/01; 8/29/05)

The Peer Review Processes, as defined in the Quality Improvement Plans of Adventist La Grange Memorial Hospital and Adventist Hinsdale Hospital, are hereby incorporated in their entirety for the purpose of this document as if more fully set forth herein. In the event the Peer Review Process triggers corrective action, the Corrective Action Plan set forth in Article 7 of this Manual shall be followed.

SECTION 6.1 COLLEGIAL INTERVENTION

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 are encouraged. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

a. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

b. All collegial interventional efforts by medical staff leaders and hospital management are part of the hospital’s performance improvement and professional and peer review activities.
c. The relevant medical staff leader(s) shall 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 shall be maintained in that individual’s file, along with the original documentation.

d. The President of the Medical Staff, in conjunction with the CMO or CEO, shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Physician Health and Advocacy or the Code of Conduct Policy, or to direct it to the Medical Executive Committee for further determination.

ARTICLE 7
CORRECTIVE ACTION

SECTION 7.1 ROUTINE CORRECTIVE ACTION.

7.1.1 Criteria for Initiating Routine Corrective Action. Corrective action against the practitioner may be initiated whenever a staff member engages in, makes or exhibits acts, statements, demeanor or professional conduct, either within or outside of the hospital, which is reasonably likely to be, or may reasonably lead to conduct or acts that are, detrimental to patient, medical staff or employee safety or to the quality of patient care in the hospital or disruptive to hospital operations such that the quality or efficiency of patient care services is or may reasonably be adversely affected or in violation of the bylaws or associated manuals, rules or policies or the member exhibits signs of physical or mental impairment.

7.1.2 Initiation. Corrective action may be initiated by (a) any medical staff officer, (b) the chair of any department, (c) the credentials committee or any other standing committee of the medical staff, (d) the CEO, (e) the board, or (f) the CMO.

7.1.3 Form of Requests. All requests for corrective action shall be in writing and supported by reference to the specific activities or conduct which constitute the grounds for the request and any information including the names of witnesses supporting the charges. A request shall be given to the CMO, who shall forward it to the medical executive committee, the president of the staff, and the CEO.

7.1.4 Discretionary Interview Prior to Corrective Action. Prior to initiating or proceeding with corrective action against a practitioner, the initiating party may, but is not obligated to, afford the practitioner an interview at which the circumstances prompting the corrective action shall be discussed and the practitioner shall be permitted to present relevant information in his/her own behalf. The CMO shall be notified of the request for an interview, and the CMO shall give the practitioner special notice of the request and the date, time and place of the interview. The CMO shall forward a copy thereof to the president of the staff and the CEO. A written record reflecting the substance and conclusion of the interview shall be made. The CMO shall transmit a copy thereof to the practitioner by special notice. The president of the staff, and the CEO or their respective designees may, at their option, be present as observers at the interview. Following the interview or if the practitioner declines to participate in the interview, the CMO forwards the request for corrective action to the medical executive committee. The interview shall not be a procedural right of the practitioner and need not be conducted according to the procedural rules provided in the fair hearing plan.
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7.1.5 **Investigation.** At its next meeting following receipt of the request for corrective action, the medical executive committee may either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The medical executive committee may conduct such investigation itself or may assign this task to the CMO, a medical staff officer, department, standing or ad hoc committee, or other organizational component of the medical staff. This investigative process shall not be 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 medical executive committee, that group or individual shall forward a written report of the investigation to the CMO, who shall forward it to the medical executive committee, as soon as is practicable after the assignment to investigate has been made. The medical executive committee may at any time within its discretion, and shall at the request of the board, terminate the investigative process and proceed to a decision as provided below. Nothing contained herein is intended to limit or restrict the rights of the board, CEO or medical staff to undertake reviews and investigations in the absence of a formal request for corrective action. Independent reviews and investigations may also be conducted by outside consultants and may serve as the basis for such request for corrective action.

7.1.6 **Medical Executive Committee Decision.** At the next regular meeting after receipt of the report of investigation, the medical executive committee shall either defer consideration or recommend an action thereon which is either adverse or not adverse to the staff member.

7.1.7 **Deferral.** If additional time is needed to complete the investigative process, the medical executive committee may defer action on the request. The CMO shall notify the practitioner by special notice of the deferral. A recommendation on the request must be made at the next meeting of the medical executive committee.

7.1.8 **No Adverse Recommendation.** Action taken by the medical executive committee reporting the request for corrective action, issuing a warning to the affected member, invoking a probationary period with retrospective review, but without special requirements of prior or mandatory concurrent consultation and direct supervision, issuing a formal letter or reprimand, or other similar actions which do not restrict a member’s right to exercise clinical privileges independently, shall create no right to the hearing and appeal procedures set forth in the fair hearing plan. Such actions shall, however, be reported in writing to the board by the CMO. In the event an action as set forth in this Section 6.1.8 is taken against the affected member, he/she may submit a written response which shall be placed in the member’s file.

7.1.9 **Adverse Recommendations.** If the medical executive committee recommends any of the actions as listed in Section 1.7.7 of the bylaws, such a recommendation shall be deemed to be adverse to the staff member.

7.1.10 **Notice.** The CMO shall give the staff member special notice of the recommendation of the medical executive committee. An adverse medical executive committee recommendation shall entitle the practitioner to the procedural rights contained in the fair hearing plan, and further processing of the adverse recommendation shall follow the procedures described in Article 2 of the fair hearing plan.

7.1.11 **Board Action.**
7.1.2.1 **On Favorable Medical Executive Committee Recommendation.** The board may adopt or reject, in whole or in part, a favorable recommendation of the medical executive committee or refer the recommendation back to the medical executive committee for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the board shall be effective as its final decision. If the board's action constitutes an adverse decision, the CMO shall promptly so inform the practitioner by special notice, and the practitioner shall then be entitled to the procedural rights provided in the fair hearing plan, and further processing of the adverse action shall proceed as set forth therein.

7.1.2.2 **Without Benefit of Medical Executive Committee Recommendation.** If, in its determination, the board does not receive an medical executive committee recommendation in a timely fashion, the board may, after notifying the medical executive committee in advance through the CMO and including a reasonable period of time for response, take action on the board's own initiative, employing the same type of information usually considered by the medical executive committee. Any favorable action shall be effective as the board's final action. If the board's action is adverse in any respect, the CMO shall promptly so inform the practitioner by special notice, and the practitioner shall be entitled to the procedural rights provided in the fair hearing plan, and further processing of the adverse action shall proceed as set forth therein.

**SECTION 7.2 PRECAUTIONARY SUSPENSION.**

7.2.1 **Grounds for Precautionary Suspension.** The president of the medical staff, the chief medical officer, the chief of a clinical department, the chair of the credentials committee, the chief executive officer, or the chair of the board shall each have the authority to suspend all or any portion of the clinical privileges of a medical staff member or other individual whenever the practitioner willfully disregards or grossly violates the bylaws, rules, manuals or other policies of the medical staff, exhibits signs of impairment, refuses to undergo a mental, physical or toxicology examination or failure to take such action may result in an imminent danger to and/or adversely affects or could adversely affect the life, health and/or safety of any individual (e.g., patients, visitors and/or hospital employees or staff) or to the orderly operation of the hospital. Precautionary suspension is an interim precautionary step in the professional review activity related to any ultimate professional review action, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

7.2.2 **Imposition of Precautionary Suspension.** A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the chief executive officer, the president of the medical staff, the affected member’s department chair and the chair of the credentials committee, and shall remain in effect unless or until modified by the chief executive officer or the board.

7.2.3 **Notice to Staff Members.** The person initiating the suspension shall notify the staff member immediately of the suspension. The notice may be oral but in any event shall be given by special notice as soon as practicable after the suspension is imposed. The notice shall include an explanation of the grounds for the suspension. A suspension shall entitle the staff member to the procedural rights contained in the fair hearing plan.
7.2.4 **Patient Coverage.** Immediately upon imposition of a precautionary suspension, the CMO or responsible department chair shall have the authority and responsibility to provide for alternative medical coverage for the suspended member’s patients still in the hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of alternative coverage.

**SECTION 7.3 AUTOMATIC SUSPENSION** (amended 8/29/05)

7.3.1 **Grounds.**

7.3.1.1 **License Revocation.** Whenever a practitioner's license to practice in this State is revoked, his/her staff membership and clinical privileges shall be immediately and automatically revoked. Whenever a practitioner's license is partially limited or restricted in any way, those clinical privileges which he/she has been granted that are within the scope of the limitation or restriction shall be similarly, immediately and automatically limited or restricted.

7.3.1.2 **License Suspension.** Whenever a practitioner's license is suspended, his/her staff membership and clinical privileges shall be immediately and automatically suspended effective upon and for at least the term of the suspension.

7.3.1.3 **License Probation.** Whenever a practitioner is placed on probation by the licensing authority, his/her voting and office-holding prerogatives shall be immediately and automatically suspended unless the board, upon the recommendation of the medical executive committee, acts to stay the suspension.

7.3.1.4 **License Expiration.** Whenever a practitioner’s license to practice in Illinois has expired, his/her staff membership and clinical privileges shall be immediately and automatically suspended.

7.3.1.5 **Drug Enforcement Administration (DEA) Revocation.** Whenever a practitioner's DEA registration or other controlled substances number is revoked, he/she medical staff membership and privileges shall be immediately and automatically suspended, effective on the effective date of revocation of the DEA registration or other controlled substances number. If within 90 days after such effective date the practitioner does not provide evidence that a revoked DEA registration or other controlled substances numbers has been returned to good standing, the practitioner’s medical staff membership and privileges shall terminate automatically.

7.3.1.6 **DEA Suspension.** Whenever a practitioner's DEA registration or other controlled substances number is suspended, he/she shall be immediately and automatically prohibited from prescribing medications covered by the number effective upon the effective date of the suspension of the DEA registration or other controlled substances number, and for at least the term of the suspension. If within 90 days after such effective date the practitioner does not provide evidence that the suspended DEA registration or other controlled substances number has been returned to good standing, the practitioner’s medical staff membership and privileges shall terminate automatically.
7.3.1.7 **Voluntary Surrender of DEA.** Whenever a practitioner voluntarily surrenders a DEA registration or other controlled substances number for cause, this shall be treated as the equivalent of revocation or suspension of the registration, if a DEA registration is required for the medical staff member’s practice. For cause is defined as a surrender in lieu of, as a consequence of, or during the course of any Federal or state administrative, civil or criminal action resulting from an investigation of the individual’s handling of controlled substances. The practitioner’s medical staff membership and privileges shall be immediately and automatically suspended, effective on the date of surrender. If within 90 days after such surrender date the practitioner does not provide documentation that the registration or other controlled substances number has been reinstated and is in good standing, the practitioner’s medical staff membership and privileges shall be automatically terminated.

7.3.1.8 **DEA Denial.** Whenever a practitioner’s DEA registration or other controlled substances number is denied, he/she medical staff membership and privileges shall be immediately and automatically suspended, effective on the date the practitioner receives notice of the denial. If within 90 days after such effective date the practitioner does not provide evidence that the denied DEA registration or controlled substances number has been received and is in good standing, the practitioner’s medical staff membership and privileges shall terminate automatically.

7.3.1.9 **Expiration of DEA Registration.** If a practitioner’s DEA registration or other controlled substances number has expired, the practitioner shall be immediately and automatically prohibited from prescribing controlled medications until the registration has been reinstated, effective on the expiration date of the DEA registration or other controlled substances number. If within 90 days after such effective date the practitioner does not provide documentation that the DEA registration or other controlled substances number has been reinstated and is in good standing, the practitioner’s medical staff membership and privileges shall be automatically terminated.

7.3.1.10 **Medicare/Medicaid.** Whenever any medical staff member is involuntarily excluded or precluded from the Medicare or Medicaid program, his/her staff membership and privilege shall be automatically suspended effective as of the date of the termination, exclusion, or preclusion, except for physicians who voluntarily choose not to participate in such programs. The suspension shall remain in effect until the practitioner is permitted to participate in the program, and a request for reinstatement of privileges has been approved by the credentials committee, the medical executive committee and the board. In the event the member’s participation in these programs is not fully reinstated by the expiration of the member’s then current reappointment term, the member will be deemed to have resigned from the medical staff.

7.3.1.11 **Failure to Document Professional Liability Insurance** as required by the board of directors. If a practitioner does not provide evidence that his/her professional liability insurance is in good standing within 90 days after the policy has expired, the practitioner's medical staff membership and privileges shall terminate automatically.

7.3.1.12 **Failure to Respond for a Request for an Interview** as defined in Section 6.7.3 of the bylaws.
7.3.1.13 **Failure to comply with the geographical proximity** requirement of Section 1.3.1.14 of the medical staff bylaws.

7.3.2 **No Hearing Rights.** Automatic suspension or termination of medical staff membership and/or privileges in accordance with Section 7.3.1 above shall not entitle the practitioner to a hearing or appellate review, except as provided in Section 7.3.3 below.

7.3.3 **Medical Executive Committee Deliberation.** Within five business days (a) after a practitioner's license is revoked, suspended, restricted, or placed on probation, or (b) after his/her controlled substances number is revoked, restricted, suspended or made probationary, the staff member shall notify the CMO, and the CMO shall notify the chair of the medical executive committee. The medical executive committee shall convene to review and consider the facts of the situation. The medical executive committee 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 7.1.8 (No Adverse Recommendation) or 7.1.9 (Adverse Recommendations), as applicable, shall be followed, but only with respect to any additional corrective action recommended by the medical executive committee or board.

**SECTION 7.4 MEDICAL RECORD COMPLETION AND PREPARATION.**

7.4.1 All portions of a patient's medical record shall be completed within the course of care and in accordance with medical staff Rules and Regulations, and local, state, federal and accreditation standards.

7.4.2 Patterns of incomplete/delinquent, inadequate, illegible, or other problem documentation will be continuously monitored by the hospital and reported to the medical staff department chair and appropriate quality review committees for appropriate action.

7.4.3 Records are approved to be recorded/filed as incomplete only after notification, in accordance with applicable policies, to the medical staff member and department chair.

7.4.4 The credentials committee shall utilize documentation indicators as an essential quality element to be used in the reappointment process. Corrective action may be taken throughout the year as problems and deficiencies are discovered and monitored in the documentation process. This may include peer review, intensified audit, suspension from privileges, fines, letters of reprimand, requests for appearance before a quality/administrative committee for explanation, or other forms of corrective action in accordance with the bylaws and other staff policies.

**SECTION 7.5 REAPPLICATION BY STAFF MEMBER AFTER FINAL ADVERSE ACTION.**

A staff member who has received a final adverse board action regarding any aspect of his/her staff membership status or clinical privileges shall not be eligible to enjoy or apply for reinstatement of these until the later of (a) the expiration of any time period established by the adverse board action, (b) the completion of any action required of the staff member, or (c) a period of 24 months after such final adverse board action; provided, however, that the board may waive this provision at its
discretion. If the final adverse board action only imposed a period of time during which the adverse action would be effective, upon the expiration thereof, the CMO shall give special notice to the staff member, the president of the staff, the applicable department chairs, the CEO, and the board that the staff member has been restored to his/her status prior to the adverse board action. If the final adverse board action imposed an obligation on the staff member to obtain additional training or medical treatment or to be observed in the performance of certain privileges, upon completion of any such requirement, the staff member may reapply for his/her prior status. Any such reapplication, if required, shall be processed as an initial application under Article 2 hereof, and the staff member shall submit such additional information as the staff or the board may require to demonstrate that the basis for the earlier adverse action no longer exists. Failure to provide such additional information satisfactory to the applicable board and staff authorities shall constitute voluntary withdrawal of the reapplication, and the reapplication shall not be processed.

ARTICLE 8
LEAVE OF ABSENCE (amended 12/4/03)

8.1 PURPOSE, APPLICABILITY, AND EFFECT. The leave of absence shall be a vehicle by which a staff member may temporarily interrupt his/her professional practice at the hospital, without resigning staff membership or privileges, in order, for example, to pursue personal matters or to augment his/her skills or credentials in a specialty. During the period of the leave, the staff member's clinical privileges, prerogatives and responsibilities shall be suspended. Leave shall be granted only for good cause.

8.2 REQUEST FOR LEAVE. A staff member may submit a request for a voluntary leave of absence by giving written notice to the CMO, who shall transmit it to the president of the staff and the applicable department chairs, Credentials Committee and Medical Executive Committee chairs, CEO, and the Board of Directors for approval. The notice must state the reason for and the approximate duration of the leave, which may not exceed one year, except for military service.

8.3 LEAVE OF ABSENCE NOT IN GOOD STANDING. When a physician takes a leave of absence, his/her charts will be closed complete or incomplete four months after the leave began. A list of incomplete records will be sent to the Medical Staff Office to be attached to the physician’s file. A status will be given of leave of absence not in good standing. If the charts are not completed when the leave of absence expires and turns into a resignation, it will then be deemed a resignation not in good standing. In order to return from a leave, the practitioner must complete any incomplete charts.

8.4 TERMINATION OF LEAVE. The staff member shall, at least 30 days prior to the termination of the leave, or at any earlier time, request reinstatement by sending a written notice to the CMO, who shall forward it to the medical executive committee. The staff member shall submit a written summary of relevant activities during the leave, if the medical executive committee or the board so requests. The medical executive committee shall make a recommendation concerning reinstatement to the CMO, who shall forward it to the board, and the procedures in Sections 2.7.6 (Medical Executive Committee Action), 2.7.7 (Effect of Medical Executive Committee Recommendation), 2.7.8 (Board Action) and 2.8 (Reapplication by Applicant After Final Adverse Action), as applicable, shall then be followed as if it were an initial appointment application. Failure to request reinstatement or provide requested information shall constitute a voluntary resignation from the staff, and the member shall have no right to a review under the fair hearing plan.
ARTICLE 9
ALLIED HEALTH PROFESSIONALS

SECTION 9.1 PROCEDURE FOR SPECIFICATION OF SERVICES

9.1.1 Position Descriptions. Written guidelines for the performance of specified services by each category of allied health professional shall be developed by the credentials committee and the CEO, subject to approval by the medical executive committee and the board and with input, as applicable, from the physician/director of the clinical unit involved, from the physician supervisor/employer of the individual, or from other representatives or groups of the medical staff, management and the hospital's other professional staffs. For each category of allied health professional, such guidelines shall include at least:

- Specification of classes of patients that may be seen;
- A description of the services to be provided and procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record; and
- Definition of the degree of assistance that may be provided to a practitioner in the treating of patients on hospital premises and any limitations thereon, including the degree of practitioner supervision required for each service.

9.1.2 Evaluation of Individual Allied Health Professional Applications. The procedure for evaluating applications for specified services shall be defined separately for each category of allied health professional as part of the guidelines required under Section 8.1.1 (Position Descriptions). These procedures shall become effective when approved by the medical executive committee and board and shall provide for the participation of representatives of the board, the medical staff, the hospital management and other professional staffs as appropriate for the particular category of personnel.

SECTION 9.2 TERMS AND CONDITIONS OF AFFILIATION.

Allied health professionals shall be individually assigned, when applicable, to the clinical unit appropriate to their professional training and subject to a provisional period, formal periodic reviews and disciplinary procedures as determined for each specific category. An allied professional shall be entitled to the same procedural due process rights as provided by the hospital to its employees.

ARTICLE 10
AMENDMENT

All proposed amendments to the credentialing policy and procedure manual shall be presented to the medical executive committee for review at least 21 days before its vote on the amendments. In addition, notice of all proposed amendments shall be posted on the medical staff bulletin board at least 14 days prior to the medical executive committee vote, and any medical staff member shall have the right to submit written comments to the medical executive committee regarding the same. The medical executive committee shall not vote on the amendments until it has received and reviewed the written recommendations of the credentials committee concerning the proposed amendments, which shall be provided in a timely manner. Proposed amendments may be further modified or secondarily
amended by the medical executive committee during the meeting at which the voting occurs. These secondary amendments, or changes to the amendments that were previously posted and received comment, shall not require notification of the credentials committee or the medical staff. No amendment shall be effective unless and until it has been approved by the board.

This policy may also be amended by the board on its own motion, provided that any such amendment (a) shall first be submitted to the credentials and medical executive committees for review and comment at least 30 days prior to any final action by the board on such amendment and (b) is required to comply with (1) changes in any laws that affect the hospital; (2) requirements imposed by the hospital’s general and professional liability or director’s and officer’s insurance carriers; or (3) state licensure requirements, JCAHO Accreditation Standards, and Medicare/Medicaid Conditions of Participation for hospitals.
ARTICLE 11
CERTIFICATION OF ADOPTION AND APPROVAL

SECTION 11.1  MEDICAL STAFF.

This Credentialing Policy/Procedure Manual was adopted and recommended to the Board of Directors by the Medical Staff in accordance with and subject to the Medical Staff Bylaws.

__________________________________________  September 7, 2000
Joseph C. McConaughy, M.D.
President, Medical Staff  

SECTION 11.2  BOARD.

This Credentialing Policy/Procedure Manual was approved and adopted by resolution of the Board of Directors after considering the Medical Staff's recommendations and in accordance with and subject to the hospital's corporate bylaws.

__________________________________________  September 14, 2000
Thomas L. Werner  
Chairman, Board of Directors  

Date
DEFINITION of terms used in bylaws and associated manuals.

ADVERSE DECISION means an action or recommendation to reduce, restrict, suspend, revoke, deny or not renew medical staff membership or clinical privileges or failure to terminate the provisional period (described in Section 5.1 of the credentialing policy and procedural manual) or to grant an extension thereof at the end of 12 months.

ALLIED HEALTH PROFESSIONAL or AHP is an individual, not a member of the medical staff, who can provide specified patient care services within the scope of their professional skills and abilities. Their degree of participation in patient care shall be determined according to limits established by the governing board and applicable state practice acts.

APPELLATE REVIEW BODY means the body which is designated to hear a request for appellate review properly filed and pursued by a practitioner.

BOARD means the board of directors of Adventist Hinsdale Hospital/Adventist La Grange Memorial Hospital.

CHIEF EXECUTIVE OFFICER (CEO) means the individual appointed by the board to serve as the chief executive officer and/or senior executive officer and to act on its behalf in the overall administrative management of the hospital, or his/her authorized representative.

CHIEF MEDICAL OFFICER (CMO) means the administrative physician functioning on behalf of the medical staff and the hospital.

CLINICAL PRIVILEGES means permission to provide medical or other patient care services and permission to use hospital resources, including equipment, facilities and personnel, that are necessary to effectively provide medical or other patient care services.

DENTIST means an individual with a DDS or DMD degree licensed to practice other than oral and maxillofacial/surgery/dentistry in Illinois.

DEPARTMENT CHAIR means the medical staff member elected in accordance with these bylaws to serve as the head of a clinical department.

GOOD STANDING means that a medical staff member is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at the hospital.

HEARING COMMITTEE means a review committee appointed under the fair hearing plan to conduct an evidentiary hearing properly requested, filed and pursued by a practitioner.

HOSPITAL means Adventist Hinsdale Hospital/Adventist La Grange Memorial Hospital.
JOINT CONFERENCE COMMITTEE means an ad hoc committee appointed by the quality council of the board consisting of equal board and medical staff representation and chaired by the chief executive officer who may vote only to break a tie.

MEDICAL EXECUTIVE COMMITTEE (MEC) means the medical executive committee of the medical staff.

MEDICAL STAFF or STAFF means all Illinois licensed physicians, dentists, and podiatrists who have been appointed to the hospital’s medical staff.

MEDICAL STAFF YEAR means the period from January 1 to December 31 of each year.

ORAL or MAXILLOFACIAL SURGEON means an individual with a DDS or DMD degree who is board certified or board eligible to practice oral or maxillofacial surgery, whose credentials have been approved by the hospital board to perform such procedures.

PARTIES mean the practitioner who requested the hearing or appellate review and the body or bodies upon whose adverse action or recommendation for a hearing or appellate review request is predicated.

PHYSICIAN means an individual with an MD degree or DO degree who is licensed to practice medicine in the State of Illinois.

PODIATRIST means an individual with a diploma or certificate of graduation from a school or college of podiatry approved by the Illinois State Board of Medical Examiners and who is currently licensed to practice podiatry in Illinois.

PRACTITIONER means, unless otherwise expressly limited, any physician, dentist, or podiatrist who is applying for medical staff membership and/or clinical privileges, or who is a medical staff member and who exercises clinical privileges in this hospital or a medical staff member against whom an adverse action has been recommended or taken.

PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a medical staff member, which is exercisable subject to, and in accordance with, the conditions imposed by these bylaws and by other hospital and medical staff rules, regulations, or policies.

PRESIDENT OF THE MEDICAL STAFF means the chief elected officer of the medical staff.

SPECIAL NOTICE means written notification delivered in person or by facsimile, courier or certified mail/return receipt requested, which shall be deemed to have been given and have become effective (a) upon receipt if delivered in person or by courier or facsimile, or (b) be received two days after mailing regardless of actual receipt if properly addressed to (i) the practitioner as set forth on the application or the Hospital’s records or (ii) to the CMO acting on behalf of the hospital.

VOLUNTARY OR AUTOMATIC RELINQUISHMENT of medical staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.