SECTION III

CREDENTIALS POLICY
OF THE BYLAWS
MEDICAL AND DENTAL STAFF
CAROLINAS MEDICAL CENTER

APPROVED BY THE MEDICAL AND DENTAL STAFF: 04/04/08; 11/2/09; 11/01/10; 02/18/11; 06/15/11 (no changes to this section); 10/12/11 (no changes to this section)

APPROVED BY THE BOARD OF COMMISSIONERS: 06/10/08; 12/8/09; 12/14/10; 03/15/11; 09/13/11 (no changes to this section); 12/13/11 (no changes to this section)
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INTRODUCTION

This Policy describes the credentialing and peer review processes for Physicians and Dentists who desire to practice within CHS. It outlines the procedure for assessing an individual’s qualifications to provide patient care services, the manner in which that individual is authorized to provide those services, and the process for limiting or revoking that authorization based on concerns with clinical competence and/or professional conduct. All credentialing and peer review processes described in this Policy shall be subject to the confidentiality provisions described in Article 8 of this Policy.
ARTICLE I
DEFINITIONS

ARTICLE I – PART A:

DEFINITIONS

For the purpose of these Bylaws, the following definitions shall apply:

1. "Allied Health Professional" means either a Dependent Practitioner or an Independent Practitioner. “Allied Health Professionals” means all Dependent Practitioners and Independent Practitioners.

2. “Specialty Board” shall mean those specialty boards that are members of the American Board of Medical Specialties or the American Osteopathic Association.

3. “Applicant” shall mean a Practitioner who has applied for appointment to the Medical Staff.

4. “Appointee” shall mean a Practitioner who has been appointed to the Medical Staff.

5. "Board" shall mean the Board of Commissioners of Carolinas HealthCare System, which has the overall responsibility for the conduct of the Hospital.

6. "Bylaws" shall mean the Bylaws of the Medical and Dental Staff of Carolinas Medical Center.

7. “CHS Hospitals” shall mean Carolinas Medical Center, Carolinas Medical Center-Mercy, Carolinas Medical Center-Pineville, Carolinas Medical Center-University and Carolinas Rehabilitation.

8. "Clinical Privileges" shall mean permission to provide medical or other patient care services in the Hospital or its facilities, as approved by the Board, within defined limits of these Bylaws.

9. “CMC-C Credentials Committee” shall mean the credentials committee for the CHS Hospitals as further described in the CREDENTIALS POLICY.

10. “CMC-C Allied Health Review Committee” shall mean the allied health review committee for the CHS Hospitals as further described in the POLICY ON CLINICAL PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS.

11. “CMC-C Medical Executive Committee” shall mean the executive committee for the CHS Hospitals as further described in the CREDENTIALS POLICY.
12. "Dentist" shall mean a doctor of dental surgery (D.D.S.) or a doctor of dental medicine (D.M.D.) and an oral surgeon who has completed training requirements for certification by the American Board of Oral and Maxillofacial Surgery.

13. "Dependent Practitioner" shall mean a health care professional who is licensed by his/her respective licensing agency and who can only provide service under the direct supervision of a Supervising Physician, including without limitation: (i) a physician assistant; (ii) a certified registered nurse anesthetist; (iii) a certified nurse midwife; (iv) a registered nurse, first assistant; (v) a nurse practitioner; (vi) any other advanced practice registered nurse who is required to provide service under the direct supervision of a Supervising Physician; and (vi) a recent graduate in any of the above-referenced professions who is permitted by state law and the applicable certifying agencies to practice at the Hospital prior to certification.

14. “DIPLOMATE” means that the physician is certified in their primary area of practice by the appropriate specialty and/or subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association or the Commission on Dental Accreditation of the ADA, as applicable.

15. “Facility Credentials Committee” shall mean the credentials committee of the Medical and Dental Staff.

16. “Facility Medical Executive Committee” shall mean the executive committee of the Medical and Dental Staff.

17. “Graduate Medical Education” shall mean the educational programs, which prepare Physicians for practice in a medical specialty. Graduate Medical Education programs, including transitional year programs, are called residency training programs, and the Physicians training in them, residents. Following completion of a residency, fellows may also train in Graduate Medical Education programs.

18. “Hospital” shall mean Carolinas Medical Center.

19. "Hospital Bylaws" shall mean the Bylaws of Carolinas HealthCare System.

20. “House Staff” shall mean fellows and residents appointed through the Division of Education and Research in conjunction with the respective residency program directors of the educational departments. The duties of each member of the House Staff shall be specified by the department to which they are appointed.

21. "Independent Practitioner" shall mean a health care professional, other than a Physician or a Dentist, who holds a doctorate degree, who has been licensed or certified by his/her respective licensing or certifying agencies and who is not required to provide service under the direct supervision of a Supervising Physician.
22. "Invasive Procedure" shall mean a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

23. "Medical and Dental Staff" shall mean all Physicians and Dentists who are authorized under Article III to admit and attend patients at Carolinas Medical Center.

24. "Medical Staff" shall mean the Medical and Dental Staff of Carolinas Medical Center.

25. "Patient Encounter" shall mean any action on the part of the Practitioner to provide medical or other patient care services to the patient in the Hospital or its facilities, including, without limitation, admission, treatment, performance or interpretation of diagnostic tests, or consultation, and may include the supervision of house staff and medical students; provided however, that Patient Encounter shall not include the ordering of tests on an out-patient basis.

26. "Peer" shall mean with respect to any Practitioner, any other Practitioner from the same discipline (for example, Physician and Physician, Dentist and Dentist).

27. "Peer Review Activity" shall mean (I) any activity of the Hospital and/or Medical Staff with respect to a Practitioner (A) to determine whether an Applicant or Appointee may have clinical privileges at the Hospital or membership on the Medical Staff; (B) to determine the scope or conditions of such privileges or membership; (C) to change or modify such privileges or membership; (ii) any quality reviews activity conducted to measure, assess, and improve individual or organizational performance; or (iii) any activity of a Hospital or Medical Staff committee established to review the quality and appropriateness of care provided by individuals who have been granted or are seeking privileges on the Medical Staff. In appropriate circumstances, upon approval of at least one of the officers of the Medical Staff, the Hospital or any committee that conducts Peer Review Activity may use the services of an external peer review body or organization to assist in conducting a Peer Review Activity. For example, the Hospital or any committee that conducts Peer Review Activity, upon approval of at least one of the Officers of the Medical Staff, may require the services of an external peer review body when there is no Practitioner within the service area of the Hospital who specializes in the same area as the Practitioner who is the subject of Peer Review Activity and is available to conduct a Peer Review Activity or when there is no Practitioner within the service area of the Hospital who is not either in practice with, or in direct economic competition with the Practitioner who is the subject of Peer Review Activity.

28. "Peer Review Action" shall mean an action or recommendation of the Hospital, the Board or any committee of the Hospital or the Medical Staff which is taken or made in the conduct of Peer Review Activity, which is based on the competence or professional conduct of an individual Practitioner or Allied Health Professional (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely, with respect to a Practitioner, the clinical privileges or Medical Staff membership of the Practitioner, and with respect to an Allied Health Professional, the clinical privileges of the Allied Health Professional.
29. "Physician" shall mean a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

30. "Practitioner" shall mean a Physician or Dentist licensed to practice under the laws of the State of North Carolina.

31. "President of the Medical Staff" shall mean the President of the Medical and Dental Staff of Carolinas Medical Center.

32. "President" or "President of the Hospital" shall mean the Chief Executive Officer of the Hospital or the Chief Executive Officer's designee.

33. "Staff case" shall mean an indigent or medically indigent patient who is unable to pay the usual charges for medical care.

34. "Supervising Physician" shall mean a Physician on the Medical Staff who supervises a Dependent Practitioner in the manner described in the Policy on Clinical Privileges for Allied Health Professionals.

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the content requires. The definitions, captions, and headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Bylaws.
ARTICLE I – PART B: TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

ARTICLE I – PART C: DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person or the committee (through its chair) may delegate performance of the function to one or more qualified designees.

ARTICLE II

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

ARTICLE II – PART A: QUALIFICATIONS
SECTION 1. Eligibility Criteria:

Only Physicians and Dentists who satisfy the following threshold conditions shall be qualified for appointment to the Medical Staff:

(a) have a current, license to practice in the state and have never had a license to practice revoked by any state licensing agency, provided that individuals who apply for initial staff appointment after the date of adoption of this subsection shall have a current, unrestricted license to practice in the state;

(b) are located within the geographic service area of the Hospital as defined by the Hospital, close enough to provide timely care for their patients;

(c) possess current, valid professional liability insurance coverage from an insurance company licensed or approved to do business in this state, in the amount of a minimum of $1 million, unless the Board specifies otherwise;

(d) not currently excluded or debarred from participation in Federal Healthcare Benefit programs, including, without limitation, in the Medicare or Medicaid programs;

(e) can document their:

(1) background, including an accounting of all time spans since initiation of medical/dental education, current professional qualifications, relevant training or experience, judgment and current clinical competence;

(2) adherence to ethics of their profession;

(3) good reputation and character, including physical health and mental and emotional stability, ability to perform the privileges requested; and
(4) ability to work harmoniously with others, including but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of Hospital healthcare teams;

(f) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;

(g) have never been convicted of Medicare, Medicaid, or other federal or state or third-party payor fraud or program abuse;

(h) have never been convicted of or entered a plea of guilty or no contest to: (i) any felony relating to controlled substances, illegal drugs, insurance fraud and abuse, sexual crimes, or violence; (ii) any misdemeanor relating to insurance fraud and abuse, sexual crimes, or violence; or (iii) any misdemeanor relating to controlled substances or illegal drugs on or after the individual’s twenty-fifth birthday;

(i) comply with the requirements set forth in the Policy of Occupational Health Services for Physicians and Allied Health Professionals (which applies to all physicians).

(j) have coverage arrangements with other members of the Medical Staff qualified within the same specialty for those times when the individual will be unavailable;

(k) be graduates of a medical or dental school fully accredited during the time of their attendance by the Liaison Committee on Medical Education, the American Osteopathic Association, the Commission on Dental Accreditation of the American Dental Association (“ADA”), or by a successor agency to any of the foregoing. Notwithstanding the foregoing, foreign medical graduates shall have attended medical schools certified by the Educational Council for Foreign Medical Graduates, or have a Fifth Pathway Certificate and shall have passed the International Medical Graduate Examination in the Medical Sciences;

(l) agree to authorize the Hospital to procure criminal investigative background reports regarding the individual’s background for their review in connection with the individual’s application and during the time when the individual may function as a member of any Medical Staff or exercise any clinical privileges at the Hospital, for whatever reasons the Hospital deems appropriate.

(m) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the ADA;

(n) be certified in their primary area of practice by the appropriate specialty and/or subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association or the Commission on Dental Accreditation of the ADA, as applicable. Those applicants who are not board
certified at the time of application but who have completed their residency or fellowship training within the last five years (or, for those specialty and/or subspecialty boards that have required time periods for achieving board certification, within such time periods) shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the date of completion of their residency or fellowship training (or within such other applicable time periods mandated by specialty and/or subspecialty boards). Notwithstanding anything herein to the contrary, the criteria set forth in this subsection is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this subsection. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments; and

(o) maintain certification in accordance with the criteria established by the applicable specialty and/or subspecialty board. Satisfaction of all maintenance criteria will be assessed at reappointment. Notwithstanding anything herein to the contrary, the criteria set forth in this subsection is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this subsection.

ARTICLE II – PART A- QUALIFICATIONS
SECTION 2. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of CHS Hospital healthcare teams;

(e) ability to perform, safely and competently, the clinical privileges requested; and

(f) recognition of the importance of, and willingness to support, CHS’s commitment to quality patient care.

These factors will be interpreted in accordance with applicable accreditation and regulatory requirements.
ARTICLE II – PART A - QUALIFICATIONS
SECTION 3. No Entitlement to Appointment or Reappointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staffs at the CHS Hospitals or to be granted particular clinical privileges merely because he or she:

(a) is licensed to practice a profession in this or any other state;
(b) is a member of any particular professional organization;
(c) has had in the past, or currently has, medical staff appointment or privileges at any hospital or health care facility;
(d) resides in the geographic service area of the CHS Hospitals; or
(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

ARTICLE II – PART A- QUALIFICATIONS
SECTION 4. Standards of Profession:

All Medical Staff members and others exercising clinical privileges in any CHS Hospital shall uphold the highest ethical standards of their profession and shall agree to work harmoniously with other members of the Medical Staff, CHS Hospital administration and employees, and CHS Hospital professional staff in a cooperative, professional manner to maintain quality patient care.

ARTICLE II – PART A- QUALIFICATIONS
SECTION 5. Non-Discrimination Policy:

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

ARTICLE II – PART B: GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT
SECTION 1. Basic Responsibilities and Requirements for Applicants and Members:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, each applicant and member specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;
(b) to abide by all Bylaws, Policies, Rules and Regulations, procedures and protocols of CHS, the CHS Hospitals and the Medical Staffs in force during the time the individual is appointed consistent with his or her classification at each CHS Hospital;
(c) to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned at each CHS Hospital consistent with his or her classification at such CHS Hospital;

(d) to provide in a timely manner, with or without request, new or updated information to the President of the Medical Staff at the applicant’s Primary Hospital, as it occurs, that is pertinent to any question on the application form. If an applicant fails to provide information that would be considered material by the President of the Medical Staff at the applicant’s Primary Hospital, any Department Chief or any Facility Credentials Committee in the processing of an application, including notification of any hearing, consent order or other public action by the North Carolina Medical Board, the South Carolina Medical Board or any other State’s applicable medical board as well as notification of any report made to the National Practitioner Data Bank, the President of the Medical Staff at the applicant’s Primary Hospital may stop the processing of the applicant’s application or, if appointment has already been granted, appointment and privileges may be deemed by the President of the Medical Staff at the applicant’s Primary Hospital to be automatically relinquished without entitlement to any hearing or appeal;

(e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Policies, Rules and Regulations, procedures and protocols of CHS, the CHS Hospitals and the Medical Staffs, and agrees to be bound by them consistent with his or her classification at each CHS Hospital;

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to use the CHS Hospitals sufficiently to allow continuing assessment of current competence;

(h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(i) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(j) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(k) to seek consultation whenever necessary;

(l) to participate in monitoring and evaluation activities;

(m) to complete in a timely manner all medical and other required records, containing all information required by the CHS Hospitals;
(n) to participate in an Organized Health Care Arrangement with CHS and to abide by the terms of CHS’s Notice of Privacy Practices with respect to health care delivered at CHS;

(o) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(p) to promptly pay any applicable dues, fines, and assessments;

(q) to satisfy continuing medical education requirements; and

(r) agree that, if there is any material misstatement in, or material omission from, the application, as determined by the President of the Medical Staff at the applicant’s Primary Hospital, any Department Chief or any Facility Credentials Committee, the President of the Medical Staff at the applicant’s Primary Hospital may stop processing the application or, if appointment has been granted prior to the discovery of a material misstatement or material omission, appointment and privileges may be deemed by the President of the Medical Staff at the applicant’s Primary Hospital to be automatically relinquished. In either situation, there shall be no entitlement to any hearing or appeal and the individual may not submit a new application for appointment or reappointment for a period of 1 year following the stop date of the current application or the effective date of the automatic relinquishment, as applicable.

ARTICLE II – PART B: GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

SECTION 2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Board for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required shall be deemed to be withdrawn. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) It is the responsibility of the individual seeking appointment or reappointment to provide a complete application, including adequate responses from references. An incomplete application will not be processed.
ARTICLE II – PART C: APPLICATION
SECTION 1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. In addition, upon initial adoption of this Policy, all existing Medical Staff members at a CHS Hospital and new applicants will be required to designate one of the CHS Hospitals as their Primary Hospital. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant’s medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant has been or is involved in any professional or peer review investigations or actions that are pending at any other hospital or health care facility;

(3) information as to whether the applicant’s license to practice any relevant profession in any state, DEA registration, or any state’s controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(4) information concerning the applicant’s professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Facility Credentials Committee, CMC-C Credentials Committee, CMC-C Medical Executive Committee, Facility MEC or the Board may request;

(5) the names and complete addresses of at least 3 Peers who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant’s current professional competence, specific training or experience, ethical character, ability to perform the procedures requested, and health status. These references may not be associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least 1 reference shall be from the same specialty area as the applicant; and

(6) current information regarding the applicant’s ability to safely and competently exercise the clinical privileges requested.
(c) The applicant shall certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

ARTICLE II – PART C: APPLICATION
SECTION 2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to, CHS, the CHS Hospitals, the Medical Staffs at the CHS Hospitals, their respective authorized representatives, and appropriate third parties with respect to any acts, communications or documents, recommendations, or disclosures involving the individual as set forth below:

(1) applications for appointment or clinical privileges, including temporary privileges;

(2) evaluations concerning reappointment or changes in clinical privileges;

(3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;

(4) summary suspension;

(5) hearings and appellate reviews;

(6) medical care evaluations;

(7) other activities relating to the quality of patient care or professional conduct; or

(8) matters or inquiries concerning the individual's professional qualifications, licensure, specific training or experience, current competence, credentials, clinical competence, character, mental or emotional stability, physical condition, ability to perform the privileges requested, ethics, or behavior.

(b) Authorization to Obtain Information from Third Parties:

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

(c) **Authorization to Release Information to Third Parties:**

The individual also authorizes CHS representatives to release information to other hospitals, health care facilities, managed care organizations, and their respective agents when information is requested in order to evaluate his or her professional qualifications for appointment, reappointment, clinical privileges, and/or participation status at the requesting organization/facility.

(d) **Authorization to Share Information Among the CHS Hospitals:**

The individual specifically authorizes CHS and the CHS Hospitals to share credentialing and peer review information pertaining to the individual’s clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual’s appointment to the Medical Staffs at the CHS Hospitals.

(e) **Hearing and Appeal Procedures:**

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action related to behavior or clinical competence (as described in Section 6.B.1(a)) taken by CHS or any CHS Hospital.

**ARTICLE III**

**PROCEDURE FOR APPOINTMENT**

**ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT**

**SECTION 1. Request for Application:**

(a) Applications for appointment shall be submitted electronically pursuant to computer programs and forms approved by the CMC-C Medical Executive Committee and the CMC-C Credentials Committee.

(b) An individual seeking initial appointment shall contact the Medical Staff Services Office. The Medical Staff Services Office will screen the individual to ensure that certain specific eligibility criteria for appointment can be met. Those individuals who can meet the specific eligibility criteria for appointment shall be given a password to access the online application. Individuals who
fail to meet the specific eligibility criteria shall not be given a password and shall be so notified. An individual who fails to satisfy the specific eligibility criteria for appointment shall not be entitled to the hearing and appeal provisions set forth in Article 7 of this Policy.

(c) The password provided by the Medical Staff Services Office will enable the individual to access the application form online. A completed application must be electronically submitted within 30 days after receipt of the password if the individual desires further consideration. The password will automatically expire after such 30 day period has passed. In addition, copies of all required supplementary documents and any applicable application fee must be forwarded to the Medical Staff Services Office within 30 days after receipt of the password.

(d) Passwords may be provided to residents who are in the final 6 months of their training, but the completed applications will not be processed until satisfaction of all applicable eligibility criteria is documented.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT
SECTION 2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Medical Staff Services Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the eligibility criteria will be notified that their applications will not be processed.

(b) The Medical Staff Services Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Services Office shall also be responsible for confirming that all references and other information or materials deemed pertinent have been received.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT
SECTION 3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant’s character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from references and other available sources, including the applicant’s past or current department chiefs at other health care entities, residency training directors, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant’s application, qualifications, and requested clinical privileges. This interview may be conducted by any of the following: any applicable Department Chief, any Facility Credentials Committee representative, any full Facility Credentials Committee, any Facility MEC representative, any full Facility MEC, a CMC-C Credentials Committee representative, the full CMC-C Credentials
Committee and the President of the Medical Staff at the applicable CHS Hospital(s).

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT

SECTION 4. Department Chief Procedure:

(a) For individuals applying to practice at the CHS Hospitals, the appropriate Department Chief at each of the CHS Hospitals shall receive Notice of the application, but the evaluation (which may include an interview) shall be performed by the Department Chief at the CHS Hospital designated as the individual’s Primary Hospital. Any Department Chief at a CHS Hospital other than the individual’s Primary Hospital may, but is not required to, perform a separate evaluation (which may include an interview) of the individual; provided, that any Department Chief exercising this option shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested and shall submit this report to the Department Chief at the Primary Hospital. Further, if a department has a Chairman in addition to the Department Chief, the Department Chief may request that the Chairman prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested and submit this report to the Department Chief at the Primary Hospital.

(b) Each applicable Department Chief at the individual’s Primary Hospital shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. Such Department Chiefs shall submit reports from other Department Chiefs at CHS Hospitals other than the Primary Hospital as supplemental reports to their own reports.

(c) Each applicable Department Chief shall be available to answer any questions that may be raised with respect to that Department Chief’s report and findings.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT

SECTION 5. Facility Credentials Committee Procedure:

(a) The Facility Credentials Committee at the individual’s Primary Hospital shall review and consider the report prepared by the relevant Department Chief(s) and shall make a recommendation regarding the application to the Facility MEC at the individual’s Primary Hospital. The Facility Credentials Committee at the individual’s Primary Hospital shall forward a copy of its completed credentials report to the Credentials Committee chairperson of the Facility Credentials Committee at all of the other CHS Hospitals as well as to the Facility MEC at all of the other CHS Hospitals.

(b) The Facility Credentials Committee may use the expertise of the Department Chiefs, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.
(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Facility Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the Facility Credentials Committee if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the Facility Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Facility Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) The Facility Credentials Committee may require the applicant to meet with the Facility Credentials Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges.

(e) The Facility Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Facility Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT
SECTION 6. Facility MEC Procedure (Interim):

(a) The Facility MEC at the individual’s Primary Hospital shall review and consider the recommendation of its Facility Credentials Committee and shall make an interim recommendation regarding the application to the CMC-C Credentials Committee. This interim recommendation shall not constitute a recommendation that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.

(b) The Facility MEC may use the expertise of the Department Chiefs, the Facility Credentials Committee, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Facility MEC may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the Facility MEC if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the Facility MEC for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Facility MEC shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. An application so withdrawn may not be resubmitted
for 1 year following such withdrawal.

(d) The Facility MEC may require the applicant to meet with the Facility MEC to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges.

(e) The Facility MEC may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Facility MEC may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

(f) Each other Facility MEC shall also make an interim recommendation regarding the application based on its review of the information contained in the credentials report from the applicant’s Primary Hospital. These interim recommendations shall not constitute recommendations that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT
SECTION 7. CMC-C Credentials Committee Procedure:

(a) The CMC-C Credentials Committee shall review and consider the interim recommendation of the Facility MEC at the individual’s Primary Hospital as well as the interim recommendations of the other Facility MECs and shall make a single recommendation regarding the application to the CMC-C Medical Executive Committee.

(b) The CMC-C Credentials Committee may use the expertise of the Department Chiefs, any Facility Credentials Committee, any Facility MEC, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the CMC-C Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the CMC-C Credentials Committee if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the CMC-C Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the CMC-C Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) The CMC-C Credentials Committee may require the applicant to meet with the CMC-C Credentials Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges.
(e) The CMC-C Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The CMC-C Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT
SECTION 8. CMC-C Medical Executive Committee Procedure:

(a) The CMC-C Medical Executive Committee shall review and consider the recommendation of the CMC-C Credentials Committee and shall make a recommendation regarding the application to the Facility MEC at each CHS Hospital.

(b) The CMC-C Medical Executive Committee may use the expertise of the Department Chiefs, any Facility Credentials Committee, any Facility MEC, the CMC-C Credentials Committee, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the CMC-C Medical Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the CMC-C Medical Executive Committee if there is any question about the applicant’s ability to perform the privileges requested and the responsibilities of appointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the CMC-C Medical Executive Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the CMC-C Medical Executive Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) The CMC-C Medical Executive Committee may require the applicant to meet with the CMC-C Medical Executive Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges. If it becomes apparent to the CMC-C Medical Executive Committee that it is considering a recommendation to deny appointment, or to not grant clinical privileges, the Chairperson may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The CMC-C Medical Executive Committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.
(e) The CMC-C Medical Executive Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The CMC-C Medical Executive Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT

SECTION 9. Facility MEC Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the CMC-C Medical Executive Committee, each Facility MEC shall:

(1) adopt the findings and recommendation of the CMC-C Medical Executive Committee as its own; or

(2) refer the matter back to the CMC-C Medical Executive Committee along with a report stating its reasons, as well as supporting information, for its disagreement with the CMC-C Medical Executive Committee’s recommendation.

(b) If all of the Facility MECs at the CHS Hospitals adopt the findings and recommendation of the CMC-C Medical Executive Committee as their own, and if the recommendation of the CMC-C Medical Executive Committee is to appoint with the privileges requested, the recommendations of the Facility MECs shall be forwarded to the Board through the Board’s Quality Care and Comfort Committee.

(c) If all of the Facility MECs at the CHS Hospitals adopt the findings and recommendation of the CMC-C Medical Executive Committee as their own, and if the recommendation of the CMC-C Medical Executive Committee regarding an applicant’s initial appointment and requested privileges would entitle the applicant to request a hearing pursuant to Article 7 of this Policy, the Facility Administrator at the applicant’s Primary Hospital shall send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital. The Facility Administrators of each CHS Hospital shall then hold the application until after the applicant has completed a hearing and appeal or waived his/her right to a hearing and appeal.

(d) If any Facility MEC refers the matter back to the CMC-C Medical Executive Committee under subsection (a)(2) above, representatives from each Facility MEC shall meet with the CMC-C Medical Executive Committee to discuss the matter and attempt to resolve the differences. If the differences cannot be resolved, the recommendations of each of the Facility MECs shall be forwarded to the Board through the Board’s Quality Care and Comfort Committee for resolution. In such event, none of the recommendations of the Facility MECs shall constitute a recommendation that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.
ARTICLE III – PART A:  PROCEDURE FOR INITIAL APPOINTMENT
SECTION 10.  Board Action:

(a) Upon receipt of a recommendation from each Facility MEC that the applicant be granted appointment and requested clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Facility MECs, the CMC-C Medical Executive Committee, or to another source inside or outside CHS, for additional research or information; or

(3) reject or modify the recommendations.

(b) If the Board determines to accept the favorable recommendations, the individual shall be appointed to the requested and recommended classification (e.g., Attending, Associate, Courtesy, etc.) at the individual’s designated Primary Hospital. The individual shall be appointed to the Affiliate classification at all CHS Hospitals other than the Primary Hospital unless otherwise requested and recommended. The individual shall be responsible for fulfilling all Medical Staff duties and obligations associated with his or her classification at each of the CHS Hospitals, including the Primary Hospital.

(c) If the Board determines to reject or limit the favorable recommendation of all Facility MECs, it shall communicate the reasons for its decision to all Facility MECs and the CMC-C Medical Executive Committee. Thereafter, the Facility Administrator at the Primary Hospital shall promptly send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital.

(d) Upon receipt of conflicting recommendations from the Facility MECs, the Board shall review all applicable reports and information from the Facility MECs and the CMC-C Medical Executive Committee as well as any other information the Board deems relevant and shall make the final decision to grant, limit or deny appointment and clinical privileges. If the determination of the Board would entitle the applicant to request a hearing pursuant to Article 7 of this Policy, the Facility Administrator at the applicant’s Primary Hospital shall send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital.

(e) Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges shall be disseminated to appropriate individuals and, as required, reported to appropriate entities.
ARTICLE III – PART A: PROCEDURE FOR INITIAL APPOINTMENT

SECTION 11. Time Periods for Processing:

All applications for initial appointment shall be processed in a timely manner. Absent a concern with the application, each complete application that proceeds through the full CMC-C Credentials Committee procedure shall be processed within 120 days unless it becomes incomplete. These time periods are intended to be guidelines designed to assist the individuals/bodies in accomplishing their tasks. They shall not be deemed to create any right for the applicant to have an application processed within these precise time periods, nor shall they create the basis for any hearing or appeal.

ARTICLE IV

CLINICAL PRIVILEGES

ARTICLE IV – PART A: CLINICAL PRIVILEGES

SECTION 1: General:

(a) Medical Staff appointment or reappointment at a CHS Hospital shall not confer any clinical privileges or right to practice at any CHS Hospital.

(b) Each individual who has been appointed to the Medical Staffs at the CHS Hospitals is entitled to exercise only those clinical privileges specifically granted by the Board at the CHS Hospitals.

(c) The granting of clinical privileges includes responsibility for emergency service call established to fulfill CHS’s responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards as interpreted by CHS.

(d) Clinical privileges may be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations.

(e) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.

(f) Requests by new applicants for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

(g) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the healthcare teams, and peer evaluations related to the same;
(2) ability to perform the privileges requested competently and safely;

(3) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, including all relevant information, reports and results from the Quality Assessment and Improvement Committee of each CHS Hospital in which the individual holds Clinical Privileges;

(4) availability of qualified Medical Staff members to provide coverage in case of the applicant's illness or unavailability;

(5) adequate professional liability insurance coverage for the clinical privileges requested;

(6) CHS’s available resources and personnel;

(7) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(8) any information concerning professional review actions or voluntary or involuntary termination, denial, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(9) relevant practitioner-specific data, as compared to aggregate data, when available;

(10) morbidity and mortality data, when available;

(11) other relevant information, including a written report and findings by the Department Chief of each of the clinical departments in which privileges are sought; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(h) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(i) The report of the Department Chief(s) of the clinical department in which privileges are sought shall be forwarded to the applicable Facility Credentials Committee and processed as a part of the application for appointment or reappointment.

(j) During the term of appointment, a Medical Staff member may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges. If the Board denies a
request for an increase of privileges, the individual shall be entitled to request a hearing and appeal pursuant to Article 7 of this Policy.

(k) Whenever, during the term of appointment to the Medical Staff, decreased clinical privileges are desired, the Medical Staff member requesting a decrease in clinical privileges shall notify, in writing, the Facility Administrator. The Medical Staff member shall state in detail the specific clinical privileges being removed, and where possible, allow for sufficient time for a smooth transition of duties and responsibilities to other Medical Staff members.

ARTICLE IV – PART A: CLINICAL PRIVILEGES

SECTION 2. Clinical Privileges for Dentists and Oral Surgeons:

(a) The scope and extent of surgical procedures that a Dentist or an Oral Surgeon may perform in the CHS Hospitals shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by a Dentist shall be under the overall supervision of the appropriate Chief of Dentistry. A medical history and physical examination of the patient shall be made and recorded by a Physician who is a member of the Medical Staff at the applicable CHS Hospital before dental surgery shall be performed, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Surgical procedures performed by an Oral Surgeon shall be under the overall supervision of the appropriate Chief of Dentistry. Oral Surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so through the credentialing process.

(d) The Dentist or Oral Surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient’s record. Dentists and Oral Surgeons may write orders within the scope of their license and consistent with the applicable Medical Staff Rules and Regulations and in compliance with this Policy and other applicable CHS policies.

ARTICLE IV – PART A: CLINICAL PRIVILEGES

SECTION 3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at a CHS Hospital or a significant new technique to perform an existing procedure (in either case, a “New Procedure”) will only be processed as set forth in this subsection.

(b) The applicable Department Chief shall make a preliminary recommendation as to whether the New Procedure should be offered, considering whether the applicable CHS Hospital has the resources, including space, equipment, personnel, and other support services, to perform the New Procedure. The
Department Chief shall consult with the applicable Facility Administrator in making its recommendation. In the event that the New Procedure could be offered in more than one CHS Hospital, the applicable Department Chiefs at each CHS Hospital, in consultation with the applicable Facility Administrators at each CHS Hospital, shall participate in the development of the preliminary recommendation and shall select one Facility Credentials Committee to perform the tasks set forth in subsection (c) below.

(c) If the Department Chief recommends that the New Procedure be offered, the applicable Facility Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff at the applicable CHS Hospital(s) (e.g., Department Chiefs, individuals on the Medical Staff at the applicable CHS Hospital(s) with special interest and/or expertise) and those outside CHS (e.g., other hospitals, residency training programs, specialty societies), and develop recommendations regarding: (1) the minimum education, training, and experience necessary to perform the New Procedure; (2) the extent of monitoring and supervision that should occur if the privileges are granted; and (3) the proposed delineation of privileges form appropriate for the New Procedure.

(d) Once the applicable Facility Credentials Committee has finalized its recommendations and the accompanying delineation of privileges form, the Facility Credentials Committee shall initiate the process set forth in Article V, Part C, Section 3 in the General Provisions of each CHS Hospital’s Medical Staff Bylaws (Article VI, Part C, Section 3 for Carolinas Rehabilitation) for developing delineations of privileges generally. The recommendation and approval process for the New Procedure shall track this process all the way through Board approval.

ARTICLE IV – PART A: CLINICAL PRIVILEGES
SECTION 4. Clinical Privileges That Cross Specialty Lines:

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

(b) An individual’s request must first receive approval from the Department Chief at the relevant CHS Hospital(s). If approved, the request for privileges that cross specialty lines will be forwarded by the Department Chief to the CMC-C Credentials Committee.

(c) The CMC-C Credentials Committee shall: (i) notify all Department Chiefs of affected Departments at all CHS Hospitals and solicit comments regarding the request for privileges; and (ii) appoint an ad hoc committee comprised of representatives from affected Departments from the CHS Hospitals to conduct research and consult with experts, including those on the Medical Staff at the applicable CHS Hospital(s) (e.g., Department Chiefs, individuals on the Medical Staff at the applicable CHS Hospital with special interest
and/or expertise) and those outside CHS (e.g., other hospitals, residency training programs, specialty societies).

(d) The ad hoc committee shall report its findings and recommendation to the CMC-C Credentials Committee.

(e) Based on review of the report of the ad hoc committee, the CMC-C Credentials Committee shall develop recommendations regarding: (1) the minimum education, training, and experience necessary to perform the clinical privileges in question; (2) the extent of monitoring and supervision that should occur if the privileges are granted; and (3) the proposed delineation of privileges form appropriate for the cross specialty privileges after consultation with each Facility Credentials Committee.

(f) Once the CMC-C Credentials Committee has finalized its recommendations and the accompanying delineation of privileges form, the CMC-C Credentials Committee shall initiate the process set forth in Article V, Part C, Section 3 in the General Provisions of each CHS Hospital’s Medical Staff Bylaws (Article VI, Part C, Section 3 for Carolinas Rehabilitation) for developing delineations of privileges generally. The recommendation and approval process for the cross specialty privileges shall track this process all the way through Board approval.

ARTICLE IV – PART A: CLINICAL PRIVILEGES
SECTION 5. Clinical Privileges After Age 67:

(a) Individuals who desire to exercise clinical privileges after the age of 67 must obtain appropriate health assessments as part of the reappointment process.

(b) Specifically, as part of the reappointment process, these individuals will be required to have a physical and mental health assessment performed by a physician who is acceptable to both the Facility Credentials Committee at the applicant’s Primary Hospital and the applicant. The cost of the health assessment shall be borne by the applicant. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to each Facility Credentials Committee at the CHS Hospitals and shall be available to discuss any questions or concerns that the Facility Credentials Committees may have.

(c) Upon attaining the age of 75, members of the Medical Staff shall assume Emeritus Staff status and shall have clinical privileges to admit or care for patients at the Hospital only to the extent recommended by the applicable Department Chiefs, the Facility Credentials Committees, the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, the Facility MECs and approved by the Board. No individual is entitled to an exception or to a hearing if the Board determines not to grant an exception,
but the individual may meet with the CMC-C Credentials Committee to discuss his/her clinical privileges upon request.

ARTICLE IV – PART A: CLINICAL PRIVILEGES
SECTION 6. Physicians in Training:

Participants registered in professional graduate medical education programs shall not hold appointments to the Medical Staff and shall not be granted specific privileges.

ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES
SECTION 1: Temporary Clinical Privileges for Applicants with Clean Application:

(a) The Facility Administrator at a CHS Hospital, upon recommendation of the applicable President of the Medical Staff or applicable Department Chief, may grant temporary clinical privileges in accordance with this Section 4.B.1 for a period of time not to exceed one hundred and twenty (120) days if such applicant has a clean application and is awaiting review by the applicable Facility MEC and the Board. An application shall be considered clean if the following requirements are satisfied:

- there is verification (which may be accomplished by a telephone call) of:
  - current licensure
  - relevant training or experience
  - current competence
  - ability to perform the privileges requested
  - other criteria as may be required by the Medical Staff bylaws
- the results of the National Practitioner Data Bank query have been obtained and evaluated
- the Applicant has:
  - a complete application
  - no current or previously successful challenge to licensure or registration
  - not been subject to involuntary termination of medical staff membership at another organization
  - not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

(b) Temporary clinical privileges granted to an applicant in accordance with this Section 4.B.1 may only be exercised at the CHS Hospital whose Facility Administrator has granted such privileges to such applicant; provided, that an applicant may be granted the same or different temporary clinical privileges in accordance with this Section 4.B.1 at more than one CHS Hospital.
ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES

SECTION 2. Temporary Clinical Privileges for Applicants to Meet Patient Care Needs:

(a) The Facility Administrator at a CHS Hospital, upon recommendation of the applicable President of the Medical Staff, the Chair of the applicable Facility Credentials Committee or applicable Department Chief, may also grant temporary clinical privileges to an applicant on a case-by-case basis when an important patient care need mandates an immediate authorization to practice, for a period not to exceed ninety (90) days, while the full credentials information is verified and approved; provided, that the applicant’s current licensure and competence have been verified. Examples include a situation in which a current Medical Staff member becomes ill or takes a leave of absence and an applicant would need to cover such member’s practice until such member returns, or a specific applicant has the necessary skills to provide care to a patient that no current Medical Staff member possesses.

(b) Temporary clinical privileges granted to an applicant in accordance with this Section 4.B.2 may only be exercised at the CHS Hospital whose Facility Administrator has granted such privileges to such applicant; provided, that an applicant may be granted the same or different temporary clinical privileges in accordance with this Section 4.B.2 at more than one CHS Hospital.

ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES

SECTION 3. Temporary Clinical Privileges for Non-Applicants:

(a) Temporary clinical privileges for care of a specific patient or patients may be granted by the Facility Administrator at a CHS Hospital, with the concurrence of the President of the Medical Staff, the Chairperson of the applicable Facility Credentials Committee or the applicable Department Chief, to a Physician or Dentist who is not an applicant for appointment in the same manner and upon the same conditions as set forth in Section 4.B.2 provided that the Facility Administrator first obtains such individual's signed acknowledgment to be bound by the CHS Hospital’s Medical Staff Bylaws then in force in all matters relating to temporary clinical privileges. Such privileges shall be restricted to the specific patients for which they are granted.

(b) Non-applicants granted temporary clinical privileges in accordance with this Section 4.B.3 may only assist the primary sponsoring Medical Staff member and may not assume responsibility for admission/treatment of any patient. A sponsoring Medical Staff member must be physically present in the room at all times.

(c) Temporary clinical privileges granted to an individual in accordance with this Section 4.B.3 may only be exercised at the CHS Hospital whose Facility Administrator has granted such privileges to such individual; provided, that an individual may be granted the same or different temporary clinical privileges in accordance with this Section 4.B.3 at more than one CHS Hospital.
ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES
SECTION 4. Temporary Clinical Privileges for Locum Tenens:

(a) The Facility Administrator at a CHS Hospital, with the concurrence of the President of the Medical Staff, the Chairperson of the applicable Facility Credentials Committee or the applicable Department Chief, may grant an individual serving as a locum tenens for a Medical Staff member temporary admitting and clinical privileges to attend patients of that Medical Staff member for a period not to exceed ninety (90) days. This shall be done in the same manner and upon the same conditions as set forth in Section 4.B.2; provided, that the Facility Administrator shall first obtain such individual's signed acknowledgment that the individual has had an opportunity to read copies of the Medical Staff Bylaws then in force and agrees to be bound by their terms in all matters relating to temporary clinical privileges.

(b) The individual serving as a locum tenens must complete a request for clinical privileges form and must have in force and effect a current license to practice in this state, a DEA license, if applicable, and professional liability insurance in an amount and terms acceptable to the CHS Hospital.

(c) Temporary clinical privileges granted to an individual in accordance with this Section 4.B.4 may only be exercised at the CHS Hospital whose Facility Administrator has granted such privileges to such individual; provided, that an individual may be granted the same or different temporary clinical privileges in accordance with this Section 4.B.4 at more than one CHS Hospital.

ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES
SECTION 5: Special Conditions:

Special conditions of supervision and reporting may be imposed by any applicable Department Chief, the President of the Medical Staff at a particular CHS Hospital, the Chair of any applicable Facility Credentials Committee or any applicable Facility Administrator upon the recommendation of any of the foregoing individuals on any individual granted temporary clinical privileges in accordance with Sections 4.B.1-4. Temporary privileges may be immediately terminated by the applicable Facility Administrator upon notice of any failure by the individual to comply with such special conditions.

ARTICLE IV – PART B: TEMPORARY CLINICAL PRIVILEGES
SECTION 6: Termination of Temporary Clinical Privileges:

(a) Temporary privileges shall expire at the end of the time period for which they are granted or at any earlier time in accordance with the procedures below.
(b) The Facility Administrator of a CHS Hospital may, at any time after receiving a recommendation from the Chairperson of the applicable Facility Credentials Committee, the President of the Medical Staff or the Department Chief responsible for the individual's supervision, terminate temporary admitting privileges. Temporary clinical privileges shall then be terminated when the individual's inpatients are discharged from the CHS Hospital; however, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary clinical privileges, a summary termination of temporary clinical privileges may be imposed by the Facility Administrator of the CHS Hospital, and such termination shall be immediately effective.

(c) The applicable Department Chief or the President of the Medical Staff shall assign to a Medical Staff member responsibility for the care of the terminated individual's patients until such patients are discharged from the applicable CHS Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute Medical Staff member.

(d) The granting of any temporary privileges is a courtesy on the part of the CHS Hospitals. Neither the denial nor termination of such privileges shall entitle the individual to a hearing pursuant to Article 7 or any of the other procedural rights provided in this Policy.

(e) Temporary privileges shall be automatically terminated at such time as the CMC-C Credentials Committee recommends unfavorably with respect to the applicant's appointment to the Medical Staff. At the applicable Facility Credentials Committee's discretion, it may modify temporary clinical privileges to conform to its recommendation that the applicant be granted different permanent privileges from the temporary privileges previously granted.

ARTICLE IV – PART C: EMERGENCY SITUATIONS

(1) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff at the applicable CHS Hospital may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any Physician or Dentist who is not currently appointed to the Medical Staff at the applicable CHS Hospital may administer treatment to the extent permitted by his or her license.

(3) When the emergency situation no longer exists, the patient shall be assigned by the applicable Department Chief, or the President of the Medical Staff at the applicable CHS Hospital, to a Medical Staff member with appropriate clinical privileges, considering the wishes of the patient.
ARTICLE IV – PART D: DISASTER PRIVILEGES

When the disaster plan at a CHS Hospital has been implemented and the immediate needs of patients in a CHS Hospital cannot be met, the Administrator of the CHS Hospital, the President of the Medical Staff of the CHS Hospital or the Chairperson of the Facility Credentials Committee at the CHS Hospital, or any designee of any of the above-named individuals, may grant disaster privileges to eligible volunteer licensed independent practitioners in accordance with the Carolinas HealthCare System Disaster Privileges Policy. The Medical Staff will oversee the care provided by volunteer licensed independent practitioners.

ARTICLE V

REAPPOINTMENT

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT

SECTION 1: Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records;

(b) completed all continuing medical education requirements;

(c) satisfied all applicable Medical Staff responsibilities at each applicable CHS Hospital, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) had sufficient patient contacts to enable the Department Chief(s) to assess current clinical judgment and competence for the privileges requested; and

(f) paid the reappointment processing fee.

Any individual seeking reappointment who has insufficient practitioner-specific data available at the CHS Hospitals to enable evaluation pursuant to subsection (e) above must submit: (1) peer recommendations obtained from a practitioner in the same professional discipline as the individual with personal knowledge of the individual’s ability to practice; (2) non-CHS Hospital primary facility evaluation; and (3) any other information specifically requested, which may include a copy of his/her confidential quality profile from his/her primary facility and/or clinical information from the individual’s private office practice. The peer recommendations must include information pertaining to the individual’s relevant training and experience, current competence, and any effects of health status on privileges being requested. Sources for peer recommendations may include, but are not limited to, the following: a hospital performance improvement committee, the majority of whose members are the individual’s peers; a reference letter(s), written documentation, or documented
ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT

SECTION 2. Additional Factors for Evaluation:

In addition to the factors listed in Section 2.A.2, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Policies, Rules and Regulations, procedures and protocols of CHS, the CHS Hospitals and the Medical Staffs consistent with the applicant’s classification at each CHS Hospital;

(b) participation in Medical Staff duties and obligations consistent with the applicant’s classification at each CHS Hospital;

(c) the results of each CHS Hospital’s performance improvement, ongoing professional practice evaluations, and other peer review activities, including all relevant information, reports and results from the Quality Assessment and Improvement Committee of each CHS Hospital in which the individual holds Clinical Privileges;

(d) any focused professional practice evaluations;

(e) appropriate resolution of any verified complaints received from patients, members of any Medical Staff and/or CHS staff;

(f) whether the individual’s medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, or otherwise limited at any other hospital or health care facility, or are currently being investigated or challenged;

(g) whether the individual’s license to practice in any state or DEA registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;

(h) whether the individual’s professional liability coverage and/or professional liability litigation experience has changed, including specifically information concerning past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the applicable Facility Credentials Committee, the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, the applicable Facility MEC, or the Board may request; and

(i) other reasonable indicators of continuing qualifications.
ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT

SECTION 3. Reappointment Process:

(a) An application for reappointment shall be furnished to eligible members at least 4 months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services Office within 30 days of receipt of the application.

(b) Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least 3 months prior to the expiration of the Medical Staff member’s current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment, and the individual may not practice until an application is processed.

(c) Reappointment, if granted, shall be for a period of not more than 2 years.

(d) The application will be reviewed by the Medical Staff Services Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

(e) The Medical Staff Services Office shall oversee the process of gathering and verifying all relevant information. The Medical Staff Services Office shall also be responsible for confirming that all relevant information has been received.

(f) The Medical Staff Services Office shall forward the application to the relevant Department Chief(s), as indicated in Section 5.A.4.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT

SECTION 4. Department Chief Procedure:

(a) For individuals applying for reappointment and renewal of privileges at the CHS Hospitals, the appropriate Department Chief at each of the CHS Hospitals shall receive Notice of the application. A separate evaluation (which may include an interview) shall be performed by: (i) the Department Chief at the CHS Hospital designated as the individual’s Primary Hospital; and (ii) the Department Chief at any other CHS Hospital at which the individual is a current member in the Active Consulting, Associate, Attending or Senior Attending classification (each, an “Active Non-Primary Hospital”). Any Department Chief at a CHS Hospital other than the individual’s Primary Hospital or Active Non-Primary Hospitals may, but is not required to, perform a separate evaluation (which may include an interview) of the individual. Further, if a department has a Chairman in addition to the Department Chief, the Department Chief may request that the Chairman prepare a written report regarding whether the applicant has satisfied all of the qualifications for reappointment and the clinical privileges requested and submit this report to the applicable Department Chief.
(b) The Department Chief indicated above shall each prepare a written report regarding whether the individual has satisfied all of the qualifications for reappointment and the clinical privileges requested. Each Department Chief shall submit his/her report to the Facility Credentials Committee at the Department Chief’s CHS Hospital.

(c) Each applicable Department Chief shall be available to answer any questions that may be raised with respect to that Department Chief’s report and findings.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 5. Facility Credentials Committee Procedure:

(a) The Facility Credentials Committee at the individual’s Primary Hospital, any Active Non-Primary Hospital and any other CHS Hospital that has elected to perform a separate evaluation shall each separately review and consider the report prepared by the relevant Department Chief and shall make a recommendation. Each of the Facility Credentials Committees referenced above shall forward a copy of its completed credentials report to the Credentials Committee chairperson of the Facility Credentials Committee at all of the other CHS Hospitals as well as to the Facility MEC at all of the other CHS Hospitals.

(b) Each Facility Credentials Committee may use the expertise of the Department Chiefs, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for reappointment and renewal of privileges, a Facility Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the Facility Credentials Committee if there is any question about the applicant’s ability to perform the privileges requested for renewal and the responsibilities of reappointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the Facility Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Facility Credentials Committee shall be considered a voluntary withdrawal of the application for reappointment and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) Each Facility Credentials Committee may require the applicant to meet with the Facility Credentials Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges.

(e) Each Facility Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). Each Facility Credentials Committee may also recommend that
reappointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 6. Facility MEC Procedure (Interim):

(a) Each Facility MEC at the individual’s Primary Hospital, any Active Non-Primary Hospital and any other CHS Hospital that has elected to perform a separate evaluation shall review and consider the recommendation of its Facility Credentials Committee and shall make an interim recommendation regarding the application to the CMC-C Credentials Committee. This interim recommendation shall not constitute a recommendation that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.

(b) Each Facility MEC may use the expertise of the Department Chiefs, the Facility Credentials Committee, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for reappointment and renewal of privileges, a Facility MEC may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the Facility MEC if there is any question about the applicant’s ability to perform the privileges requested for renewal and the responsibilities of reappointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the Facility MEC for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Facility MEC shall be considered a voluntary withdrawal of the application for reappointment and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) Each Facility MEC may require the applicant to meet with the Facility MEC to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges.

(e) Each Facility MEC may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). Each Facility MEC may also recommend that reappointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

(f) Each Facility MEC at the CHS Hospitals which did not perform a separate evaluation of the applicant shall also make an interim recommendation regarding the application based on its review of the information contained in the credentials reports from the individual’s Primary Hospital, any Active Non-Primary Hospital and any other CHS Hospital that has elected to perform a separate evaluation. These interim recommendations shall not constitute
recommendations that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 7. CMC-C Credentials Committee Procedure:

(a) The CMC-C Credentials Committee shall review and consider the interim recommendation of all of the Facility MECs and shall make a single recommendation regarding the application to the CMC-C Medical Executive Committee.

(b) The CMC-C Credentials Committee may use the expertise of the Department Chiefs, any Facility Credentials Committee, any Facility MEC, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for reappointment and renewal of privileges, the CMC-C Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the CMC-C Credentials Committee if there is any question about the applicant’s ability to perform the privileges requested for renewal and the responsibilities of reappointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the CMC-C Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the CMC-C Credentials Committee shall be considered a voluntary withdrawal of the application for reappointment and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) The CMC-C Credentials Committee may require the applicant to meet with the CMC-C Credentials Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges. If it becomes apparent to the CMC-C Credentials Committee that it is considering a recommendation to deny reappointment, or to reduce clinical privileges, the Chairperson may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The CMC-C Credentials Committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

(e) The CMC-C Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The CMC-C Credentials Committee may also recommend that
reappointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT

SECTION 8. CMC-C Medical Executive Committee Procedure:

(a) The CMC-C Medical Executive Committee shall review and consider the recommendation of the CMC-C Credentials Committee and shall make a recommendation regarding the application to the Facility MEC at each CHS Hospital.

(b) The CMC-C Medical Executive Committee may use the expertise of the Department Chiefs, any Facility Credentials Committee, any Facility MEC, the CMC-C Credentials Committee, any other member of the Medical Staffs of the CHS Hospitals, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(c) After determining that an applicant is otherwise qualified for reappointment and renewal of privileges, the CMC-C Medical Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) acceptable to both the applicant and the CMC-C Medical Executive Committee if there is any question about the applicant’s ability to perform the privileges requested for renewal and the responsibilities of reappointment. The applicant shall bear the cost of any such examination(s). The results of this examination shall be made available to the CMC-C Medical Executive Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the CMC-C Medical Executive Committee shall be considered a voluntary withdrawal of the application for reappointment and all processing of the application shall cease. An application so withdrawn may not be resubmitted for 1 year following such withdrawal.

(d) The CMC-C Medical Executive Committee may require the applicant to meet with the CMC-C Medical Executive Committee to discuss any aspect of the applicant’s application, qualifications, or requested clinical privileges. If it becomes apparent to the CMC-C Medical Executive Committee that it is considering a recommendation to deny reappointment, or to reduce clinical privileges, the Chairperson may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The CMC-C Medical Executive Committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

(e) The CMC-C Medical Executive Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The CMC-C Medical Executive Committee may also recommend
that reappointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 9. Facility MEC Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the CMC-C Medical Executive Committee, each Facility MEC shall:

(1) adopt the findings and recommendation of the CMC-C Medical Executive Committee as its own; or

(2) refer the matter back to the CMC-C Medical Executive Committee along with a report stating its reasons, as well as supporting information, for its disagreement with the CMC-C Medical Executive Committee’s recommendation.

(b) If all of the Facility MECs at the CHS Hospitals adopt the findings and recommendation of the CMC-C Medical Executive Committee as their own, and if the recommendation of the CMC-C Medical Executive Committee is to reappoint with the privileges requested, the recommendations of the Facility MECs shall be forwarded to the Board through the Board’s Quality Care and Comfort Committee.

(c) If all of the Facility MECs at the CHS Hospitals adopt the findings and recommendation of the CMC-C Medical Executive Committee as their own, and if the recommendation of the CMC-C Medical Executive Committee regarding an applicant’s reappointment and requested privileges would entitle the applicant to request a hearing pursuant to Article 7 of this Policy, the Facility Administrator at the applicant’s Primary Hospital shall send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital. The Facility Administrators of each CHS Hospital shall then hold the application until after the applicant has completed a hearing and appeal or waived his/her right to a hearing and appeal.

(d) If any Facility MEC refers the matter back to the CMC-C Medical Executive Committee under subsection (a)(2) above, representatives from each Facility MEC shall meet with the CMC-C Medical Executive Committee to discuss the matter and attempt to resolve the differences. If the differences cannot be resolved, the recommendations of each of the Facility MECs shall be forwarded to the Board through the Board’s Quality Care and Comfort Committee for resolution. In such event, none of the recommendations of the Facility MECs shall constitute a recommendation that would entitle the applicant to request a hearing pursuant to Article 7 of this Policy.
ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 10. Board Action:

(a) Upon receipt of a recommendation from each Facility MEC that the applicant be granted reappointment and renewal of requested clinical privileges, the Board may:

1. reappoint the applicant and grant the renewal of clinical privileges as recommended; or

2. refer the matter back to the Facility MECs, the CMC-C Medical Executive Committee, or to another source inside or outside CHS, for additional research or information; or

3. reject or modify the recommendations.

(b) If the Board determines to reappoint the individual, the Board will make any requested changes in clinical privileges or staff category at the applicable CHS Hospitals consistent with the recommendation received. The individual shall be responsible for fulfilling all Medical Staff duties and obligations associated with his or her classification at each of the CHS Hospitals, including the Primary Hospital.

(c) If the Board determines to reject or limit the favorable recommendation of all Facility MECs, it shall communicate the reasons for its decision to all Facility MECs and the CMC-C Medical Executive Committee. Thereafter, the Facility Administrator at the Primary Hospital shall promptly send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital.

(d) Upon receipt of conflicting recommendations from the Facility MECs, the Board shall review all applicable reports and information from the Facility MECs and the CMC-C Medical Executive Committee as well as any other information the Board deems relevant and shall make the final decision to grant, limit or deny reappointment and renewal of clinical privileges. If the determination of the Board would entitle the applicant to request a hearing pursuant to Article 7 of this Policy, the Facility Administrator at the applicant’s Primary Hospital shall send Special Notice to the applicant that he or she is entitled to request a hearing pursuant to Article 7 of this Policy. The hearing, if requested, shall be conducted at the Primary Hospital.

(e) Any final decision by the Board to grant, deny, revise, or revoke reappointment and/or clinical privileges shall be disseminated to appropriate individuals and, as required, reported to appropriate entities.

ARTICLE V – PART A: PROCEDURES FOR REAPPOINTMENT
SECTION 11. Time Periods for Processing:

All applications for reappointment shall be processed in a timely manner. Absent a concern with the application, each complete application that proceeds through the
 ARTICLE VI

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

ARTICLE VI – PART A: COLLEGIAL INTERVENTION

(1) This Policy encourages collegial and educational efforts by Medical Staff leaders and CHS administration at the CHS Hospitals, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

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

(3) All collegial intervention efforts at the CHS Hospitals are part of CHS's ongoing and focused professional practice evaluation, performance improvement, and peer review activities.

(4) Documentation of collegial intervention efforts shall be included in an individual's confidential file. If documentation is included in an individual's confidential file, the individual will have an opportunity to review such documentation and respond in writing. The response shall be maintained in that individual's file, along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(6) The President of the Medical Staff at the applicable CHS Hospital shall determine whether a matter should be handled in accordance with (i) the means set forth above, (ii) any other reasonable means, such as by a Department Chief or Facility Credentials Committee, or (iii) another Policy, such as the Physician Health Policy. The President of the Medical Staff may also consider whether to direct the matter to the CMC-C Credentials Committee for determination of whether to conduct an investigation.

ARTICLE VI – PART B: INVESTIGATIONS

SECTION 1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:
(1) the clinical competence or clinical practice of any member of the Medical Staff at any CHS Hospital, including the care, treatment or management of a patient or patients;

(2) the known or suspected violation by any member of the Medical Staff at any CHS Hospital of applicable ethical standards or the Bylaws, Policies, Rules and Regulations, procedures or protocols of CHS, the CHS Hospitals and the Medical Staffs; and/or

(3) conduct by any member of the Medical Staff at any CHS Hospital that reflects the inability of the member to work harmoniously with others sufficient to enable them to maintain professional relationships with patients, families, and other members of CHS Hospital healthcare teams;

the matter may be referred to the applicable Department Chief, the chair of any standing committee, the President of the Medical Staff at the applicable CHS Hospital, or the Facility Administrator at the applicable CHS Hospital.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the CMC-C Credentials Committee.

(c) No action taken pursuant to this Section 6.B.1 shall constitute an investigation.

ARTICLE VI – PART B: INVESTIGATIONS
SECTION 2. Initiation of Investigation:

(a) When a question involving clinical competence, behavior or conduct is referred to, or raised by, the CMC-C Credentials Committee, the CMC-C Credentials Committee shall review the matter and determine whether to conduct an investigation.

(b) The CMC-C Credentials Committee may discuss the matter with the individual, but is not required to.

(c) An investigation shall begin only after a determination to do so is made by the CMC-C Credentials Committee.

ARTICLE VI – PART B: INVESTIGATIONS
SECTION 3. Investigative Procedure:

(a) Once a determination has been made by the CMC-C Credentials Committee to begin an investigation, the Facility Credentials Committee at the facility where the matter occurred (or, if the matter did not occur at a particular CHS Hospital, the Facility Credentials Committee at the individual’s Primary Hospital) shall either investigate the matter itself or appoint an ad hoc committee consisting of no less than 3 persons (in any case, the “Investigating Committee”) to conduct the investigation. The Investigating Committee shall not include partners, associates, or relatives of the individual
being investigated and at least one individual on the Investigating Committee shall be a Peer of the individual being investigated or a suitable and qualified Medical Staff member. The Investigating Committee may include individuals not on the Medical Staff.

(b) The Investigating Committee shall provide notice to the individual that an investigation has begun and inform the individual that he/she will be given an opportunity to meet with the Investigating Committee to discuss the matter prior to the Investigating Committee’s final recommendation, unless the Investigating Committee determines that doing so would compromise the investigation or disrupt the operations of the CHS Hospitals or the Medical Staff at the CHS Hospitals.

c) The Investigating Committee shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff at each CHS Hospital and CHS, as well as the authority to use outside consultants, if needed.

d) The Investigating Committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The applicable CHS Hospital shall bear the cost of any such required examination(s). The results of such examination(s) shall be made available for consideration by the Investigating Committee.

e) The individual shall have an opportunity to meet with the Investigating Committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the Investigating Committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(f) At the conclusion of the investigation, the Investigating Committee shall prepare a report with its findings, conclusions and recommendations. The report shall be presented to the Facility Credentials Committee.

(g) In making its recommendations, the Investigating Committee may consider (i) relevant literature and clinical practice guidelines, as appropriate; (ii) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); (iii) any information or explanations provided by the individual under review, and (iv) what is in the best interests of patient care.

(h) The Chair of the Facility Credentials Committee shall keep the President of the Medical Staff at the applicable CHS Hospital, the CMC-C Credentials Committee and the CMC-C Medical Executive Committee fully informed of all action taken in connection with an investigation.
ARTICLE VI – PART B: INVESTIGATIONS
SECTION 4. Recommendation:

(a) The Facility Credentials Committee may accept, modify or reject the recommendation it receives from the Investigating Committee. The Facility Credentials Committee shall transmit its recommendation to the Facility MEC.

(b) The Facility MEC may accept, modify, or reject any recommendation it receives from the Facility Credentials Committee. Specifically, the Facility MEC may:

(1) determine that no action is justified;
(2) issue a letter of guidance or counsel;
(3) issue a letter of warning or reprimand;
(4) impose conditions for continued appointment;
(5) impose a requirement for monitoring or consultation;
(6) recommend additional training or education;
(7) recommend reduction of clinical privileges;
(8) recommend suspension of clinical privileges for a term;
(9) recommend revocation of appointment and/or clinical privileges; or
(10) make any other recommendation that it deems necessary or appropriate.

(c) A recommendation by the Facility MEC that would entitle the individual to request a hearing shall be forwarded to the applicable Facility Administrator, who shall promptly inform the individual by Special Notice. The Facility Administrator shall hold the recommendation until after the individual has completed or waived a hearing and appeal. The Facility MEC shall also forward a report of the recommendation to the CMC-C Credentials Committee and the CMC-C Medical Executive Committee for information.

(d) If the Facility MEC makes a recommendation that does not entitle the individual to request a hearing, the recommendation shall take effect immediately at all CHS Hospitals without action of the Board and without the right of appeal to the Board. The Facility MEC shall forward a report of the action taken to the CMC-C Credentials Committee and the CMC-C Medical Executive Committee for their information. The CMC-C Medical Executive Committee shall forward a report of the action taken to the Board through the Quality Care and Comfort Committee, and the action shall stand unless modified by the Board.
(e) In the event the Board considers a modification to the recommendation of the Facility MEC, the Board shall communicate the reasons for its modification to the applicable Facility MEC and other committees or individuals the Board deems appropriate. In addition, if the Board’s modification to the recommendation would entitle the individual to request a hearing, the applicable Facility Administrator shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(f) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by the applicable Medical Staff leaders on an ongoing basis through CHS’s performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

ARTICLE VI – PART C: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES
SECTION 1. Grounds for Precautionary Suspension:

(a) The applicable Department Chief, the applicable President of the Medical Staff, the applicable Facility Administrator, the chairperson of the applicable Facility Credentials Committee and the chairperson of the CMC-C Credentials Committee shall each have the authority to suspend or restrict all or any portion of an individual’s clinical privileges whenever failure to take such action may result in an imminent danger to the health of any individual. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation of the concerns raised.

(b) Precautionary suspension or restriction is an interim step in the professional review activity, but it 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 or restriction.

(c) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Facility Administrator and the President of the Medical Staff at each CHS Hospital as well as the CMC-C Credentials Committee, and shall remain in effect unless it is modified by the CMC-C Credentials Committee. The precautionary suspension or restriction shall be in effect at all CHS Hospitals.

ARTICLE VI – PART C: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES
SECTION 2. CMC-C Credentials Committee Procedure:

(a) The CMC-C Credentials Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the CMC-C Credentials Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and employees of CHS, depending on the circumstances.
(b) After considering the matters resulting in the suspension or restriction and the individual’s response, if any, within the 14 day period noted in subsection (a), the CMC-C Credentials Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation, which investigation shall be conducted in as expeditious a manner as possible. The CMC-C Credentials Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

ARTICLE VI – PART C: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES
SECTION 3. Care of Suspended Individual’s Patients:

(a) Immediately upon the imposition of a precautionary suspension, the President of the Medical Staff at the applicable CHS Hospitals or the appropriate Department Chiefs shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual’s hospitalized patients. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering Physician or Dentist.

(b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff at the applicable CHS Hospitals, the applicable Department Chiefs, and the CMC-C Credentials Committee in enforcing suspensions and restrictions.

ARTICLE VI – PART D: AUTOMATIC RELINQUISHMENT
SECTION 1. Action by Government Agency:

(a) Any action taken by any licensing board, court or government agency regarding any of the matters set forth below must be promptly reported to the Facility Administrator of the individual’s Primary Hospital.

(b) An individual’s clinical privileges at every CHS Hospital shall be automatically restricted if any of the following occur:

   (1) Licensure: The placement of conditions or restrictions on an individual’s license.

   (2) Controlled Substance Authorization: The placement of conditions or restrictions on an individual’s federal or state controlled substance certificate.

(c) Automatic restriction shall take effect immediately and continue until the matter is resolved and a request for reinstatement of privileges has been acted upon by the CMC-C Medical Executive Committee, the Facility MECs and the Board.
ARTICLE VI – PART D: AUTOMATIC RELINQUISHMENT
SECTION 2. Failure to Provide Requested Information:

Failure, without a showing of good cause, to provide reasonable and relevant information pertaining to an individual’s qualifications for appointment or clinical privileges in a timely manner, in response to a written request from the Facility Administrator at a CHS Hospital, any Facility Credentials Committee, any Facility MEC, the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, or any other committee or individual authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided, at which time, the individual’s privileges shall be automatically reinstated.

ARTICLE VI – PART D: AUTOMATIC RELINQUISHMENT
SECTION 3. Failure to Attend Special Meeting:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the Department Chief or the President of the Medical Staff at the applicable CHS Hospital(s) may require the individual to attend a special meeting with applicable Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff at the applicable CHS Hospital(s).

(b) The notice to the individual regarding this meeting shall be given by Special Notice at least seven days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(e) Failure of the individual to attend the meeting shall be reported to the applicable Facility Credentials Committee. Unless excused by the Facility Credentials Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual’s clinical privileges as the Facility Credentials Committee (upon recommendation of the applicable President of the Medical Staff) may direct. Such relinquishment shall remain in effect until the matter is resolved, at which time the relinquished clinical privileges shall be automatically reinstated.

ARTICLE VI – PART D: AUTOMATIC RELINQUISHMENT
SECTION 4. Action at Another CHS Hospital:

Any denial, revocation, reduction, suspension, restriction, limitation, leave of absence, or condition imposed upon an individual at one CHS Hospital shall automatically and immediately be effective in all CHS Hospitals, without recourse to any additional hearing or appeal (as applicable).

ARTICLE VI – PART D: AUTOMATIC RELINQUISHMENT
SECTION 5 Failure to Satisfy Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency that would affect the ability of the individual to meet the eligibility criteria set forth in Section 2.A.1 of this Policy
must be promptly reported to the Facility Administrator of the individual’s Primary Hospital.

(b) Failure at any time during appointment or reappointment to satisfy the eligibility criteria set forth in Section 2.A.1 shall result in automatic relinquishment of all clinical privileges at each CHS Hospital, except as set forth in Section 6.D.2. with respect to restrictions imposed by government agencies. Automatic relinquishment shall take effect immediately and continue until the matter is resolved and a request for reinstatement of privileges has been acted upon by the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, the Facility MECs and the Board.

ARTICLE VI – PART E: LEAVE OF ABSENCE

(a) An individual appointed to the Medical Staffs at the CHS Hospitals may request a leave of absence by submitting a written request to the Department Chief at the individual’s Primary Hospital. The request must state the beginning and ending dates of the leave, which shall not exceed 2 years, and the reasons for the leave.

(b) The Department Chief at the individual’s Primary Hospital shall transmit the request together with a report to the applicable Facility Administrator for action by the applicable Facility Credentials Committee, the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, the applicable Facility MEC and the Board. The granting of a leave of absence or reinstatement, as appropriate, may be conditioned upon the individual’s completion of all medical records.

(c) No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to the Facility Administrator at the individual’s Primary Hospital a written summary of professional activities during the leave of absence. The Facility Administrator shall transmit the request together with the summary for action by the applicable Facility Credentials Committee, the CMC-C Credentials Committee, the CMC-C Medical Executive Committee, the applicable Facility MEC and the Board. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

(d) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual’s Physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(e) Absence for longer than 2 years shall result in automatic relinquishment of Medical Staff appointment and clinical privileges at each CHS Hospital unless an extension is granted by the Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of CHS and will only be granted prior to the end of the current leave.
(f) If an individual’s current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(g) Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension of a leave is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE VII

HEARING AND APPEAL PROCEDURES

ARTICLE VII – PART A: INITIATION OF HEARING

SECTION 1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever a Facility MEC or Board (as permitted in this Policy) makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staffs at the CHS Hospitals;

(2) denial of reappointment to the Medical Staffs at the CHS Hospitals;

(3) revocation of appointment to the Medical Staffs at the CHS Hospitals;

(4) denial of requested clinical privileges, including requests for increased clinical privileges;

(5) revocation or reduction of clinical privileges;

(6) suspension or restriction (other than precautionary suspension or restriction) of clinical privileges for more than 30 days; or

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

(b) No other recommendations shall entitle the individual to a hearing.

(c) The hearing shall be conducted in as informal a manner as possible.

(f) An individual may also request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior Facility MEC recommendation. In this instance, all references in this Article to the “Facility MEC” shall mean the “Board.”
ARTICLE VII – PART A: INITIATION OF HEARING
SECTION 2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing and they shall take effect without hearing or appeal:

(a) issuance of a letter of guidance, warning, or reprimand;
(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
(c) termination of temporary privileges;
(d) automatic relinquishment of appointment or privileges or automatic restriction of appointment or privileges pursuant to Article 6.D of this Policy;
(e) imposition of a requirement for additional training or continuing education;
(f) precautionary suspension or restriction;
(g) denial of a request for leave of absence, or for an extension of a leave, or for reinstatement from a leave;
(h) determination that an application is incomplete, withdrawn and/or will not be processed; or
(i) determination of ineligibility based on a failure to meet eligibility criteria.

ARTICLE VII – PART B: THE HEARING
SECTION 1. Notice of Recommendation:

The applicable Facility Administrator shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;
(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of such notice; and
(c) a copy of this Article.

ARTICLE VII – PART B: THE HEARING
SECTION 2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the applicable Facility Administrator and shall include the name, address, and telephone number of the individual’s counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.
ARTICLE VII – PART B: THE HEARING
SECTION 3. Notice of Hearing and Statement of Reasons:

(a) The applicable Facility Administrator shall schedule the hearing and provide, by Special Notice, the following:

(1) the time, place, and date of the hearing;

(2) the time, place, and date of the pre-hearing conference;

(3) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(4) the names of the Hearing Panel members and Presiding Officer, if known; and

(5) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation (referred to in this Article as the “Statement of Reasons”). This Statement of Reasons may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual’s qualifications and the individual has had sufficient opportunity, up to 30 days, to review and rebut the additional information.

(b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

ARTICLE VII – PART B: THE HEARING
SECTION 4. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Hearing Panel Chair, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party.

ARTICLE VII – PART B: THE HEARING
SECTION 5. Hearing Panel, Hearing Panel Chair, and Presiding Officer:

(a) Hearing Panel:

(1) The President of the Medical Staff at the applicable CHS Hospital shall appoint a Hearing Panel composed of not less than 3 members. The Hearing Panel shall be composed of members of the Medical Staff who did not actively participate in the matter at any previous
level, physicians or laypersons not connected with CHS, or a combination thereof; provided, that the Hearing Panel must include at least one Medical Staff member. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by CHS or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a referral relationship with, the individual requesting the hearing.

(b) Hearing Panel Chair:

(1) The President of the Medical Staff shall designate 1 of the Hearing Panel members as Chair. The Hearing Panel Chair shall be entitled to 1 vote.

(2) The Hearing Panel Chair shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

(vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Panel wishes to be present.

(3) The Hearing Panel Chair may be advised by legal counsel to CHS with regard to the hearing procedure.

(c) Presiding Officer

(1) In lieu of a Hearing Panel Chair, the President of the Medical Staff may appoint a Presiding Officer who may be an attorney. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
(2) The Presiding Officer shall have the authority of and perform all of the functions assigned to the Hearing Panel Chair.

(3) Legal counsel to CHS may continue to advise the Review Panel and the Board following the hearing.

(d) Objections:

Any objection to any member of the Hearing Panel, or to the Presiding Officer, shall be made in writing, within 10 days of receipt of notice, to the President of the Medical Staff. A copy of such written objections must include the basis for the objection and may include proposed questions to be asked of the Hearing Panel member(s) regarding any potential bias. The Hearing Panel Chair may pose some or all of such questions to the Hearing Panel member(s). The Hearing Panel Chair shall then make a recommendation to the President of the Medical Staff regarding the objections, and the President of the Medical Staff shall determine whether to replace any Hearing Panel member(s).

ARTICLE VII – PART B: THE HEARING
SECTION 6. Counsel:

The Presiding Officer and counsel for either party may be attorneys at law who are licensed to practice, in good standing, in any state.

ARTICLE VII – PART C: PRE-HEARING PROCEDURES
SECTION 1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. This is a continuation of the peer review process and should be conducted as such. Formal rules of evidence or procedure shall not apply.

ARTICLE VII – PART C: PRE-HEARING PROCEDURES
SECTION 2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided, as such terms are used in the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual’s expense;
(2) reports of experts relied upon by the Facility MEC;
(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
(4) copies of any other documents relied upon by the Facility MEC.

The provision of this information is not intended to waive any privilege under any state peer review protection statute.

(c) The individual shall have no right to discovery beyond the above information.

(d) At least 10 days prior to the pre-hearing conference, on a date set by the Hearing Panel Chair or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Hearing Panel Chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact CHS employees appearing on the Facility MEC’s witness list concerning the subject matter of the hearing, until specific arrangements are made with counsel.

ARTICLE VII – PART C: PRE-HEARING PROCEDURES
SECTION 3. Pre-Hearing Conference:

The Hearing Panel Chair shall require a representative (who may be counsel) for the individual and for the Facility MEC to participate in a pre-hearing conference, which shall be scheduled at least 10 days before the date of the hearing. At the pre-hearing conference, the Hearing Panel Chair shall resolve all procedural questions, including any objections to exhibits or witnesses, and shall establish the time to be allotted to each witness’s testimony and cross-examination. Notwithstanding the time limitations established during the pre-hearing conference, the Hearing Panel Chair may, during the hearing and after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

ARTICLE VII – PART C: PRE-HEARING PROCEDURES
SECTION 4. Stipulations:

The parties and their counsel shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.
ARTICLE VII – PART C: PRE-HEARING PROCEDURES
SECTION 5. Provision of Information to the Panel:

At least one week in advance of the hearing, the Hearing Panel Chair shall transmit to the Hearing Panel the Statement of Reasons and the exhibits for each of the parties, without the need for authentication.

ARTICLE VII – PART D: THE HEARING
SECTION 1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

ARTICLE VII – PART D: THE HEARING
SECTION 2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by CHS. Copies of the transcript shall be available at the individual’s expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

ARTICLE VII – PART D: THE HEARING
SECTION 3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Panel Chair:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit a written statement at the close of the hearing.

(b) The individual who requested the hearing and who does not testify may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.
ARTICLE VII – PART D: THE HEARING
SECTION 4. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

ARTICLE VII – PART D: THE HEARING
SECTION 5. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing. The Hearing Panel Chair, in his or her discretion, may set a page limit with respect to such written statements and may select an outside date for submission.

ARTICLE VII – PART D: THE HEARING
SECTION 6. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present, as requested by the Facility Administrator(s) or the President of the Medical Staff at the applicable CHS Hospital(s).

ARTICLE VII – PART D: THE HEARING
SECTION 7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Hearing Panel Chair on a showing of good cause.

ARTICLE VII – PART E: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATION
SECTION 1. Order of Presentation:

The Facility MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

ARTICLE VII – PART E: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATION
SECTION 2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the Hearing Panel shall recommend in favor of the Facility MEC unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious or not supported by substantial evidence.
ARTICLE VII – PART E: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATION

SECTION 3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

ARTICLE VII – PART E: HEARING CONCLUSION, DELIBERATIONS AND RECOMMENDATION

SECTION 4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the applicable Facility Administrator. The Facility Administrator shall send, by Special Notice, a copy of the report to the individual who requested the hearing. The Facility Administrator shall also provide a copy of the report to the Facility MEC, the CMC-C Credentials Committee and the CMC-C Medical Executive Committee.

ARTICLE VII – PART F: APPEAL PROCEDURE

SECTION 1. Time for Appeal:

Within 10 days after notice of the Hearing Panel’s recommendation, either party may request an appeal. The request shall be in writing, delivered to the Facility Administrator by Special Notice, and shall include a statement of the grounds for appeal as indicated in Section 7.F.2 below. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel’s report and recommendation shall be forwarded to the Board for final action.

ARTICLE VII – PART F: APPEAL PROCEDURE

SECTION 2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Bylaws of the Medical Staff at the applicable CHS Hospital(s) in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or

(b) the recommendations of the Hearing Panel were made arbitrarily, capriciously or were not supported by substantial evidence.

ARTICLE VII – PART F: APPEAL PROCEDURE

SECTION 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held
as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

ARTICLE VII – PART F: APPEAL PROCEDURE
SECTION 4. Nature of Appellate Review:

(a) The Chair of the Board shall appoint a Review Panel composed of not less than three persons who have not actively participated in the matter previously, at least one of whom shall be a Physician, and which may include either members of the Board or others, including but not limited to reputable persons outside CHS, to consider the record upon which the recommendation before it was made.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have 10 days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument in accordance with time limits established by the Review Panel.

(c) The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel.

(d) The Review Panel shall recommend final action to the Board within 20 days from the date that the last written statement is due or within 20 days from the date of oral arguments, if any, whichever is later.

ARTICLE VII – PART F: APPEAL PROCEDURE
SECTION 5. Final Decision of the Board:

As soon as practicable following receipt of the Review Panel’s recommendation, but in no event later than the day following the Board’s next regularly-scheduled meeting, the Board shall render a final decision in writing, including specific reasons, and shall send Special Notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board’s ultimate legal responsibility to grant appointment and clinical privileges. A copy of the Board’s final decision shall also be provided to the Facility MEC, the CMC-C Credentials Committee and the CMC-C Medical Executive Committee for its information.
ARTICLE VII – PART F: APPEAL PROCEDURE
SECTION 6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 7.F.5, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed 90 days except as the parties may otherwise agree.

ARTICLE VII – PART F: APPEAL PROCEDURE
SECTION 7. Right to One Hearing and One Appeal Only:

No applicant or member of the Medical Staff of any CHS Hospital shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment, or revokes the appointment and/or clinical privileges of a current member of the Medical Staff at the CHS Hospitals, that individual may not apply for Medical Staff appointment at the CHS Hospitals or for those clinical privileges for a period of two (2) years unless the Board provides otherwise.

ARTICLE VIII
CONFIDENTIALITY AND PEER REVIEW PROTECTION

ARTICLE VIII – PART A: CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of Medical Review Committee meetings, except:

1. when the disclosures are to another authorized member of the Medical Staff at one or more of the CHS Hospital(s) or to an authorized CHS Hospital employee and are for the purpose of conducting legitimate peer review activities, or

2. when the disclosures are authorized, in writing, by the Facility Administrator or legal counsel to CHS.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

ARTICLE VIII – PART B: PEER REVIEW PROTECTION; MEDICAL REVIEW COMMITTEES

All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by “Medical Review Committees” in accordance with applicable state law. Medical Review Committees include, but are not limited to:
(1) all committees;

(2) all departments and services;

(3) the Board of Directors and its committees; and

(4) any individual acting for or on behalf of any such entity, including but not limited to Department Chiefs, service chiefs, committee chairs, committee members and officers of the Medical Staff at one or more of the CHS Hospital(s), as well as experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by Medical Review Committees are confidential and covered by the provisions of all federal and state statutes providing protection to peer review or related activities. All Medical Review Committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

ARTICLE IX

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Policies or Rules and Regulations of the Medical Staff, the CHS Hospitals or CHS pertaining to the subject matter thereof.