

**YORK HOSPITAL**

**CREDENTIALS**

**POLICY AND PROCEDURE MANUAL**

Updated May 2017

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## YORK HOSPITAL

### CREDENTIALS POLICY AND PROCEDURE MANUAL PROCEDURE MANUAL

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# **CREDENTIALS POLICY AND PROCEDURE MANUAL**

## **DEFINITIONS**

The definitions set forth in the Bylaws of the Medical Staff of York Hospital shall apply to the provisions of this Credentials Policy and Procedure Manual.

## **ARTICLE I. APPOINTMENT PROCEDURES**

### **1.1 APPLICATION PACKET**

Any Practitioner requesting appointment to the Medical Staff, or rights to exercise clinical privileges or perform patient care services in the Hospital, shall forward a request to the Vice President of Medical Affairs or designee for an application packet. At WellSpan Health, the Central Verification Office supports all hospital medical staffs by performing this function. An application packet which includes application documents from all requested system entities will be provided to the Applicant. The application packet shall include the following items for Hospital Applicants - an application form; a privileges request form, a list of requirements for completing the application packet and information on how to view the following documents - the Medical Staff Bylaws, Rules and Regulations, and accompanying manuals.

### **1.2 APPLICATION CONTENT**

Every applicant must furnish complete information concerning the following:

- (a) Postgraduate training, including the name of each institution attended, degrees granted, programs completed, dates attended, and names of Physicians responsible for the applicant's performance;
- (b) Copies of all currently valid medical, dental, and other professional licenses or certifications, and Drug Enforcement Administration registration, with the date and number of each;
- (c) Specialty or sub-specialty board eligibility, qualification, certification, or recertification status;
- (d) Health impairments, if any, affecting the applicant's ability to perform professional and Medical Staff duties fully;
- (e) Professional liability insurance coverage as required by Section 3.1.4 of the Medical Staff Bylaws, and information on malpractice claims history and experience (suits, settlements, and judgments pending, made, or concluded);
- (f) The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment (by resignation or expiration) of license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state, or national professional organizations; specialty or sub-specialty board eligibility, qualification, or certification; faculty membership at any medical or other professional school; or staff membership status, prerogatives, or clinical privileges or rights to perform patient care services at any other hospital, clinic, or health care institution or organization;

(g) Location of offices, names and addresses of other Physicians with whom the applicant is or was associated and inclusive dates of such association; and names and locations of any other hospital, clinic, or health care institution or organization where the applicant provides or provided clinical services with the inclusive dates of each affiliation;

(h) The Department and/or Division to which the applicant is seeking appointment; the Staff category which the applicant is seeking; and the specific clinical privileges or rights to perform patient care services in the Hospital which the applicant is requesting;

(i) Any current felony charges pending against the applicant and any past charges, including their resolution;

(j) Any sanctions of any kind imposed or proposed to be imposed by any federal, state, or third party payor; and

(k) Applicant's acceptance of the scope and extent of the authorization, immunity, and release provisions as set forth in the application form.

### **1.3 EFFECT OF APPLICATION**

The applicant must sign the application and in so doing:

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

(b) authorizes Hospital representatives to consult with and request information or documents from others who have been associated with him or who may have information bearing on his competence, professional ability, ethical character, other qualifications, physical and mental health status, insurance coverage, and/or all other matters included or sought in the application;

(c) consents to Hospital representatives' inspection of all records and documents that may be material to an evaluation of his competence, professional ability, ethical character, other qualifications, physical and mental health status, insurance coverage, and/or all other matters included or sought in the application;

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

(e) signifies that he has read the current Medical Staff Bylaws, Rules and Regulations, and accompanying manuals and agrees to abide by their provisions and with all other standards, policies, and rules of the Staff and the Hospital; and

(f) agrees to waive all legal claims against any Hospital representative who acts in accordance with this Article according to the terms of the release contained in the Hospital's application form.

For purposes of this section, the term “Hospital representatives” includes but is not limited to the Board; its directors and committees; the Chief Executive Officer or his designee; the Vice President of Medical Affairs or his designee; registered nurses and other employees of the system; the Medical Staff and all Medical Staff appointees, Advance Practice Clinicians; clinical units and committees which have responsibility for collecting and evaluating the applicant’s credentials or acting upon his application; and any authorized representative of any of the foregoing.

## **1.4 PROCESSING THE APPLICATION**

### **1.4.1 APPLICATION PACKET**

Upon request and receipt of the non-refundable application fee, the amount of which will be set from time to time by the Vice President of Medical Affairs, eligible applicants will be given an application packet, as defined in Section 1.1 of this Credentials Policy and Procedure manual. Providing all necessary documentation is received by the Central Verification Office from the applicant, the CVO will share the documents with the Medical Staff Office. From the initial request for application, processing and approval/denial of the Medical Staff within four months.

### **1.4.2 ADDITIONAL DOCUMENTATION**

Documentation necessary to complete an application shall consist of the following is listed below and hyperlinked to this policy. It is the applicant’s responsibility to provide all the following documentation, or to see that it is provided. Until all the following documentation is received, the application will not be processed further and considered incomplete):

- (a) A completed, signed application form and privileges request form;
- (b) A copy of the applicant’s current license in the Commonwealth of Pennsylvania and, where applicable, his DEA number or certificate;
- (c) A copy of the applicant’s current professional liability insurance policy in the minimum amount required by Section 3.1.4 of the Medical Staff Bylaws;
- (d) Copies of certifications or letters confirming completion of an approved residency/training program or other educational curriculum;
- (e) Verification (copies of certificates or copy of letter from appropriate specialty board) of board status (i.e., board qualification, eligibility, or certification); and
- (f) References: The names of at least three references will be requested by the CVO if not previously received. A peer reference from the applicant’s current place of work/affiliation is requested. The most recent place of employment or affiliation must provide a reference to advance to the Medical Staff Credentials Committee.

Peers must have worked with and *directly observed* the applicant's professional performance and can provide personal knowledge of the applicant's current clinical ability, organizational responsibility for the applicant's performance, ethical character, fitness, and ability to work cooperatively with others, and who will provide specific written comments on these matters upon request. It is recommended that at least one reference has worked closely with the applicant within the last year.

(i) *References must be within your degree level or higher; at least one reference must be a medical doctor. Provide one reference with the same degree.*

(ii) *If the applicant has graduated from a training program in the last five (5) years, WSH organization(s) requires the Program Director be a reference.*

(iii) *If the applicant is out of training for five (5) years or more, WSH organization(s) recommend a reference from the applicant's most recent place of employment or hospital affiliation.*

(iv) *Do not use a current WellSpan department chair or division chief unless he/she is your program director*

References must be from individuals practicing in a field similar to the applicant.

(g) A completed, signed "Disclosure and authorization to obtain Criminal Background Reports."

(h) For Advance Practice Clinicians, copies of current collaborative or supervisory agreements as required by Pennsylvania law.

### **1.4.3 VERIFICATION AND ADDITIONAL INFORMATION**

Upon receipt of a completed and signed application form and supporting documentation as set forth in 1.4.2 above, the office of the Vice President of Medical Affairs, or designee will seek to verify the application's contents and collect additional information as follows (In the event of undue delay in obtaining the information required in this Section 1.4.2 the Office of the Vice President of Medical Affairs or designee will request assistance from the applicant. Failure of an applicant to respond adequately to a request for assistance may, after thirty (30) days, result in termination of the application process, without any recourse to the procedural rights afforded by Article II of the Corrective Action Procedures and Fair Hearing Plan.):

(a) Information from past insurance carriers concerning malpractice claims history and experience (suits, settlements, and judgments pending, made, or concluded);

(b) Completed professional references and hospital affiliations;

(c) Sufficient information documenting the applicant's clinical work, in acceptable form, to enable the applicant to be credentialed;

(d) Verification of licensure status in all current and past states of licensure;  
and



(e) A criminal background check will be performed for all new applicants to the medical staff. If any of the following are discovered, the Physician may be ineligible for appointment to the Medical Staff.

(i) any conviction of, or plea of guilty or no contest to, or received probation without verdict, disposition in lieu of trial or an Accelerated Rehabilitative Disposition in the disposition of, any felony charge, or any misdemeanor charge related to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence, or moral turpitude;

(f) Any other information required by applicable state or federal law or regulations -- e.g., obtaining reports from the National Physician Data Bank, and confirmation of the Cumulative Sanctions List maintained by the Office of the Inspector General of the Department of Health and Human Services.

#### **1.4.4 TELEPHONE FOLLOW-UP**

The Vice President of Medical Affairs, or his designee, may solicit additional information from each hospital, clinic, or health care institution or organization at which the applicant was a member of the staff or exercised clinical privileges or rights to perform patient care services during the past ten (10) years.

#### **1.4.5 SUMMARY**

With the completion of the applicant's file, (i.e., all documentation listed above has been received), the file will then be presented to the appropriate Department Chairman (men). The only item that can be outstanding to advance the file to Credentials Committee is a DEA pending a PA address.

#### **1.4.6 INTERVIEW**

The Department Chairman, or his designee, may interview the applicant and document the results of the interview. A copy of the interview documentation will be placed in the applicant's file.

#### **1.4.7 ASSIGNMENT OF THE REVIEW PROCESS**

Upon completion of the applicant's file, the Vice President of Medical Affairs, the relevant Department Chairman (following his review) and the Chairman of the Credentials Committee (following review of the applicant by the full Credentials Committee), or, in the event of the unavailability of any of them, their designees, shall assign the applicant to one of the following review processes, depending upon the extent to which the applicant has clearly demonstrated his qualifications for Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services:

(a) expedited review; or

- (b) full review.

## **1.5 DELEGATED CREDENTIALING PROCESS**

### **1.5.1 PROCESS**

In circumstances where the Hospital contracts with a Joint Commission accredited organization for telemedicine services, the Hospital may choose to delegate the responsibility of credentialing to the telemedicine organization, by accepting the credentialing process of the telemedicine organization.

In the circumstance of delegated credentialing, the credentialing and privileging processes will differ in the following ways:

- (a) Pre-application form requests, letters of acknowledgement, and notices of final decision will not be required or included in the delegated process.
- (b) All medical staff dues and fees are waived.
- (c) Information consistent with that required in Section 1.2, Application Content, and 1.4.2, Additional Documentation, must be made available upon request by the Hospital.
- (d) The verification of information and documentation is also delegated to the telemedicine organization.
- (e) Physicians who provide telemedicine services at the Hospital must be properly trained, licensed in the state of Pennsylvania, experienced in performing telemedicine services, and shall meet the same criteria, as established for the regular medical staff at the Hospital.
- (f) The Hospital shall grant clinical privileges to the telemedicine physician using credentialing information provided from the telemedicine organization, with approval of the Dept. Chairmen, Credentialing Committee, Medical Executive Committee, and Hospital Board.
- (g) The physician shall be privileged at the Hospital for the same services and procedures as the telemedicine organization.
- (h) The services provided by the telemedicine organization shall be consistent with commonly accepted quality standards.
- (i) Once the telemedicine services begin, the Hospital shall provide, when available, information relevant to assessing the quality of care, treatment, and services provided to the telemedicine organization. Minimally, the information provided shall include sentinel events, and complaints received from patients, licensed independent physicians, and staff at the Hospital.

- (j) The other circumstance where delegated Credentialing applies is with regards to intra-WSH credentialing. If an applicant has privileges at a WellSpan Health hospital, all of our hospitals follow the same requirements. The physician's file from the WellSpan hospital accompanied by a completed delineation of privilege form for York Hospital, and a report from the NPDB are the steps that must be completed prior to taking the applicant's file to the Credentials Committee.

## **1.6 EXPEDITED REVIEW PROCESS**

### **1.6.1 ELIGIBILITY FOR EXPEDITED REVIEW**

Determinations of an applicant's eligibility for expedited review shall be based on the applicant meeting criteria for expedited review which have been approved by the Medical Executive Committee. The determination that an applicant is not eligible for expedited review should not be viewed as an indication that the applicant is unqualified, and shall not be deemed an "adverse event" as defined in Article IX of the Medical Staff Bylaws. In general, expedited review is only for those applicants who, upon a thorough review of their application file and a personal interview, have clearly demonstrated their qualifications for Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services, as requested, without any unresolved questions or issues.

### **1.6.2 PROCESS**

(a) Approval: An applicant will be recommended for approval for Medical Staff Appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services, as requested, upon review and signed recommendation for approval by the relevant Department Chairman, the Chairman of the Credentials Committee (or designee) and the Medical Executive Committee. After obtaining these recommendations for approval, the Hospital Board or a subcommittee of the Board consisting of at least two members will review the recommendation for Appointment and privileges requested. The Board or the Board subcommittee may adopt or reject in whole or in part these recommendations. Action by the Board or the Board subcommittee will be handled in the manner described in Section 1.51 to 1.6.2 of the Credentials Policy and Procedure Manual.

(b) Non-Approval: If the relevant Department Chairman, the Chairman of the Credentials Committee (or designee) or the Medical Executive Committee do not give their signed approval of the applicant under the expedited review process, for any reason, the application shall be referred to the Vice President of Medical Affairs for review under the full review process, as described below.

### **1.6.3 EMERGENCY PRIVILEGES**

In case of an emergency which could result in serious harm to a patient, or in which the life of a patient is in immediate danger, any Medical Staff Appointee or Physician who has the right to perform patient care services in the Hospital is authorized to do everything

possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Physician's license, but regardless of Department or Division affiliation, category, or level of privileges. A Physician exercising emergency privileges is obligated to summon all consultative assistance considered necessary and to arrange appropriate follow-up care.

#### **1.6.4 DISASTER PRIVILEGES**

For purposes of this Section, a disaster is defined as a natural or manmade event that significantly disrupts the environment of care, significantly disrupts care, treatment, and services, or that results in sudden, significantly changed, or increased demands for the Hospital's services, or a situation in which there is immediate danger of loss of life or a permanent or serious disability and in which any delay in treatment might increase that danger. Disaster is further defined as a natural disaster, national emergency, bioterrorism, act of war, or other similar mass emergency. Following activation of the Hospital emergency management plan or following a disaster in which the treatment of patients on an emergent basis requires the assistance of medical Physicians who are not members of the Medical Staff, the President of the Medical Staff, the Chief Executive Officer, or their designees, may grant disaster privileges to a medical Physician whose skills and services are necessary to treat Hospital patients. Prior to granting disaster privileges to any medical Physician that is not on the Medical Staff, the Chief Executive Officer, the President of the Medical Staff, or their designee, may grant disaster privileges upon presentation of:

- A valid government-issued photo identification issued by a federal or state agency (e.g. driver's license, passport) AND one of the following:
- A current picture hospital ID card that clearly identifies professional designation
- A current license to practice
- Primary source verification of the license
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corp (MRC), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by federal, state, or municipal entity)
- Identification by a current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent Physician during a disaster

Verification shall take place as soon as the immediate situation is under control, and is typically completed within 72 hours from the time the volunteer Physician presents to the organization. When the situation does not permit verification to occur within 72 hours, there must be documentation explaining why primary verification was not completed, with evidence of the Physician's demonstrated abilities.

The medical staff is responsible for oversight of the volunteer Physician through direct observation, mentoring, and record review, when necessary. Based on preliminary information of the volunteer Physician's professional practice through observation, the VPMA or his designee makes a decision within 72 hours whether the disaster privileges initially granted are continued.

The Vice President of Medical Affairs may rely on telephone or electronic verification by the appropriate entity. When an emergency situation no longer exists, such Physician must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or in the event the Physician does not desire to request such privileges, the patient shall be referred by the Physician or, in the default thereof, by the Vice President of Medical Affairs, to another Physician who has been awarded appropriate privileges to provide the care required.

## **1.7 FULL REVIEW PROCESS**

### **1.7.1 DEPARTMENT AND DIVISION ACTION**

(a) Department Chairman: The Chairman of each Department in which the applicant seeks clinical privileges or rights to perform patient care services shall review the application and its supporting documentation and forward to the Credentials Committee a written report evaluating the applicant's training, experience, demonstrated ability, competence, and judgment. In connection with his report, the Department Chairman may make telephone calls to solicit additional information from the applicant's past practice settings. The Chairman may consult with the appropriate Division Chief on these matters prior to making a final recommendation. This report shall state the Department Chairman's recommendation as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services.

(b) Vice President – Patient Care Services: The application for all Advance Practice Nurses (CRNA, CRNP, CNM) is forwarded by the Chairman of the appropriate department to the Vice President – Patient Care Services. The Vice President – Patient Care Services reviews the application, support documentation, references and recommendation from the department chair, and will consult with the department chair if there are any areas of concern identified from the professional nursing practice perspective. The Vice President – Patient Care

Services then submits signature of approval and forwards to Credentials Committee for action.

(c) Alternative Process: If the Vice President of Medical Affairs, after approval of the Credentials Committee, considers it appropriate to use an outside consultant (i.e., one with no affiliations to the Hospital or its Medical Staff) as a replacement for the Department Chairman and/or Division Chief in the appointment process, the Vice President of Medical Affairs may do so.

### **1.7.2 CREDENTIALS COMMITTEE ACTION**

The Credentials Committee shall review the application, the supporting documentation, the reports from the Department Chairman and Division Chief or outside consultant (if any), and any other relevant information available to it. The Credentials Committee then shall transmit to the Medical Executive Committee the written report of the Credentials Committee and recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services. If the Credentials Committee requires further information about an applicant, it may defer transmitting its report, and it shall seek, from relevant sources, the required additional information.

### **1.7.3 MEDICAL EXECUTIVE COMMITTEE ACTION**

As soon after receipt of the Credentials Committee recommendation as is reasonably practical, the Medical Executive Committee may review the application, the supporting documentation, the reports and recommendations from the Department Chairman, Division Chief, outside consultant (if any), and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee shall either defer action on the application or prepare a written report with recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services.

### **1.7.4 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION**

(a) Deferral: Action by the Medical Executive Committee to defer an application for further consideration must be followed, as soon as is reasonably practical, by subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services.

(b) Favorable Recommendation: When the Medical Executive Committee's recommendation is favorable to the applicant as to approval of Medical Staff appointment, category of Staff appointment, Department and Division affiliation, and scope of clinical privileges or rights to perform patient care services, the Vice President of Medical Affairs shall promptly forward it, together with all supporting documentation to the Board, as requested. "All

supporting documentation” means the completed application packet and the reports and recommendations of the Department Chairman, Division Chief, outside consultant (if any), Credentials Committee, and Medical Executive Committee, including the existence of any dissenting views.

(c) Adverse Recommendation: When the Medical Executive Committee’s recommendation is adverse to the applicant as defined in Article IX of the Medical Staff Bylaws, the Vice President of Medical Affairs shall so inform the applicant by special notice, and the applicant shall then be entitled to the procedural rights as provided in the Corrective Action Procedures and Fair Hearing Plan.

### **1.7.5 BOARD ACTION**

On a Favorable Recommendation: The Board may adopt or reject in whole or in part a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Board is effective as its final decision. If, after a favorable recommendation of the Medical Executive Committee, the Board’s action is adverse to the applicant as defined in Article IX of the Medical Staff Bylaws, the Vice President of Medical Affairs shall promptly so inform the applicant by special notice, and he shall then be entitled to the procedural rights as provided in Article II of the Corrective Action Procedures and Fair Hearing Plan.

### **1.7.6 BASIS FOR RECOMMENDATIONS AND ACTIONS**

The report of each individual or group, including the Board, required to act on an application must state the reasons for each recommendation or action taken. The existence of any dissenting views at any point in the process must also be noted in the majority report.

### **1.7.7 CONFLICT RESOLUTION**

Whenever the Board determines that it will decide a matter contrary to the latest recommendation of the Medical Executive Committee, if any, the matter shall be resolved pursuant to the procedure outlined in Article VII of the Fair Hearing Plan regarding Appellate rights.

### **1.7.8 TELEMEDICINE PROCESS**

(a) The telemedicine organization shall provide the hospital with information regarding each telemedicine Physician’s credentials which shall include, at a minimum: the Physician’s full name, confirmation that the Physician holds a license issued or recognized by Pennsylvania, is certified by an appropriate board, has professional liability insurance coverage in required amounts, and is a participant in good standing with Medicare and other appropriate payers; a listing of the privileges granted to the Physician by the telemedicine entity; the results of any internal reviews of the Physician’s performance, such as the quality of the Physician’s radiology interpretations; and a summary of all criminal background checks.

(b) Upon receipt of the credentialing information provided by the telemedicine organization, the hospital shall query the National Physician Data Bank (and any other data source as may be required by applicable law) regarding each telemedicine Physician.

(c) The Vice President of Medical Affairs or his/her designee shall review the information received from the telemedicine organization, the NPDB, and any other data source, to confirm that it is complete and does not raise any concerns regarding the Physician's credentials.

(d) Upon such confirmation, the Vice President of Medical Affairs or his/her designee shall obtain the signed recommendations of the appropriate Department Chair, the Chair of the Credentials Committee, the President of the Medical Staff, or their respective designees.

(e) Upon receipt of these signed recommendations, and based upon the credentialing and privileging decisions made by the telemedicine entity, the Vice President of Medical Affairs or his/her designee shall obtain the signed approval by the President of the hospital, or his/her designee, as the authorized representative of the hospital Board.

(f) The President's signed approval shall be communicated to the telemedicine entity, as official notice that the telemedicine Physician has been appointed to the hospital medical staff and granted clinical privileges.

#### **1.7.9 NOTICE OF FINAL DECISION**

(a) The Vice President of Medical Affairs shall give the applicant written notice of the Board's final decision.

(b) A decision and notice to appoint shall include:

(i) the Staff category to which the applicant is appointed;

(ii) the Department and Division to which he is assigned;

(iii) the clinical privileges or rights to perform patient care services he may exercise; and

(iv) any special conditions attached to the appointment.



## **ARTICLE II. CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD**

### **2.1 SUCCESSFUL CONCLUSION**

#### **2.1.1 DEPARTMENT CHAIRMAN**

The applicable Department Chairman shall, at least thirty (30) days before the end of the Physician's provisional period, recommend whether the provisional period should be concluded by virtue of the Physician's demonstration of his qualifications for Medical Staff appointment, his ability to abide by the Medical Staff Bylaws and Rules and Regulations and the specific Rules and Regulations of any Department to which he is appointed or granted clinical privileges or rights to perform patient care services, and of his ability to exercise the clinical privileges or rights to perform patient care services granted. The Department Chairman shall forward his recommendation to the Credentials Committee.

#### **2.1.2 ACTION REQUIRED**

The Credentials Committee shall consider the recommendation of the Department Chairman and shall make a recommendation to the Medical Executive Committee, which shall in turn consider the recommendations of the Department Chairman and the Credentials Committee and make a recommendation to the Board. Final processing shall follow the procedures set forth in Section 1.7 of this Credentials Policy and Procedure Manual for the appointment process.

### **2.2 EXTENSION OF PROVISIONAL PERIOD**

If the Department Chairman is unable to recommend conclusion of a Physician's provisional period because the Physician's caseload at the Hospital was inadequate to demonstrate ability to exercise the privileges or rights granted to him or because the Physician failed to abide by the Medical Staff Bylaws and Rules and Regulations and/or the specific Rules and Regulations of any Department to which he is appointed or granted clinical privileges or rights to perform patient care services, and the Physician submits to the Credentials Committee a statement to this effect describing his case load and signed by the applicable Department Chairman, the Physician's provisional period may be extended for one (1) additional year by approval of the Credentials Committee, the Medical Executive Committee, and the Board. Only one (1) such extension is permissible. Failure to complete successfully the provisional appointment will result in a forfeiture of the Physician's Staff appointment, clinical privileges, or rights to perform patient care services in the Hospital.

### **2.3 SHORTENED PROVISIONAL PERIOD**

If a Physician wishes to end his provisional period in less than one (1) year, he may request the applicable Department Chairman to submit the required documentation to the Credentials Committee after a six (6) month period. No provisional period will be for a period shorter than six (6) months.

## **ARTICLE III. REAPPOINTMENT PROCEDURES**

### **3.1 INFORMATION COLLECTED AND VERIFICATION**

#### **3.1.1 FROM PHYSICIANS**

At least three (3) months before the expiration of a Medical Staff appointment, the Vice President of Medical Affairs or designee shall notify each Physician of the date of expiration and provide him with a form seeking information for reappointment. At least sixty (60) days before the expiration of his appointment (unless the Medical Executive Committee grants an extension of no more than thirty (30) days), each Physician shall complete the reappointment form and furnish at least the following:

- (a) complete information to update the Physician's credentials file on items listed in his original application;
- (b) proof of continuing training and education external to the Hospital during the preceding period and in accordance with all requirements mandated by the applicable licensing board;
- (c) specific requests for clinical privileges or rights to perform patient care services sought on reappointment, with any basis for requested changes;
- (d) any requests for changes in staff category or Department or Division assignment; and
- (e) The names and locations of any other hospital, clinic, or health care institution or organization where the Physician provides or provided clinical services, with the inclusive dates of each application.

Failure, without good cause, to provide this information shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of appointment at the expiration of the term, without any procedural rights. Appointees of the Honorary and Executive category are exempted from the requirement of completing reappointment forms. The Vice President of Medical Affairs shall verify the additional information provided, and shall notify the Physician of any information inadequacies or verification problems. The Physician then has the burden of producing adequate information and resolving any doubts about the data.

#### **3.1.2 FROM INTERNAL AND EXTERNAL SOURCES**

The Vice President of Medical Affairs also shall collect from the Physician's credentials file and other relevant sources information regarding the Physician's professional and collegial activities and performance and conduct in the Hospital and at any other hospital, clinic, or health care institution or organization where the Physician provides or provided clinical services. Such information shall include but not be limited to patterns of care as demonstrated in findings of quality assurance activities; continuing education activities; attendance at required

Medical Staff and Department meetings; service on Medical Staff, Department, and Hospital committees; timely and accurate completion of medical records; and compliance with the Medical Staff Bylaws, Rules, and Regulations, and accompanying manuals, and all other standards, policies, and rules of the Medical Staff and the Hospital.

### **3.1.3 OTHER INFORMATION**

The Vice President of Medical Affairs also shall collect any other information required by applicable state or federal law or regulations -- e.g., National Physician Data Bank reports or confirmation of the Office of Inspector General Cumulative Sanctions List.

At the time of reappointment or at any other time during any period of appointment, the Vice President of Medical Affairs may require that a criminal background report be performed if deemed to be reasonably necessary based upon the circumstances. If any of the following are discovered, the Physician may be ineligible for reappointment to the Medical Staff, and may be subject to removal from the Medical Staff.

(a) any conviction of, or plea of guilty or no contest to, or received probation without verdict, disposition in lieu of trial or an Accelerated Rehabilitative Disposition in the disposition of, any felon charge, or any misdemeanor charge related to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence, or moral turpitude.

### **3.1.4 ASSIGNMENT OF REVIEW PROCESS**

Upon collection and verification of all relevant information regarding an applicant for reappointment, the Vice President of Medical Affairs, the relevant Department Chairman and the Chairman of the Credentials Committee (following review of the applicant by the full Credentials Committee), or, in the event of the unavailability of any of them, their designees, shall complete a full review of all pertinent information.

## **3.2 REVIEW PROCESS**

### **3.2.1 DEPARTMENT ACTION**

Each Chairman of a Department in which the Physician requests or has exercised privileges or rights to perform patient care services, and the Vice President – Patient Care Services (for advance practice nurses) shall review the Physician’s credentials file and forward to the Credentials Committee a written report of the Physician’s performance, including a statement as to whether or not he knows of, or has observed or been informed of, any conduct which indicates significant problems (physical or behavioral) affecting the Physician’s ability to perform his professional and Medical Staff duties appropriately, and with recommendations for reappointment or non-reappointment to the Medical Staff, and for Staff category, Department and Division assignment, and clinical privileges or rights to perform patient care services.

### **3.2.2 FURTHER ACTION REQUIRED**

The Credentials Committee shall consider the recommendation of the Department Chairman and the Vice Present – Patient Care Services shall make a recommendation to the Medical Executive Committee, which in turn shall consider the recommendations of the Department Chairman and the Credentials Committee and make a recommendation to the Board. Final processing shall follow the procedures set forth in Sections 1.7.4 through 1.7.8 of this Credentials Policy and Procedure Manual for the appointment process.

### **3.3 REQUEST FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES**

A Physician, either in connection with reappointment or at any other time, may request modification of his Staff category, Department or Division assignment, or clinical privileges or rights to perform patient care services by submitting a written request to the appropriate Department Chairman. A request for such a modification shall be processed according to the procedures set forth in Sections 3.2 and 3.3 above.

## **ARTICLE IV. LEAVE OF ABSENCE**

### **4.1 VOLUNTARY LEAVE**

A Physician may request a leave of absence by submitting written notice to the Vice President of Medical Affairs (VPMA) for transmittal to the President of the Medical Staff, the appropriate Department Chairman, and the Board. The notice must state the approximate period of time of the leave, which may not exceed one (1) year, except for military service. In response to requests for leave of absence, the VPMA or the President of the Medical Staff will render a determination within 30 days of receipt of the written request, assuming that any clarifying information is also available. During the leave, all of the Physician's clinical privileges, prerogatives and responsibilities are suspended. Unless for military purposes, leaves of absence exceeding one (1) year will be considered resignations from the Medical Staff.

#### **4.1.1 CATEGORIES OF LEAVE**

- (a) Medical Leave: A medical leave of absence may be requested when medically supported. It is incumbent for requests for medical leave to be submitted with the appropriate documentation. Independent medical evaluations may be required before the leave is granted. Before reinstating privileges, the Physician must provide documentation of health status to justify reinstatement of privileges.
- (b) Educational Leave: An educational leave of absence may be requested, when accompanied with sufficient verification of the education and attendance being pursued.
- (c) Personal Leave: A personal leave of absence may be granted, as long as the Physician is not actively engaged in medical practice in the hospital service area

- (d) **Military Leave:** A military leave may be requested when a provider is called to active military duty for a period of time consistent with the assignment. A copy of the military orders should be submitted with the request.

#### **4.1.2 DENIAL OF LEAVE**

In the event that a Physician has not demonstrated sufficient cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing or appeal.

#### **4.1.3 TERMINATION OF LEAVE**

A Physician must, at least forty-five (45) days before the termination of his leave, or may at any earlier time, request reinstatement by sending a written request for reinstatement to the Vice President of Medical Affairs. The Physician must submit a written summary of relevant activities during the leave, if the Medical Executive Committee or Board so requests. The Physician must demonstrate that he is qualified for Medical Staff appointment and for the category of Staff appointment, Department and Division affiliation, and clinical privileges or rights to perform patient care services that he is requesting.

For the safety of the patients at York Hospital, proctoring, mentoring or other educational support may be required with reinstatement of privileges after a leave of absence for six (6) months or more. Department Chairmen will be responsible for identifying requirements when providers return from leave. The Medical Executive Committee shall make a recommendation to the Board concerning reinstatement, and further action on the request for reinstatement shall follow the procedures set forth in Section 1.7 of the Credentials Policy and Procedure Manual for the appointment process.

### **ARTICLE V. GAPS IN CLINICAL ACTIVITY**

#### **5.1 ABSENCE FROM CLINICAL ACTIVITY**

##### **5.1.1 REQUEST**

A Physician may request privileges at the time of initial credentialing or re-credentialing following an absence from clinical activity for greater than 90 days.

### **5.1.2 RESPONSIBILITIES**

Prior to the credentialing meeting, it will be the responsibility of the Department Chairperson to develop and present to the Credentials Committee a re-integration plan to address the gap in clinical activity. The plan will offer resources for a safe return to active clinical practice at York Hospital. The plan will include:

- Clarification of the actual time of the gap in clinical activity;
- All of the provider's pertinent efforts to remain current with clinical activity during the gap;
- A detailed plan to re-integrate the provider to clinical activity, to include but not be limited to specific requirements for education, supervision, proctoring, mentoring, and/or peer review.

At the conclusion of the re-integration, the Department Chairperson shall provide a report to the Credentials Committee certifying that the Physician has successfully completed the re-integration. If the Physician is not successfully re-integrating, the Department Chairperson must take steps to ensure patient safety and must notify the Credentials Committee if the Physician's privileges should be modified. Documentation of the re-integration plan should be available in the Department Chairperson's files, if requested.

## **ARTICLE VI. REQUEST FOR REDUCTION OF RESPONSIBILITIES**

### **6.1. INSTIGATION**

A Physician may request a reduction of responsibilities (as listed in Article IV of the Medical Staff Bylaws) by submitting written notice to the Vice President of Medical Affairs (VPMA) for transmittal to the President of the Medical Staff, the appropriate Department Chairman, and the Board. The notice must state the approximate period for the reduction of responsibilities. Except in rare circumstances, the reduction of responsibilities shall be no longer than 6 months. Unless urgent in nature, the VPMA or the President of the Medical Staff will render a determination within 30 days of receipt of the written request, assuming that any clarifying information is also available. All responsibilities will remain in place until a determination is made. Assessment by means of an independent medical examination may be required before a determination is made. Special determinations may occur that apply to the Americans with Disabilities Act (ADA).

Requests to extend the reduction of responsibilities must be made in writing at least forty-five (45) days before normal responsibilities are to resume, or at any earlier time, may request resumption of full responsibilities by sending a written request for reinstatement to the Vice President of Medical Affairs. Assessment by an independent medical examination can be required before an extension is given.

The Medical Executive Committee shall make a recommendation to the Board concerning reductions in responsibilities. Proctoring, mentoring or other educational support may be required when responsibilities are resumed.

## **ARTICLE VII. RESIGNATIONS**

### **7.1 NOTIFICATION**

A Physician who chooses to resign from the Medical Staff must submit a signed letter of resignation to the Vice President of Medical Affairs. The letter must contain the effective date of the resignation.

## **ARTICLE VIII. PROFESSIONAL SERVICES PROVIDED PURSUANT TO CONTRACT**

### **8.1 QUALIFICATIONS**

A Physician who is or will be exercising clinical privileges or who has or will have rights to perform patient care services pursuant to a contract with the Hospital must meet the same qualifications, must be processed for appointment, reappointment, and clinical privileges or rights to perform patient care services in the same manner, and must fulfill all the obligations of his appointment category, as any other Physician.

### **8.2 EFFECT OF CONTRACT**

A contract may restrict right of access to Hospital equipment, facilities, and personnel exclusively to contracting Physicians; provided, however, that for contracts initially entered into after the effective date of the Medical Staff Bylaws:

(a) the contract was not initially entered into without consultation with the Medical Executive Committee as to the reasons for and alternatives to the arrangement; and

(b) any Physician whose existing privileges or rights would be affected by the Hospital's initial entry into the contract was given and a reasonable opportunity to become a party in the initial contract.

### **8.3 BOARD ACTION**

In the event the provisions of Section 6.2 of this Credentials Policy and Procedure Manual are followed and a Physician's existing privileges or rights are adversely affected by the Hospital's initial entry into a contract, such event shall be deemed adverse pursuant to Article IX of the Medical Staff Bylaws, and the Physician shall be entitled to a hearing and an appellate review as provided in Article II and Article VIII of the Corrective Action Procedures and Fair Hearing Plan.

## **ARTICLE IX. ADOPTION AND AMENDMENT**

### **9.1 AMENDMENT**

This Credentials Policy and Procedural Manual may be amended or repealed, in whole or in part, as provided by Sections 12.2.2 of the Medical Staff Bylaws.

## **9.2 ADOPTION**

### **9.2.1 MEDICAL STAFF**

The foregoing Credentials Policy and Procedure Manual was adopted and recommended to the Board by the Medical Staff in accordance with and subject to the Medical Staff Bylaws.

\_\_\_\_\_  
PRESIDENT OF THE MEDICAL STAFF

\_\_\_\_\_  
DATE

### **9.2.2 BOARD**

The foregoing Credentials Policy and Procedure Manual was approved and adopted by resolution of the Board after considering the Medical Staff's recommendation.

\_\_\_\_\_  
CHAIRMAN OF THE BOARD OF DIRECTORS

\_\_\_\_\_  
DATE

Including amendments adopted:

4/27/89;7/26/90;4/25/91;3/30/93;3/29/94;6/28/95;5/28/96;6/25/96;8/25/99;7/27/01;5/02;10/02;7/04;  
12/06; 11/07; 2/28/08;3/26/08; 2/25/09;11/25/09; 1/25/2012, 1/8/16/, 5/17