

Bylaws Adopted 11/5/13



# **Bylaws of the Medical Staff**



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## **PREAMBLE**

WHEREAS, Marion Community Hospital, Inc. is a Corporation organized under the laws of the State of Florida; and

WHEREAS, its purpose is to serve as a general hospital providing high quality patient care, in an economical manner; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Board of Trustees and that, the cooperative efforts of the Medical Staff, the Chief Executive Officer, and the Board of Trustees are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians practicing in these departmentalized hospitals hereby organize themselves into a Medical Staff in conformity with these Bylaws.

WHEREAS, these Bylaws of the Medical Staff and Rules and Regulations are reviewed as required by State law and applicable regulatory agencies. Following any significant changes to these Bylaws and Rules and Regulations, members of the Medical Staff will be provided with a revised version.

## 1. ARTICLE ONE: DEFINITIONS/CONSTRUCTION OF TERMS AND HEADINGS

### 1.1. DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO), and Chief Medical Officer (CMO) .

Administrator: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An action that adversely affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Bylaws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

Advanced Practice Professional (APP): An individual, other than those defined under "Practitioner," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP).

Applicant: An individual who has submitted a Complete Application for appointment, reappointment or clinical privileges.

Board Certification or Board Certified: A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty and has maintained certification through retesting and completion of other maintenance of certification requirements. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from a Member Board of Certification of the Bureau of Osteopathic Specialists or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon. ABMS is the umbrella organization for the 24 approved medical specialty boards in the United States. Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements. The Bureau of Osteopathic Specialists was organized in 1939 as the Advisory Board for Osteopathic Specialists to meet the needs resulting from the growth of specialization in the osteopathic profession. There are currently 18 AOA certifying boards. Each is titled, "American Osteopathic Board of (Specialty)." Podiatrists are certified through the American Board of Podiatric Surgery (ABPS) and oral surgeons are certified through the American Board of Oral/Maxillofacial Surgeons (ABOMS).

Board Certification Candidate: A Practitioner who has successfully completed a residency or fellowship program for the Practitioner's specialty within the last five years. Any applicant outside the five year period and who is able to provide proof that he/she has applied for and been accepted to take the exam for certification, or has successfully completed the written portion of the exam and is a current candidate to take an oral portion of the testing, or submit cases for review, or otherwise complete the certification requirements. A Practitioner shall no longer be deemed a Board Certification Candidate if the five year time limit has been exceeded without successful completion of Board Certification, or the Practitioner has exhausted the permitted number of attempts at the exam without

success. Acceptable certification boards are defined under “Board Certification” in this section of the Bylaws. Maintaining Board Certification is required effective January 1, 2012. Any practitioner credentialed prior to January 1, 2012 is grandfathered in and therefore not required to maintain Board Certification. Any practitioner who joined the medical staff between January 1, 2007 and December 31, 2011, shall remain on provisional staff for a maximum of 5 years if he/she has not become Board Certified and/or can’t provide proof that he/she has applied for and been accepted to take the exam for certification. Clarifications below:

- At initial appointment, the applicant who has completed his education within the last 5 years and who meets the above definition of a Board Certification Candidate, shall remain on provisional staff for a maximum of 5 years. If he/she has not achieved Board Certification at the completion of their first 5 years, he/she will no longer be eligible for medical staff membership.
- If at initial appointment, the applicant has allowed his/her Board Certification to lapse and is able to provide proof that he/she has applied for and been accepted to take the exam for certification, he/she shall be granted provisional staff privileges for a maximum of two years. If he/she has not achieved Board Certification at the completion of their provisional 2 years, he/she will no longer be eligible for medical staff membership.
- Any applicant who has been out of Residency/Fellowship 5 years or longer, and cannot show proof that he/she has applied for and been accepted to take the exam for certification, is considered not eligible for privileges.
- Maintaining Board Certification; any provider initially credentialed on or after January 1, 2012, must maintain Board Certification. If at re-appointment a provider has allowed their certification to lapse, he/she will be placed in a provisional status for 2 years. If at the end of the 2 year provisional appointment period the provider has not obtained Board Certification, he/she will no longer be eligible for medical staff membership.

Board of Directors: The governing body of the Corporation, herein referred to as the “Directors” unless otherwise specifically stated.

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. The term may also refer to a committee of the Board of Trustees that has been delegated specific governance duties and authority. It is the “governing body” as described in the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the “Trustees” or the “Board” unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

Chief of Staff/President/President of the Medical Staff: A member of the active Medical Staff who is elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital. The Chief of Staff shall be a doctor of medicine or osteopathy.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes

supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement with the Hospital.

Corporate Management: The officers of the Corporation with authority and responsibility for the Hospital.

Corporation: The legal owner of the Hospitals, Marion Community Hospitals Inc., d.b.a. Ocala Regional Medical Center & West Marion Community Hospital.

CPCS: The Clinical Patient Care System, used to electronically document patient care.

Criminal Action: Conviction of, or a plea of guilty or *nolo contendere* for, any felony or misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid or insurance or health care fraud or abuse; or (iv) violence against another. .

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospitals to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with a scope of service as defined by the Hospitals and approved by the Medical Staff.

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Executive Committee/Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Ex Officio: Service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the MEC and Board and incorporated into these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

Good Standing: The term "good standing" means a staff member who, during the current term of appointment, has maintained all qualifications for Medical Staff membership, assigned staff category, and been granted clinical privileges granted to the individual, and has met, on-call and other participation requirements, and has not received a limitation, suspension or restriction of Medical Staff membership or privileges.

Governing Body: The Board of Trustees of the Hospital or a committee of the Board of Trustees, which has been delegated specific authority and responsibility, and appointed by the Board of Directors.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.A §11101 et seq.

**Healthcare Professional:** An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

**Hospitals:** Ocala Regional Medical Center at 1431 SW First Avenue, Ocala, FL 34474 and West Marion Community Hospitals at 4600 SW 46<sup>th</sup> Court, Ocala, FL 34474. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

**Independent Healthcare Professional:** An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.

**Ineligible Person:** Any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list. **License:** An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

**License Status:** Indicates the status of the practitioner's license, which is issued by the State licensure board. The categories defined by the State board are:

- active—full and unrestricted license to practice
- inactive—practitioner is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits practice
- restricted—board imposed limitation on practice

**Licensed Independent Practitioner (LIP):** An individual who is permitted by both the applicable state law(s) and by the Hospitals to provide patient care services without direction or supervision, without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospitals to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

**Licensure:** A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.

**Medical Staff:** The medical staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM). The Medical Staff is an integral part of the Hospitals and is not a separate legal entity.

**Medical Staff Services :** The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Office is accountable to Administration. The documents maintained by the Medical Staff Office are the property of the Hospital.

**Medical Staff. Organized:** The Organized Medical Staff is the body of those individuals who, as a group, are responsible for establishing the bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members and have therefore been granted the rights to vote, to be a Member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

Medical Staff Year: The period from January 1 to December 31 of each year.

Medico-Administrative Practitioner: A Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction.

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

Membership: The approval granted by the Board to a qualified Practitioner to be a member of the Medical Staff of the Hospital.

Non-Privileged Practitioner: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Oral and Maxillofacial Surgeon, Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Advanced Practice Professionals, written procedures for peer review are part of these Bylaws.

Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. [42 U.S.C. §1395x]

Podiatrist: A doctor of podiatric medicine legally authorized to practice podiatry by the State in which he performs such function or action.

Practitioner/Licensed Independent Practitioner (LIP): Individuals who provide direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), and podiatrists (DPM).

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment, individual character and performance. . Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Qualified Medical Person or Personnel: In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals in the following professional categories who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Psychiatrist, Physician Assistant in the

Emergency Department, Advanced Registered Nurse Practitioner in the Emergency Department, Certified Registered Nurse Midwife, and Competency Validated Labor/Delivery RN.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments and Divisions as approved by the MEC and Board of Trustees.

Sexual Harassment: Unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions, or verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment.

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Florida.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

Unprofessional or Inappropriate Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

## 1.2. CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

## 2. ARTICLE TWO: NAME, PURPOSES & RESPONSIBILITIES

### 2.1. NAME

The name of the Medical Staff shall be the "Medical Staff of Marion Community Hospital, Inc., d.b.a. Ocala Regional Medical Center and West Marion Community Hospital."

### 2.2. PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the Medical Staff are:

- 2.2.1. To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff.
- 2.2.2. To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;
- 2.2.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospitals.

- 2.2.4. To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospitals with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.
  - 2.2.5. To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.
  - 2.2.6. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
  - 2.2.7. To adopt Rules and Regulations for the proper functioning of the Staff, and the integration and coordination of the Staff with the functions of the Hospitals;
  - 2.2.8. To provide a means for communication and conflict management with regard to issues of mutual concern to the Staff, Administration, and Board;
  - 2.2.9. To participate in identifying community health needs and establishing appropriate institutional goals;
  - 2.2.10. To assist the Board by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.
  - 2.2.11. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.
  - 2.2.12. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospitals policies.
  - 2.2.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.
- 2.3.1 The Hospital is owned by the Corporation. The Corporation retains all authority and control over the business, policies, operations, and assets of the Hospital via the Board of Directors. The Board of Directors is elected by the shareholders of the Corporation. The Board of Directors retains ultimate responsibility for the Hospital's compliance with all applicable Federal, State, and local laws and regulations. The Board of Directors has delegated certain duties to the Corporation's Officers and to the Board of Trustees. The rights and duties delegated to the Board of Trustees, acting in its capacity as the authorized agent of the Corporation and the governing body of the Hospital are described in these Bylaws.
- 2.3.2 The Board of Directors has appointed the Board of Trustees to assist and advise the CEO, the Corporation, the Board of Directors, and the Medical Staff. The primary function of the Board of Trustees shall be to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For this purpose, the Board of Directors has delegated to the Board of Trustees the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions in compliance with the corporation's policies regarding Medical Staff appointments, reappointments, and the granting of clinical privileges, to oversee performance improvement, utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish policies regarding such matters. All officers, Medical Staff Members, advance practice professionals, employees, non-employees who provide patient care under an approved scope of practice, and other agents of the hospital are subject to the control, direction and removal by the Board of Trustees. All practitioners are subject to

appointment, termination or modification of their medical staff membership and or clinical privileges by the board of trustees, based on factors deemed relevant by the Board of Trustees.

2.3.3 In a manner mutually agreeable to the Corporation and the Board of Trustees, the Board of Trustees shall report any matters of concern to the Corporation. Any such matters that are within the scope of duties of the Board of Trustees, but exceed the scope of their authority, such as issues related to financial management, can be referred back to the Corporation and the Board of Directors.

2.3.4 The Board of Directors, through its officers and the CEO, retains authority for the Hospital's business decisions, adherence to HCA Ethics and Compliance Policies, and financial management, including long-range and short-range planning and budgeting, but may request the advice of the Board of Trustees on such matters. The Board of Directors expressly reserves the right to amend, modify, rescind, clarify, or terminate at any time and without notice any delegation of authority given to the Board of Trustees and, if deemed necessary by the Board of Directors, to overrule decisions made by the Board of Trustees.

## 2.4 NATURE OF APPOINTMENT

No practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been appointed to the Medical Staff or has been granted clinical privileges, or temporary privileges pursuant to these Bylaws. Appointment to the Medical Staff shall confer upon the Medical Staff member a privilege in the nature of a license to exercise only such clinical privileges within the Hospital as are specifically granted by the Board of Trustees in accordance with these Medical Staff Bylaws. The requirements and procedures for appointment and reappointment to the Medical Staff and granting of clinical privileges are set forth in these Bylaws. A Medical Staff appointee or Practitioner with clinical privileges is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff member or Practitioner with clinical privileges. In the event of any conflict between the language of these Medical Staff Bylaws, Medical Staff Rules and Regulations, or Medical Staff policies and a specific contract between the Hospital and a Medical Staff member or Practitioner with clinical privileges, the language of the contract shall control.

## 2.5 ORGANIZED HEALTH CARE ARRANGEMENT; HIPAA COMPLIANCE.

2.5.1 The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives and Dependent Healthcare Professionals. Each Medical Staff member, each Physician with temporary privileges, Advanced Practice Professional with clinical privileges or practice prerogatives and Dependent Healthcare Professional agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

## 3 ARTICLE THREE: APPOINTMENT/REAPPOINTMENT

### 3.1 NATURE OF MEMBERSHIP AND GENERAL QUALIFICATIONS

To be eligible to apply for initial appointment of reappointment to the Medical Staff, or to apply for clinical privileges, a Practitioner must be a physician, dentist or oral maxillofacial surgeon, podiatrist, optometrist, advanced practice registered nurse, physician assistant and:

3.1.1 The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospitals to provide patient care independently within the Hospitals, and whom the Board appoints. Staff membership is a privilege extended by the Hospitals, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws Patients may be admitted to the Hospital only on the orders of a Physician, All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.

3.1.1.1 Patients admitted by licensed independent practitioners who are not physicians (**i.e., DDS, DMD, DPM, etc.) eligible for admitting privileges if allowed by State laws and if approved by the Board of Trustees**], shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.

- No person shall admit patients or provide services to Hospitals patients as a Practitioner or AHP unless he/she is appointed to the Staff or has been granted clinical privileges in accordance with the provisions outlined in these Bylaws.
- Appointment to the Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board based on their approval of the individual's Staff category or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" the Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board has determined the categories of healthcare professionals eligible for Staff membership and/or clinical privileges, as defined in these Bylaws. The Hospital-specific mechanism for appointment, reappointment, and for granting, renewing, or revising clinical privileges is fully documented in these Bylaws, and has been approved and implemented by the Medical Staff and the Board. All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations. Only those individuals possessing all of the following qualifications shall be eligible for appointment to the Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:

3.1.2 LICENSURE

Have proof of identity and either US Citizenship or evidence of status as a lawful permanent resident of the US; and,

- 3.1.2.1 Have a current, unlimited, unrestricted, active legal license to practice in his or her respective profession in Florida, which license permits him or her to practice in the Hospital setting and authorizes him or her to receive and examine patients, diagnose conditions and prescribe and implement a treatment plan and to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, independent of review, supervision or prescription by another Practitioner, and have never had a license to practice revoked or suspended by any state licensing agency, or in the case of an APP, to practice within the full scope of licensure with any supervision as may be required by law; and
- 3.1.2.2 If the applicant is an active duty military Practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, the current, unlimited, unrestricted, active licensure from any State shall be accepted.

### 3.1.3 CONTROLLED SUBSTANCE REGISTRATION

- To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration with the applicant's in-state address for the State of **Florida**. If the applicant is an active duty military practitioner, and will be prescribing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then DEA registration with an address from any State shall be accepted. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA and may be further limited by the Medical Staff through the delineation of medication prescribing privileges **based** on the scope of practice and current competence of the applicant.

### 3.1.4 PROFESSIONAL EDUCATION AND TRAINING

- The applicant must have graduated from a School of Medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic medicine, or a School of Dentistry accredited by the Commission on Accreditation of the American Dental Association, or a School of Podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or school appropriate to their profession.
- If the applicant is a physician who is a graduate of a foreign medical school, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school.
- An applicant Practitioner must also have successfully completed a residency program that is accredited by the Accreditation Council for Graduate medical Education (ACGME) for allopathic physicians or AOA for osteopathic physicians, or that is accredited by the American Dental Association for dentists, or that is accredited by the Council on Podiatric Medical Education for podiatrists, and the residency must be in the field of specialty for which the Practitioner requests clinical privileges, the applicant shall document his/her participation in continuing education as related to the clinical privileges requested. Participating in continuing education shall be considered when making decisions about clinical privileges.

### 3.1.5 CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

- The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the Hospitals.
- Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).

### 3.1.6 BOARD CERTIFICATION

An applicant Practitioner shall demonstrate current Board Certification by a Hospital-accepted specialty Board or provide proof of being a Board Certification Candidate as defined in these Bylaws." Physician specialty board certification programs accepted by the Hospital are those of the approved Member Boards of American Board of Medical Specialties (ABMS), or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the

American Board of Podiatric Surgery (ABPS) and for dentists the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS).

### 3.1.7 CONDUCT/BEHAVIOR

- The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospitals with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations.
- In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Division and Department Chairperson(s).

### 3.1.8 PROFESSIONAL ETHICS AND CHARACTER

- By virtue of applying for medical staff membership or clinical privileges, and agreeing to abide by the medical staff bylaws, the applicant shall be bound to adherence to the code of ethics of his/her professional discipline (e.g., the Principles of Medical Ethics of the American Medical Association, the American Osteopathic Association, the Code of Ethics of the American Dental Association, the Code of Ethics of the American Podiatry Association, or the ethical standards governing the applicant's practice if it is not listed).
- The applicant shall also agree to abide by the Code of Conduct of HCA, and the code of ethical business and professional behavior of these Hospitals.

### 3.1.9 HEALTH STATUS/ABILITY TO PERFORM

- The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental health issues that adversely affects his/her ability to practice within the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff will meet with the applicant to determine the extent of the health issue. If it is determined that the health issue does not adversely affect the applicant's ability to perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to perform such functions. If reasonable accommodation is necessary, the Hospitals will provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospitals.

### 3.1.10 COMMUNICATION SKILLS

- The applicant shall possess an ability to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospitals), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

### 3.1.11 PROFESSIONAL LIABILITY INSURANCE

The Credentials Committee will conduct initial review to assure the applicant complies with all conditions set forth in these Bylaws. The Credentials Committee will make their recommendation to the Medical Executive Committee who will forward their recommendation to the Board of Trustees for final approval.

As a continuing condition of hospital staff privileges, the physician shall be required to establish financial responsibility by one of the following methods:

- (a) Establish and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with Florida State statute 625.52 in the per claim amounts specified.
- (b) Obtain and maintain professional liability insurance in accordance with Florida State Statute 458.320.
- (c) Obtain and maintain an un-expired irrevocable letter of credit in accordance with Florida State Statute 458.320.

An applicant that does not meet any of the above stipulations will be considered if they meet all of the following criteria:

- (a) The physician has shown a good faith effort to obtain professional liability coverage through one of the established options above (a,b,c).
- (b) The hospitals would not be able to continue to render quality patient care without granting this physician privileges.

#### 3.1.12 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person as defined in these bylaws, during the term of an appointment or granting of clinical privileges.

### 3.2 HOSPITAL NEED AND ABILITY TO ACCOMMODATE

No person shall be appointed to the Staff or shall be granted clinical privileges if the Hospitals are unable to provide adequate facilities and support services for the applicant or his/her patients. The Board may decline to accept, or have the Staff review requests for Staff membership and/or particular clinical privileges in connection with appointment, reappointment or otherwise on the basis of the following:

#### 3.2.1 AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, capabilities, and business plan of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.

#### 3.2.2 EXCLUSIVE CONTRACTS

The Board may determine, in the interests of quality of patient care and as a matter of policy, that certain Hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the Hospital and qualified Practitioners.

#### 3.2.3 MEDICAL STAFF DEVELOPMENT PLAN

The Board may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.

#### 3.2.4 EFFECTS OF DECLINATION

Refusal to accept or review requests for Staff membership or clinical privileges based upon Hospital need and ability to accommodate, as described in this section, shall not constitute a denial of Staff membership or clinical privileges and shall not entitle the individual to any procedural rights of hearing or appeal. Any portion of the application which is accepted (e.g., requests for clinical privileges that are not subject to a limitation) shall be processed in accord with these Bylaws.

### 3.3 EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a member of any

professional organization, is certified by any board, or has/had staff membership or clinical privileges in another hospital or health care organization.

#### 3.4 NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, race, religion, creed, color, sexual orientation, gender identify/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national origin or ethnic origin..

#### 3.5 BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

- 3.5.1 Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;
- 3.5.2 Provide continuous care to his/her patients at the generally recognized professional level of quality and efficiency established by the Hospitals; delegate in his/her absence, the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospitals to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;
- 3.5.3 Abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospitals;
- 3.5.4 Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 3.5.5 Regularly attend meetings of the Medical Staff unless excused.
- 3.5.6 Discharge such Medical Staff, Department, committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff;
- 3.5.7 Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient, and prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospitals;
- 3.5.8 Cooperate with the Hospitals in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
- 3.5.9 Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
- 3.5.10 Participate in continuing education to maintain clinical skills and current competence.
- 3.5.11 Notify and update the Medical Staff and Hospitals immediately(immediately is defined as within one business day) upon a change in any qualifications for membership or clinical privileges, as listed in Article Three of these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges (including but not limited to becoming an Ineligible Person);
- 3.5.12 Agree that the Hospitals may obtain an evaluation of the applicant's performance by a consultant selected by the Hospitals if the Hospital considers it appropriate; and,
- 3.5.13 Perform such other responsibilities as the Hospitals or the Medical Staff may require.
- 3.5.14 Basic Obligations- By submitting an RFC the Practitioner shall agree to refrain from illegal fee splitting or other illegal inducements relating to patient referral.

- 3.5.15 Refrain from deceiving patients as to the identity of any individual providing treatment or services.
- 3.5.16 Promptly pay any applicable dues, assessments, and or fines.
- 3.5.17 Complete the Hospital's new physician orientation within a timeframe defined by the Hospital.
- 3.5.18 Agree that, if there is any misstatement in, or omission from, the Request for Consideration, Recredentialing Request for Consideration or application, the Hospital may stop processing (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board of Trustees whether the application should be processed further. In either situation, there shall be no entitlement to a hearing or appeal.

### 3.6 TERMS OF APPOINTMENT

Terms of membership and/or the granting of clinical privileges shall be for a period that may be less than, but shall not exceed two years (24 months). In the event that reappointment has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual will be considered to have been voluntarily surrendered. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit a new application if continued membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

### 3.7 CREDENTIALS VERIFICATION

#### 3.7.1 APPLICATION

- A separate credentials file shall be maintained for each potential applicant for Staff membership or clinical privileges.
- Each Request for Consideration (RFC) or Recredentialing Request for Consideration (R-RFC) for Staff appointment, reappointment, and/or clinical privileges shall be in a prescribed format, and signed by the applicant.
- Requests for consideration for credentialing may be provided to residents or fellows who are in the final six months of their training. Such RFCs may be processed, but final action shall not be taken until all applicable criteria are satisfied.
- When an individual seeks to apply for initial appointment or is initially requesting clinical privileges, he/she shall be asked to complete a RFC. When a completed RFC is received, the information shall be verified by a HCA Credentials Processing Center (CPC) to determine whether the individual is eligible to apply.
- Prior to expiration of the current term of membership or clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual should be sent a notice of the impending expiration and asked to complete a R-RFC. When a completed R-RFC is received, the information shall be verified by a HCA Credentials Processing Center (CPC) to determine whether the individual is eligible to reapply. TO PROVIDE A COMPLETE APPLICATION
- The potential applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to the HCA CREDENTIALS PROCESSING CENTER BY SUCH SOURCES. THE HCA Credentials Processing Center (CPC) shall not have any obligation to process any RFC or R-RFC unless it is complete, as defined by CPC policies, and after a time

limit defined in CPC policies, determine that there has been failure to comply and end efforts to process the RFC or R-RFC. Only after a completed RFC or R-RFC has been received and all information verified as specified by CPC policies, and the individual has been deemed eligible to apply, shall the CPC submit the information to the Hospital as an application. The Hospital shall analyze the information and determine whether additional information or investigation is needed to resolve any doubts, concerns, or gaps in the information.

- Individuals seeking appointment, reappointment and or clinical privileges have the burden of providing evidence that all statements made and information given on the RFC or RRFC are accurate and complete.
- The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Hospitals or the Medical Staff or any committee or representative thereof, determines that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or the interview is conducted.
- Any Medical Staff committee or the Board may request that the applicant appear for an interview with regard to the application.
- The Medical Staff Office shall notify the applicant by special notice of the specific information being requested, the time frame within which a response is required, and the effect on the application if the information is not received timely.
- Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. Failure to provide a complete application or failure to appear for any requested interview shall be deemed a voluntary withdrawal from the application process.
- Voluntary withdrawal from the application process shall not be considered an adverse action, and shall not entitle the applicant to exercise procedural rights outlined in these Bylaws in the event of such withdrawal.
- Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- The completed application shall include, without limitation:
  - 3.7.1.1 Identifying information, including name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background, Verification of identify may be performed by a current licensed notary public and documented with a notarized statement, or verification may be performed by the staff of Medical Staff Services provided that the applicant physically presents himself/herself for the verification process before the application may be considered complete.
  - 3.7.1.2 For new applicants, evidence of citizenship in the United States (e.g., attestation of US citizenship, birth certificate showing place of birth in this country, naturalization papers, or US passport), or evidence that the applicant is in the US legally and has the required permission(s) to work in this country. For applicants who are not US citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required. The requirements of this section do not apply to an applicant who is residing and working from a foreign country (i.e., a foreign-based telemedicine practitioner) because the immigration laws of the US do not apply.
  - 3.7.1.3 The individual requesting initial appointment or initial clinical privileges shall provide written permission to conduct a background investigation as part of the initial credentials verification process and on an ad hoc basis upon request by the CEO. Circumstances that may trigger a request for an ad hoc background investigation include, but are not limited to:

- 3.7.1.3.1 Disciplinary action against the individual's license;
- 3.7.1.3.2 Sanctions or revocation of the individual's Federal DEA or State narcotic registration;
- 3.7.1.3.3 Identification of felony or misdemeanor arrests or convictions; or
- 3.7.1.3.4 Reports of disruptive behavior, harassment, professional misconduct, or alcohol/substance abuse.
- 3.7.1.4 Evidence of current licensure in the State of Florida and information from the applicant regarding any current or past licensure in any healthcare profession or in any other state or jurisdiction;
- 3.7.1.5 For applicants requesting medication prescribing privileges, evidence of a controlled substance registration, if applicable;
- 3.7.1.6 For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, or in the case of a foreign graduate, ECFMG certificate;
- 3.7.1.7 For applicants for appointment who are not newly graduated from residency or fellowship program within the last year, and for applicants for reappointments or renewal of clinical privileges, the applicant's participation in continuing education, specifically as related to the clinical privileges requested;
- 3.7.1.8 The names of at least three peers who will provide a written evaluation of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested. The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal.
- 3.7.1.9 Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;
- 3.7.1.10 Information regarding all current healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;
- 3.7.1.11 Evidence of current professional liability insurance or alternative, including the name of the carrier, amount and dates of coverage, and professional practice covered;
- 3.7.1.12 Medicare Provider NPI for the individual provider (e.g. not a NPI for a group practice);;
- 3.7.1.13 Have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state government or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same and;
- 3.7.1.14 Accurate and complete disclosure with regard to the following queries:
  - 3.7.1.14.1 Whether the applicant's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;
  - 3.7.1.14.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges, required PRN Contract at another Hospital or other healthcare facility; Have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigations
  - 3.7.1.14.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant; and,
  - 3.7.1.14.4 Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence

- 3.7.1.15 A statement from the applicant that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article Three, Section 3.1.9;
- 3.7.1.16 Evidence that the applicant has complied with the health screening and immunization requirements of the Hospital.
- 3.7.1.17 A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations, and policies and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly adopted;
- 3.7.1.18 A pledge from the applicant to provide continuous care to his/her patients, as defined in these Bylaws;
- 3.7.1.19 By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant, Medical Staff appointee, and individual who is granted clinical privileges extends absolute immunity to and releases from all claims, damages and liability whatsoever.
  - 3.7.1.19.1 The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential (2) 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 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 information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the inspection and procurement by any Hospital Representative of such information, records and other documents. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.
  - 3.7.1.20 The Hospital and the Board of Trustees, any member of the Medical Staff and the Board of Trustees, their authorized representatives, and third parties who provide information for any matter relating to requests for consideration, re-credentialing requests for consideration, appointment, reappointment, clinical privileges, or the individual's qualifications for the same;
    - 3.7.1.20.1 Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning the individual whether the individual is a former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.
    - 3.7.1.20.2 The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:
      - 3.7.1.20.2.1 Applications for appointment and/or clinical privileges
      - 3.7.1.20.2.2 Periodic reappraisals undertaken for reappointment or for changes in clinical Privileges
      - 3.7.1.20.2.3 Corrective action
      - 3.7.1.20.2.4 Hearings and appellate reviews

- 3.7.1.20.2.5 Patient care audits
- 3.7.1.20.2.6 Medical care evaluations
- 3.7.1.20.2.7 Utilization reviews
- 3.7.1.20.2.8 Other Hospital staff, department, service, committee and subcommittee activities related to monitoring and maintain quality patient care and appropriate professional conduct;
- 3.7.1.20.2.9 Matters or inquiries concerning the credentials of any applicant, Medical Staff appointee, or Practitioner with clinical privileges;
- 3.7.1.20.2.10 Matters directly or indirectly affecting patient care or the efficient operation of the Hospital and;
- 3.7.1.20.2.11 Reports to the National Practitioners Data Bank established pursuant to the Act

3.7.1.21A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings.

3.7.1.22All physicians and other practitioners shall submit a signed Physician Acknowledgement Statement. The physician or other practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician

3.7.1.23Unless the applicant is applying for medical staff membership only, all applications must include a specific written request for clinical privileges using prescribed forms. Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

3.7.1.24As a condition of consideration for initial and continued appointment to the Medical Staff, every applicant shall specifically agree to immediately provide (within one business day of being officially notified of a change in status) to the Medical Staff and the Hospitals, with or without request, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or any state, the receipt of a QIO citation, any change in legal status to reside and/or work in the USA, any investigation by an ABMS or AOA specialty board, any payer contract termination, any change in health status, any change in location of office or residence, any criminal investigation, and/or a quality denial letter concerning alleged quality problems in patient care.

#### 3.7.1.25 AUTHORIZATION TO MAINTAIN INFORMATION

The individual authorizes the Hospital to maintain information concerning the individual's specialty, demographic information, training, board certification, licensure and other confidential information in a centralized Practitioner data base for the purpose of making aggregate Practitioner Information available for use by the Hospital and its affiliates.

- 3.7.1.26 The individual agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms:
- 3.7.1.26.1 All of the provisions in the Section Immunity from Liability are applicable in the following situations:
  - 3.7.1.26.2 Whether or not appointment or clinical privileges are granted;
  - 3.7.1.26.3 Throughout the term of any appointment or reappointment period and thereafter;
  - 3.7.1.26.4 Should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and;
  - 3.7.1.26.5 To any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

### 3.7.2 APPLICATION PROCESSING

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:

**Time Period for Processing:** Once application is complete, it is expected to be processed within 150 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. If the action of the Board of Trustees has not been taken within 150 days after an application is turned over by the CPC for MOS file review, the verifications must first be repeated to assure that the information is current before the Board of Trustees takes action.

- 3.7.2.1 **Department Report:** The Medical Staff Office shall make available the application and all supporting materials to the Chairperson of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the Division to be assigned if appropriate to the applicant's practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chairperson, the Chief of Staff or the Department Vice-Chairperson shall make the evaluation and recommendations. Following the Department Chairperson(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.
- 3.7.2.2 **Credentials Committee Report:** The Credentials Committee shall receive from the Department Chairperson and review the application, supporting materials, the report of the Department Chairperson and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within 30 days.
- 3.7.2.3 **Criteria for Additional Inquiry:** Additional inquiry shall be conducted by the Department Chairperson, Credentials Committee, or Medical Executive Committee for any of the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and

questions about the following matters are explained to the satisfaction of the Department Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees. Criteria for additional inquiry are:

- 3.7.2.3.1 Inability to verify any of the information or credentials represented in the application;
- 3.7.2.3.2 Any unexplained gaps in medical staff membership, clinical privileges and/or work history;
- 3.7.2.3.3 Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Department Chairperson Credentials Committee, Medical Executive Committee or Board of Trustees.
- 3.7.2.4 Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials; the reports of the Department Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board shall be at the next regular meeting of the committee following receipt of the Credentials Committee report-
- 3.7.2.5 Effect of MEC Recommendation
  - 3.7.2.5.1 Deferral: The MEC may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the MEC to defer the application for further consideration shall state the reasons for deferral; provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The MEC may delegate the responsibility for further consideration to the Credentials Committee or Department Chairperson as deemed appropriate.
  - 3.7.2.5.2 Favorable Recommendation: When the recommendation is completely favorable, the application shall be forwarded promptly to the Board for action at the Board's next regular meeting.
  - 3.7.2.5.3 Adverse Recommendation: If the recommendation of the MEC is adverse under Article Seven of these Bylaws, the Chief of Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Seven of these Bylaws, and the recommendation need not be transmitted to the Board until after the applicant has exercised or waived such rights.
- 3.7.2.6 Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board shall act on the application at its next regular meeting following receipt of the recommendation from the MEC. The action of the Board shall be taken within 30 days after receiving a recommendation from the MEC.
  - 3.7.2.6.1 If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.
  - 3.7.2.6.2 If the Board does not adopt the recommendation of the MEC, the Board may either refer the matter back to the MEC with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may take unilateral action. If the matter is referred back to the MEC, the MEC shall review the matter and shall forward its recommendation to the Board. If the Board adopts the recommendation of the MEC, it shall become the final action of the Hospital.
  - 3.7.2.6.3 If the action of the Board is adverse to the applicant, the Secretary of the Board shall promptly send written notice to the applicant. Such notice shall contain the information

prescribed in the Article Seven of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Seven of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action.

3.7.2.6.4 All decisions to appoint shall include a delineation of clinical privileges (with exception of appointees to the Honorary staff category), the assignment of a staff category and Department affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.

3.7.2.6.5 Subject to any applicable provisions of Article Seven, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Seven shall govern notice of the Board's final decision.

### 3.8 CREDENTIALS SUBJECT TO ONGOING VERIFICATION

In addition to being verified at the time of initial appointment and initial granting of privileges, and at reappointment or renewal or revision of clinical privileges, the following credentials shall be subject to primary source verification, , at the time of expiration and renewal or as specified, and any failure to continuously maintain the following credentials during the entire term of appointment shall result in automatic suspension actions as provided in these Bylaws and shall be reported to the Credentials Committee:

- 3.8.1 Current licensure;
- 3.8.2 Drug Enforcement Administration registration;
- 3.8.3 Professional liability insurance or alternative;
- 3.8.4 Specialty board certification, if required for membership or any of the clinical privileges granted
- 3.8.5 Have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program, as verified by screening ineligible persons against the OIG, GSA.

### 3.9 ELIGIBILITY FOR REAPPOINTMENT

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

- 3.9.1 Completed all continuing medical education requirements;
- 3.9.2 Satisfied all Medical Staff responsibilities.
- 3.9.3 Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,
- 3.9.4 For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the application shall be considered complete and processed further.

### 3.10 EXPIRATION OF CURRENT APPOINTMENT

- 3.10.1 If an application is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received shall an individual be considered for reappointment or renewal of clinical privileges.

- 3.10.2 If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. The Board may subsequently grant reappointment and renewal of clinical privileges.

### 3.11 ASSISTANCE WITH EVALUATION

The Board, the MEC, the CEO, or any committee involved in the review or evaluation of applications for Staff membership or clinical privileges, or the ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:

- 3.11.1 Obtain the assistance of an independent consultant or others to evaluate the healthcare professional being subject to review;
- 3.11.2 Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the healthcare professional under evaluation;
- 3.11.3 Request or require the healthcare professional under evaluation to submit to interviews with consultants who may be retained to assist in the review or evaluation process;
- 3.11.4 Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the healthcare professional under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,
- 3.11.5 Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence or conduct of the healthcare professional under evaluation, including information concerning threatened or pending legal or administrative proceedings.

### ~~3.12~~ PROFESSIONAL PRACTICE EVALUATION

The Board has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board shall direct and enforce the establishment of a performance improvement and quality assessment program with the requisite quality assessment processes. Processes shall include the measurement, monitoring, analysis, and improvement of the quality and appropriateness of services provided by individual Medical Staff members and other individuals with clinical privileges. The Medical Staff shall participate in quality assessment and performance improvement activities as defined in the Hospitals' Performance Improvement Plan.

The Medical Staff measurement, analysis and improvement activities shall be directed to assuring uniformly high quality and clinically appropriate care resultant from the performance of Staff members and others with clinical privileges. Such activities shall also be used to assure the fair and equitable treatment of each Staff member and others with clinical privileges in appointment, reappointment, peer review and privileging processes. The data measurements and reports established by the Medical Staff shall include clinical and other indicators directly attributable to quality and patient outcomes. Measures and their resultant analysis and performance improvement shall be managed within the established peer and quality review committees and departments of the Medical Staff for maximization of information and individual protections by state and federal peer review protections and immunity including the Health Care Quality Improvement Act.

Relevant information from Hospital performance improvement activities that is specific to an individual shall be considered and compared to aggregate information when these measures are appropriate for comparative purposes in evaluating the individual's professional performance, judgment, clinical or technical skills. Any results of peer review regarding the individual's clinical performance shall also be included. The Hospitals may use epidemiological and statistical methods to compare practice patterns of individuals on dimensions of service use, or quality (including process and outcome) of care. The Hospitals may consider quality of care by an individual through an examination of patterns of health care delivery. Performance reports, including the results of performance based measures such as patterns of treatment, health care outcomes, and patient satisfaction shall be taken into account in evaluating applications for appointment or reappointment. The data, measures and reports may include, but are not limited to, clinical and other information regarding each individual's:

- 3.12.1 Quality and appropriateness of patient care, including patient care outcomes;

- 3.12.2 Review of operative and other clinical procedures performed and their outcomes;
- 3.12.3 Patterns of blood and pharmaceutical usage;
- 3.12.4 Length of stay patterns;
- 3.12.5 Morbidity and mortality data;
- 3.12.6 Performance as related to Healthcare Quality Alliance (HQA) core measures, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, data about Hospital Acquired Conditions (HAC), and other publicly-reported evidence-based performance measures;
- 3.12.7 Malpractice and professional liability experience;
- 3.12.8 Utilization of Hospital resources and facilities;
- 3.12.9 Timely, legible and accurate completion of patient medical records;
- 3.12.10 Professional conduct;
- 3.12.11 Attainment and maintenance of board certification;
- 3.12.12 Maintenance of required levels of professional liability insurance coverage;
- 3.12.13 Attainment of continuing education requirements; and,
- 3.12.14 Attribution to sentinel events, medical errors or other risk occurrences.

The Board of Trustees shall be responsible for assuring the use of clinical and other measurements for the improvement of patient care. The sources for the information shall be identified by the Hospital and data quality shall be verified. Recommendations from the Medical Staff regarding their conclusions from Medical Staff and Hospital performance improvement and quality assessment shall be reported to the Board for their decision making and enforcement of actions for the improvement of patient care and execution of the quality assessment process.

Medical staff members and other individuals with clinical privileges are required to participate in all aspects of Medical Staff activities designed to verify the individual's ongoing qualifications and competency. If at any time a Medical Staff member or other individual with clinical privileges fails to provide required information pursuant to a formal request by the Credentials Committee, Medical Executive Committee, or the Chief Executive Officer, the individual's clinical privileges shall be deemed to be voluntarily relinquished until the required information is provided to the satisfaction of the requesting party, without the individual having a right to a hearing or appeal. For purposes of this section, 'required information' shall refer to (1) physical or mental examination reports as specified elsewhere in these Bylaws, or (2) information from another healthcare facility or agency. If voluntary relinquishment of clinical privileges occurs while the individual is subject to an investigation, this will be reported in accordance with the requirements of the National Practitioner Data Bank.,

### 3.13 PROVISIONAL STATUS AND PROCTORING

The Medical Staff shall have a process to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of performing the requested privilege at the Hospital. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process of focused professional practice evaluation shall be a time-limited period during which the Medical Staff evaluates and determines the practitioner's professional performance. Focused professional practice evaluation may entail the use of one or more types of evaluation, including but not limited to chart review, monitoring of clinical practice patterns, simulation, clinical proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel). Clinical proctoring is an objective evaluation of an individual's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff. When an initial applicant seeks clinical privileges, or an individual with existing clinical privileges seeks new privileges, or when the Medical Staff requires the individual's actual clinical competence to be evaluated for any other reason, the individual shall be proctored or observed while providing the services for which the privileges are

requested. In most instances, proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, represent the Medical Staff, and are responsible to the Medical Staff.

- 3.13.1 For initial appointment/initial clinical privileges: At the time of initial appointments and initial granting of clinical privileges, the medical staff shall determine a plan for conducting focused professional practice evaluation, during which the practitioner shall be on provisional status. The evaluation plan shall include method(s) and the time period of evaluation and may be subject to an extension of time for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges. Each individual subject to provisional status may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. The provisional status individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the patient care and services provided by Department members. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's eligibility for advancement from provisional status and for exercising the clinical privileges provisionally granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed a total of twenty-four (24) months. Advancement shall be based upon a favorable recommendation of the individual's Department Chairperson based on the Chairperson's review of the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and a favorable recommendation of the Credentials Committee and Medical Executive Committee, and approved by the Board. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the Medical Executive Committee and the Board, an individual's failure to complete the required number of cases needed to complete focused professional practice evaluation shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional status due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.
- 3.13.2 For individuals with existing privileges who are requesting new privileges: A period of focused professional practice evaluation shall be implemented for all initially requested privileges. Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials Committee, the Medical Executive Committee, and the Board shall have the option of specifying requirements for other evidence of competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. The individual requesting new privileges shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the new clinical privileges being requested. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's actual clinical competence for the new clinical privileges granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual's Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Board.

3.13.3 For evaluating of clinical competence for privileges previously granted: Medical Staff members or other individuals with existing clinical privileges who are identified for review of actual clinical competence may be subject to focused professional practice evaluation by one or more appropriate Member(s) of the Medical Staff as approved by Chairperson of the Department to which the individual is affiliated. Focused professional practice evaluation may be indicated as the result of QA/PI, peer review or patient safety information, or due to inactivity with clinical privileges granted, or due to return from a leave of absence. The individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures or treatments specified by the clinical Department as appropriate to the clinical privileges subject to review. The care under evaluation shall be relevant to the privileges granted. The purpose of the observation is to determine the individual's actual clinical competence for the clinical privileges subject to review. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The individual's Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials Committee, the Medical Executive Committee, and the Board.

3.13.4 Duties of Individuals on Provisional Status

3.13.4.1 During the provisional period, an individual must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Department Chairperson or other designated observers.

3.13.4.2 If a new member of the Medical Staff or other individual with clinical privileges fails, during the provisional period, to:

3.13.4.2.1 Participate in the required number of cases;

3.13.4.2.2 Cooperate with the monitoring and observation conditions; or

3.13.4.2.3 Fulfill all requirements of appointment, including but not limited to those relating to completion of medical records and/or emergency service call responsibilities, the individual's Medical Staff appointment and the clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for initial appointment or privileges for two years.

3.13.4.3 If a member of the Medical Staff who has been granted additional clinical privileges or other individual granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and observation conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two years.

3.13.4.4 If a member of the Medical Staff or other individual with clinical privileges who has been in a provisional period for an evaluation of competence fails to participate in the required number of cases or cooperate with the monitoring and observation conditions, the clinical privileges under review shall be automatically relinquished at the end of the provisional period, and the individual shall not be entitled to a hearing or appeal. The individual may not reapply for the privileges in question for two years.

3.13.4.5 When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual shall be entitled to a hearing and appeal.

3.14 CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

- 3.14.1 Recommendations for appointment, reappointment, initial granting of privileges and / or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute a disciplinary action or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Seven of these Bylaws.
  - 3.14.1.1 If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.
  - 3.14.1.2 If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or completes the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Six of these Bylaws shall commence.
  - 3.14.1.3 If the individual refused to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed as part of a conditional appointment, reappointment, or privileges, then corrective actions as set forth in Article Six of these Bylaws shall commence.
- 3.14.2 Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article Seven of these bylaws.
- 3.14.3 In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.
- 3.14.4 To end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment and privileging procedures.

### 3.15 PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. If an application is tendered by an individual who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that permanently disqualify the applicant for membership, as has been so designated by prior action of the Board of Trustees, then the application shall be returned to the individual as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application.

### 3.16 MEDICO-ADMINISTRATIVE OFFICERS

#### 3.16.1 DEFINED

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

### 3.16.2 STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall delineate the clinical privileges of Medico-Administrative officers who request to admit and/or treat patients.

### 3.16.3 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

In the event a Practitioner who is employed by or has contracted with the Hospital, or otherwise serves in a Medico-Administrative position pursuant to a contract, is subject to removal from office through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

An adverse action, as defined in these Bylaws, against a medico-administrative practitioner for clinical reasons or for violation of these Bylaws shall be subject to the hearing and appeal procedures in Article Seven of these Bylaws. Pursuant to any specific provisions of the contract, such adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract shall control.

## 3.17 INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

### 3.17.1 QUALIFICATIONS AND SELECTION

Practitioners providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws. Additional requirements for employment or a contractual agreement may be imposed. The Staff, as in the case of other Practitioners, shall recommend the clinical privileges of Contract Practitioners to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement. .

### 3.17.2 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. Such contract may provide, for example, that the Staff membership and clinical privileges of a Contract Practitioner or individuals providing services through a Contractor are automatically terminated or modified in the event of termination of the written contract, and the Contract Practitioner or individuals providing services through a Contractor have no rights to a hearing and appeal or otherwise with regard to such termination or modification of Staff membership or clinical privileges. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

## 3.18 LEAVE OF ABSENCE

- A Medical Staff member or Advanced Practice Professional (APP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Medical Executive Committee or CEO.

- The request must state the beginning date and ending date for the period of leave desired, , and include the reasons for the request.
- The period of leave may not exceed six months. If for any reason the Practitioner needs to extend the leave of absence, they must submit a new request for an additional period not to exceed six months. Total leave of absence may not exceed one year.
- The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances such as military leave, the Chief Executive Officer and Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Trustees.
- During the period of leave, the Practitioner or APP shall not exercise clinical privileges at the Hospitals, and membership prerogatives and responsibilities, (e.g. committee service, emergency service call obligations) shall be in abeyance.
- When the reasons for the leave of absence indicate that the leave is optional, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospitals by the absence of the member requesting the leave.
- A leave of absence shall be granted for members in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a member has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospitals matters.
- A leave of absence may be granted for the following reasons:

#### 3.18.1 MEDICAL LEAVE OF ABSENCE

Members of the Medical Staff and APPs must report to the Chief Executive Officer any time they will be away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. A Medical Staff member may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue. If a member is unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Chief of Staff or Chairperson of the Practitioner's Department may submit the written notice on his/her behalf. A certified letter will be sent to the Practitioner informing him/her of this action.

#### MILITARY LEAVE OF ABSENCE

A Medical Staff member may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members or APPs who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

#### 3.18.2 EDUCATIONAL LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article Five of these Bylaws.

### 3.18.3 PERSONAL/FAMILY LEAVE OF ABSENCE

A Medical Staff member or APP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to “Doctors without Borders/USA”) or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

### 3.18.4 REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may The Medical Staff Member or APP on leave of absence must request reinstatement of Medical Staff membership and clinical privileges by submitting a written notice to the Chief of Staff. The written request for reinstatement shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article Three, or if changes have occurred, a detailed description of the nature of the changes. If so requested, the Staff member or APP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. 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. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the section of these Bylaws addressing practitioner health issues. If the leave of absence has extended past the Practitioner's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article Three of these Bylaws and the reinstatement shall be processed as a reappointment. The Chief of Staff will forward the request for reinstatement to the member's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee shall make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee shall forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article Five, Section 5.2.4. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

3.18.4.1 Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff and the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

3.18.4.2 Leaves of absence 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 is not granted, this will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no recourse to a hearing and appeal.

### 3.18.5 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff member or APP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

### 3.19 RESIGNATION

- Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective.
- Resignations shall be submitted to the Medical Staff Office.
- Resignation of Medical Staff membership may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded.
- The Practitioner's or APP's Department Chairperson, the Medical Executive Committee, and the Board shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board.
- If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board, the request for withdrawal shall also be forwarded to the Board for consideration.
- The Board may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board, the Practitioner or APP will be notified in writing.
- When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board for reporting to the NPDB, as required by federal and state law.

#### • PRACTITIONER HEALTH ISSUES

THIS SECTION OF THE BYLAWS APPLIES TO ALL INDIVIDUALS WHO PROVIDE PATIENT CARE SERVICES IN THE HOSPITAL AND WHO HAVE BEEN GRANTED CLINICAL PRIVILEGES. THE HOSPITAL AND ITS MEDICAL STAFF ARE COMMITTED TO PROVIDING QUALITY CARE, WHICH CAN BE COMPROMISED IF AN INDIVIDUAL WITH CLINICAL PRIVILEGES IS SUFFERING FROM A HEALTH ISSUE. "HEALTH ISSUE" MEANS ANY PHYSICAL, MENTAL, OR EMOTIONAL CONDITION, OR PERSONALITY DISORDER INCLUDING ALCOHOL OR SUBSTANCE ABUSE, COGNITIVE DETERIORATION OR LOSS OF MOTOR SKILLS DUE TO THE AGING PROCESS, AND USE OF PRESCRIPTION MEDICATIONS, WHICH COULD ADVERSELY AFFECT AN INDIVIDUAL'S ABILITY TO PRACTICE SAFELY AND COMPETENTLY. IT ALSO INCLUDES A CONTAGIOUS DISEASE WHICH COULD COMPROMISE PATIENT SAFETY OR JEOPARDIZE OTHER HEALTH CARE WORKERS.

- Provide education about health issues related to Practitioners and others with clinical privileges for the purpose of facilitating the timely recognition and reporting of health issues.
- It is the policy of these Hospitals to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges has a health issue.
- The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA).

#### 3.19.1 SELF-REPORTING

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change.

- 3.19.1.1 An oral or preferably, a written report shall be given to the Chief Executive Officer, the Chief of Staff, the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. The recipient of the report shall submit it, along with a written request to investigate, to the Credentials Committee.

### 3.19.2 THIRD PARTY REPORTS

If a Medical Staff member, Allied Health Professional, or Hospital employee witnesses symptoms of a health issue, they should report the incident. Patients, family members, or others who witness symptoms of a health issue shall be encouraged to report the incident to an appropriate patient care representative. The identity of any individual reporting symptoms of a health issue shall be kept strictly confidential. Medical Staff members and others, as appropriate, shall be educated about recognition of a health specific to physicians and others with clinical privileges, including education about warning signs. Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

- 3.19.2.1 An oral or, preferably, a written report shall be given to the Chief Executive Officer, the Chief of Staff, the Chairperson of the individual's Medical Staff Department, and/or the Chairperson of the Credentials Committee. Third party reports should be factual and include a description of the incident(s) that led to the belief that an individual may be impaired. The person making the report does not need to have proof of the impairment, but must state the facts leading to the concern.

- 3.19.2.2 If, after discussing the incident(s) with the person who filed the report, the recipient of the report believes there is sufficient information to warrant further inquiry, the recipient of the report may:

3.19.2.2.1 Meet personally with the individual under inquiry or designate another appropriate person to do so; and/or,

3.19.2.2.2 Direct in writing that an investigation shall be instituted and a report thereof shall be rendered by the Peer Review Committee.

### 3.19.3 CONCERNS REQUIRING AN IMMEDIATE RESPONSE

- 3.19.3.1 Anyone who is concerned that an individual has a health issue that poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant Department Chairperson, the Chief of Staff, the Chief Medical Officer, or their designees.

- 3.19.3.2 The Department Chairperson, Chief of Staff, and/or the Chief Medical Officer (or their designees) shall immediately assess the individual and, if necessary to protect patients, may relieve the individual of patient care responsibilities. The affected individual's hospitalized patients may be assigned to another individual with appropriate clinical privileges or to the appropriate practitioner on call. The wishes of the patient(s) shall be considered in the selection of a covering practitioner. The affected patients shall be informed that their practitioner is unable to proceed with their care due to illness.

- 3.19.3.3 Following the immediate response, the Department Chairperson, Chief of Staff, and/or the Chief Medical Officer (or their designees) shall file formal reports as described in these Bylaws, in order for the health issue to be more fully assessed and addressed by the Committee.

- 3.19.3.4 The Committee may meet with the individual under investigation as part of its investigation. This meeting does not constitute a hearing under the due process provisions of the Hospital's Medical Staff Bylaws or pertinent policies and thus may not be attended by such individual's legal counsel. At this meeting, the Committee may ask the individual under investigation health-related questions. In addition, if the Committee feels that the individual may have a health issue that significantly affects his/her ability to perform essential functions concerning

patient care, it may discuss with the individual under investigation whether a reasonable accommodation is needed or could be made so that the individual could competently and safely exercise his/her clinical privileges and/or the duties and responsibilities of Medical Staff appointment.

### 3.19.4 OUTCOME OF INVESTIGATION

Based on all of the information it reviews as part of its investigation, the Peer Review Committee shall determine:

- 3.19.4.1 Whether the individual has a health issue, or what other problem, if any, is affecting the individual under investigation;
- 3.19.4.2 If the individual has a health issue, the nature of the health issue and whether it is classified as a disability;
- 3.19.4.3 If the individual's health issue is a disability, whether a reasonable accommodation can be made for the individual's health issue such that, with the reasonable accommodation, the individual would be able to competently and safely perform his/her clinical privileges and the essential duties and responsibilities of Medical Staff appointment;
- 3.19.4.4 Whether a reasonable accommodation would create an undue hardship upon the Hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital's operations or the provision of patient care; and,
- 3.19.4.5 Whether the health issue could negatively impact the quality of care or the health or safety of the individual, patients, Hospital employees, physicians or others within the Hospital..
  - 3.19.4.5.1 If the Committee determines that there is a reasonable accommodation that can be made as described above, the Committee shall attempt to work out a voluntary agreement with the individual, so long as that arrangement would neither impose an undue hardship upon the Hospital or create a direct threat, also as described above. The Chief Executive Officer shall be kept informed of attempts to work out a voluntary agreement before it becomes final and effective. Based on the severity and nature of the health issue, the Committee may recommend to the practitioner that he or she:
    - 3.19.4.5.2 Take a voluntary medical leave of absence to receive appropriate medical treatment or participate in a rehabilitation program; or
    - 3.19.4.5.3 Voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the practitioner is able to practice safely and competently; or
    - 3.19.4.5.4 Voluntarily agree to specific conditions.
  - 3.19.4.6 If the Committee recommends that the individual receive medical treatment or participate in a rehabilitation program, it may assist the individual in identifying appropriate resources.
  - 3.19.4.7 If the individual does not agree to abide by the Committee's recommendations, the matter shall be referred to the Medical Executive Committee for a review and possible investigation to be conducted pursuant to the Medical Staff Bylaws or any applicable credentials policy.
  - 3.19.4.8 If the individual agrees to abide by the recommendations of the Committee, a confidential report will be made to the applicable Department Chairperson, the Chief of Staff, the Chief Medical Officer, and the Chair of the Credentials Committee. In the event any of these individuals is concerned that the action of the Committee is not sufficient to protect patients or other health care workers, the matter will be referred back to the Committee with specific recommendations on how to revise the action or it will be referred to the Medical Executive Committee for review and possible investigation. If the Committee determines that there is no reasonable accommodation that can be made as described above, or if the Committee cannot reach a voluntary agreement with the individual, the Credentials Committee shall refer the matter with a recommendation to the Medical Executive Committee. The Medical Executive Committee may conduct its own investigation or adopt the recommendation of the Credentials Committee and shall make a recommendation and report to the Board of

Trustees, as appropriate to the action to be taken. If the Committee's recommendation would provide the individual with a right to a hearing as described in the Medical Staff Bylaws, the individual shall be promptly notified of the recommendation in writing, by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to waive the right to a hearing as provided under Article Seven of the Medical Staff Bylaws.

3.19.4.9 The original report, documentation of the investigation, and a description of the actions taken shall be included in the individual's credentials file. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the individual's credentials file and further monitoring or other follow-up shall be at the discretion of the Medical Executive Committee or the Credentials Committee.

3.19.4.10 Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this section of the Bylaws.

### 3.19.5 TREATMENT/REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the individual has a health issue that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following are recommendations for rehabilitation or treatment and reinstatement:

3.19.5.1 An individual with a health issue shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received treatment for a medical or psychological health issue such that the condition is under sufficient control.

3.19.5.2 The Medical Staff is not required to extend membership or privileges to an individual with impairment health issue, and may monitor, test or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.

3.19.5.3 Upon sufficient proof that the individual who has been found to be suffering from a health issue has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the individual for reinstatement of Medical Staff membership or clinical privileges.

3.19.5.4 In considering an individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.

3.19.5.5 The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the individual was treated, or the physician directing the individual's medical or psychological treatment. The individual must authorize the release of this information. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:

3.19.5.5.1 Whether the individual is participating in the program or treatment;

3.19.5.5.2 Whether the individual is in compliance with all of the terms of the program or treatment plan;

3.19.5.5.3 Whether the individual attends AA/NA meetings regularly (if appropriate);

3.19.5.5.4 To what extent the individual's behavior and conduct are monitored; Whether, in the opinion of the treating physician, the individual is rehabilitated or other health issue is under control;

3.19.5.5.5 Whether any conditions are required to allow the individual to safely resume practicing (e.g. supervision, limitation on work hours, limitation on privileges);

3.19.5.5.6 Whether an after-care program has been recommended to the individual (if appropriate), and if so, a description of the after-care program; and,

3.19.5.5.7 Whether, in the opinion of the treating physician, the individual is capable of resuming practice and providing continuous, competent care to patients.

- 3.19.5.6 The Medical Staff has the right to require opinion(s) from other physician consultants of its choice. Before making a recommendation on a request for reinstatement or lifting conditions, the Committee may request the practitioner to undergo an examination by a physician of its choice to obtain a second opinion on the practitioner's ability to practice safely and competently. The Committee shall make a recommendation to the Medical Executive Committee
- 3.19.5.7 Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
- 3.19.5.7.1 The individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
- 3.19.5.7.2 If the practitioner was granted a formal medical leave of absence, the final decision to reinstate an individual's clinical privileges must be approved pursuant to the Leave of Absence process set forth in the Medical Staff Bylaws
- 3.19.5.7.3 The individual shall be required to obtain periodic reports for the Medical Staff from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.
- 3.19.5.8 The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer or designee, the Chief of Staff, the Chairperson of the Credentials Committee or the pertinent Department Chairperson.
- 3.19.5.9 As a condition of reinstatement, the individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures of Article Three, Section 3.7.7 of these Bylaws. Minimally, licensure, DEA, state narcotics registration, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report and the GSA List. The Hospital may also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the health issue.
- 3.19.5.10 If at any point during the process of investigation, rehabilitation or treatment, or reinstatement the individual refuses or fails to comply with these procedures, he/she will be subject to a suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with the Medical Executive Committee states otherwise, such as when automatic termination is the penalty stated in the contract.
- 3.19.5.11 If at any time during the diagnosis, treatment, or rehabilitation phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.
- 3.19.5.12 If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the individual or others, the Chief Medical Officer or Chief Executive Officer may contact law enforcement authorities.
- 3.19.5.13 Nothing in this Section precludes immediate referral to the Medical Executive Committee or the elimination of any particular steps in this Section in dealing with conduct that may compromise patient care.
- 3.19.5.14 All requests for information concerning the individual shall be forwarded to the Chief Executive Officer for response. Information concerning an individual seeking referral or

referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation or when the safety of a patient is threatened.

### 3.20 REQUIREMENTS REGARDING PROFESSIONAL CONDUCT

- 3.20.1 Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus it is the policy of the Hospital to require all individuals working in the Hospital, including Medical Staff members, APPs, and other individuals with clinical privileges to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of unprofessional or inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.
- 3.20.2 Unprofessional or inappropriate conduct or behavior is defined as that which adversely affects or impacts the Hospital operations or the ability of others to get perform their jobs done competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purposes of these Bylaws, examples of “unprofessional or inappropriate conduct” include, but are not limited to:
  - 3.20.2.1 Rude, threatening or abusive behavior or comments to Hospital personnel, Advanced Practice Professionals, patients, or Practitioners.
  - 3.20.2.2 Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.
  - 3.20.2.3 Verbal attacks, which are of a personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel, Medical Staff, Advanced Practice Professionals, contracted staff, or patients.
  - 3.20.2.4 Irrelevant or inappropriate comments, drawings, or illustrations made in a patient’s medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Advanced Practice Professionals, nurses, other Hospital personnel, or Hospital policies.
  - 3.20.2.5 Criticism that is addressed to a recipient in such a manner as to that intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.
  - 3.20.2.6 Disruption of Hospital operations, Hospital or Medical Staff committee(s) or departmental affairs.
  - 3.20.2.7 Imposing onerous requirements on the nursing staff, other Hospital staff, Hospital-affiliated providers, APPs, or contractors, such as assigning work that is outside of their scope of practice as allowed under their state license, or outside of the scope of their Hospital job description, Hospital-approved duties, or clinical privileges, or contrary to Hospital policies and procedures, or that would otherwise jeopardize patient safety, quality of patient care or the Hospital’s or staff member’s compliance with laws, regulations or standards.
  - 3.20.2.8 Lying, cheating, knowingly making false accusations, altering, or falsifying any patient’s medical records or Hospital documents.
  - 3.20.2.9 Verbal or physical maltreatment of another individual, including physical or sexual assault.
  - 3.20.2.10 Harassment, including words, gestures and actions, verbal or physical, that interferes with a person’s ability to competently perform his or her job.
  - 3.20.2.11 Conduct or behavior that causes a hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation: offensive comments, jokes, innuendos, sexually-oriented statements, printed material, material distributed through electronic media or items posted on walls or bulletin boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.

- 3.20.2.12 Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:
  - 3.20.2.12.1 Submission to such conduct is made either explicitly or implicitly a term or condition of employment.
  - 3.20.2.12.2 Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment.
  - 3.20.2.12.3 Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.
  - 3.20.2.12.4 Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.
- 3.20.3 Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.
- 3.20.4 The Medical Staff leadership and Hospital leaders may provide education to all Medical Staff members and other individuals with clinical privileges regarding appropriate professional behavior and conduct. The Medical Staff leaders and Hospital leaders shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of policies associated with appropriate professional conduct and shall institute procedures to facilitate prompt reporting of inappropriate or unprofessional conduct, and prompt action as appropriate under the circumstances.
- 3.20.5 An employee who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with the Hospital's Human Resources policies. A Member of the Medical Staff and other individual with clinical privileges who engages in unprofessional or inappropriate conduct shall be dealt with in accordance with this Section of the Bylaws. Unprofessional or inappropriate conduct resulting from a health issue as defined in the Practitioner Health Issues section of these Bylaws should be dealt with using whichever Section is most appropriate for the conduct in question. If the matter involves an employed Practitioner or APP, the Chief Executive Officer shall consult with appropriate Medical Staff leaders, and legal counsel will determine which of any applicable policies will be applied.
- 3.20.6 In the event of any apparent or actual conflict between these Bylaws and the Rules and Regulations, policies of the Medical Staff, or other policies, the provisions of these Bylaws shall control.
- 3.20.7 This section of the Bylaws outlines initial collegial steps (i.e., warnings and meetings with a Practitioner) that may be taken in an attempt to resolve complaints about unprofessional or inappropriate conduct exhibited by a Practitioner. However, there may be a single incident of unprofessional or inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in these Bylaws precludes immediate referral to the Chief Executive Officer, the Medical Executive Committee or to the Board, with the Chief Executive Officer, Medical Executive Committee or the Board implementing immediate actions, which may include but is not limited to summary suspension, the filing of criminal charges, or the elimination of any particular step outlined herein so as to take immediate action in dealing with a complaint regarding unprofessional or inappropriate conduct.
- 3.20.8 Nurses, other Hospital employees, or other individuals who observe, or are subjected to, unprofessional or inappropriate conduct by a Practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the Chief Executive Officer (or designee). Any Practitioner who observes such behavior shall notify the Chief

Executive Officer directly. Upon learning of the occurrence of an incident of unprofessional or inappropriate conduct, the supervisor/Chief Executive Officer shall request that the individual who reported the incident document it in writing. If the observer of inappropriate or unprofessional conduct does not wish to provide a written report, the supervisor/Chief Executive Officer may document it, while also attempting to ascertain the observer's reasons for declining and providing encouragement to do so.

- 3.20.9 The documentation shall, to the extent possible, include:
  - 3.20.9.1 The date and time of the questionable behavior;
  - 3.20.9.2 A factual description of the questionable behavior;
  - 3.20.9.3 The name of any patient or patient's family members who were involved in the incident, including any patient or family Member who witnessed the incident;
  - 3.20.9.4 The circumstances which precipitated the incident;
  - 3.20.9.5 The names of other witnesses to the incident;
  - 3.20.9.6 Consequences, if any, of the unprofessional or inappropriate conduct as it relates to patient care, personnel, or Hospital operations;
  - 3.20.9.7 Any action taken to intervene in, or remedy, the incident; and,
  - 3.20.9.8 The name and signature of the individual reporting the matter.
- 3.20.10 The supervisor shall forward a documented report to the Chief Executive Officer, who shall immediately notify the Chief of Staff. The Chief Executive Officer and the Chief of Staff shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.
- 3.20.11 If a reporting individual is unwilling or uncomfortable with reporting unprofessional or inappropriate conduct using the procedure described in Section 3.21.8, then a report of the incident may be made to the Hospital's Ethics & Compliance Officer or the Ethics Line at 1-800-455-1996.
- 3.20.12 The supervisor/Chief Executive Officer who took the report shall follow-up with the individual who made the report by informing the individual that the matter is being reviewed, thanking the individual for reporting the matter, and instructing the individual to report any further incidents of inappropriate or unprofessional conduct. The individual making the report shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.
- 3.20.13 After a determination that the incident of unprofessional or inappropriate conduct has occurred, the Chief of Staff and/or Chief Executive Officer (or their respective designees) shall meet with the Practitioner. If appropriate, this initial meeting should be collegial. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident. The Practitioner shall be advised that, if the incident occurred as reported, his/her conduct was inappropriate and inconsistent with the standards of the Hospital and the Bylaws. The identity of the individual preparing the report of unprofessional or inappropriate conduct shall not be disclosed at this time, unless the Chief Executive Officer and Chief of Staff agree in advance that it is appropriate to do so. In all cases, the Practitioner shall be advised that any retaliation of any type by him/her against the person reporting the incident or anyone involved in the incident will be grounds for his/her immediate exclusion from all Hospital facilities.
- 3.20.14 This initial meeting may also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling may also be identified for the Practitioner, as appropriate.
- 3.20.15 The Practitioner shall be advised that a summary of the meeting shall be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The Chief of Staff shall cause the summary and any response that is received to be kept in the

confidential portion of the Practitioner's credentials file. The Chief Executive Officer shall cause the written report(s) of the incident, summary of the meeting, and any other records regarding the incident or the meeting to be kept as a confidential risk management record.

- 3.20.16 If another report of unprofessional or inappropriate conduct involving the Practitioner is received, a second meeting shall be held. At least three people (e.g., the Chief of Staff, the Chairperson of the Credentials Committee, other medical staff leader, and/or the Chief Executive Officer, or legal counsel) shall be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that the matter may be referred to the Medical Executive Committee or to the Board of Trustees for more formal action.
- 3.20.17 Following this meeting, a letter shall be sent to the Practitioner. The letter shall describe the unprofessional or inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm that the Practitioner could be excluded from all Hospital facilities for a period of time, a request that a formal investigation could be commenced pursuant to the Bylaws, and any other remedies could be taken to adequately protect the patients, hospital staff and others from continued unprofessional or inappropriate conduct. The letter will also define the conditions of continued practice at the Hospital which shall make continued Medical Staff membership and clinical privileges contingent on the Practitioner's adherence to the conditions and expectations for professional conduct. The Practitioner shall be required to sign it. The Chief of Staff shall cause records of the second meeting and the letter to the Practitioner to be filed in the confidential portion of the credentials file. The Chief Executive Officer shall cause records of the second meeting and the letter to the Practitioner to be filed in confidential risk management files. If the Practitioner refuses to sign the letter, the Chief Executive Officer and/or the Chief of Staff shall request that a formal investigation be commenced pursuant to the Bylaws and the advice of legal counsel should be obtained.
- 3.20.18 The Medical Executive Committee shall be fully apprised of the previous warnings issued to the Practitioner and the actions taken to address the concerns.
- 3.20.19 The Medical Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including hearing or appeal, shall then be conducted under the direction of the Board.

When, despite prior warning, the Practitioner continues to engage in unprofessional or inappropriate conduct, the Practitioner may be excluded from the Hospital's facilities and a precautionary suspension imposed during which time an investigation shall be conducted to determine the need for a professional review action. Immediate exclusion and precautionary suspension may also be imposed for a single event when a Practitioner's conduct is so unprofessional or inappropriate that failure to take such action may result in an imminent danger to the health of any individual. Precautionary suspension shall be imposed in accordance with Article Six of these Bylaws.

#### **4 ARTICLE FOUR: CATEGORIES OF THE MEDICAL STAFF**

##### **4.1 CATEGORIES**

The Staff shall include Active, Provisional/Active, Affiliate and Ambulatory Staff categories. At the time of appointment and at the time of each reappointment, the Medical Staff member's staff category shall be recommended by the Medical Executive Committee and approved by the Board.

##### **4.2 LIMITATIONS ON PREROGATIVES**

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospitals.

#### 4.3 ACTIVE STAFF

##### 4.3.1 REQUIREMENTS FOR ACTIVE STATUS

The active staff category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight. To qualify for the Active Staff category, the Medical Staff Member shall have contributed to fulfilling medical staff functions by admitting, consulting, and/or performing surgical or invasive procedures on at least 12 patients per year at the facility that the practitioner holds this category of membership, have served a minimum of one year as Provisional status and who regularly admit, or personally provide services, to patients in the hospitals and who are located (primary office and permanent residence) within a 30 mile radius of the Hospital to provide continuous care to their patients. For evaluation of clinical competence Active Staff shall be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

Hospital-based practitioners who provide patient care exclusively in the hospital setting are not subject to the “30 mile rule.”

##### 4.3.2 PREROGATIVES OF ACTIVE STATUS

Except for active staff members on provisional status, members of the active staff shall be eligible to vote, hold office within the Medical Staff organization. Any active staff member may attend Medical Staff and department meetings and serve on committees of the Board, Medical Staff or Hospitals. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.

##### 4.3.3 OBLIGATIONS OF ACTIVE STATUS

Each member of the active staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her clinical specialty as specified by the requirements of the assigned Medical Staff Department; provide continuous care and supervision of his/her patients in the Hospitals or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospitals; may attend Medical Staff and Department meetings; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations including any future changes to these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

#### 4.4 AFFILIATE STAFF

##### 4.4.1 REQUIREMENTS FOR AFFILIATE STATUS

The Affiliate staff category shall consist of Practitioners who have served a minimum of one year as Provisional status, who only occasionally admit patients to the Hospitals, who provide consultation services for other Medical Staff members, and who are located (primary office and permanent residence) within a 30 mile radius of the Hospital. Affiliate Staff members may admit, and/or perform surgical or invasive procedures on a maximum of 12 patients in one year. If the practitioner exceeds the 12 patients in one year period his/her status will be administratively adjusted to Active Status upon appropriate notification at the facility that the practitioner holds this category of membership

However, there will be no limit for the number of Consultations performed. For evaluation of clinical competence Affiliate Staff shall be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

##### 4.4.2 PREROGATIVES OF AFFILIATE STATUS

Members of the Affiliate shall be eligible to vote or hold office within the Medical Staff organization. An Affiliate staff member may serve on committees of the Board, Medical Staff or Hospitals and may attend Medical Staff and Department meetings. Subject to availability of beds,

each member of the Affiliate staff may admit patients within any established limitations, except as otherwise provided in these Bylaws or the Rules and Regulations, and exercise such clinical privileges as are granted to him/her.

#### 4.4.3 OBLIGATIONS OF AFFILIATE STATUS

Each member of the Affiliate staff shall discharge the basic obligations of staff members as required in these Bylaws; provide continuous care and supervision of his/her patients in the Hospitals or arrange a suitable alternative; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations.

NOTE: All new staff members must serve a minimum one-year term as Provisional Staff. Advancement will be considered at the end of this term or at such time that the member meets the Board Certification requirement set forth in these Bylaws, with a five-year limitation of Provisional status for any reason. If advancement is not accomplished within the five-year time frame, automatic resignation from the Medical Staff occurs with notification to the Practitioner of such action.

#### 4.5 AMBULATORY STAFF

##### 4.5.1 REQUIREMENTS FOR AMBULATORY STATUS

The Ambulatory staff category shall consist of Practitioners who have served a minimum of one-year as Provisional status, who do not practice in the Hospital but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s), and who are located (primary office and permanent residence) within a 30-mile radius of the Hospital. The Ambulatory Staff category is a membership-only category of the Medical Staff with no clinical privileges, and limited medical staff responsibilities and prerogatives. As Members of the Medical Staff, Ambulatory Staff shall be fully credentialed and shall be granted membership based on a recommendation by the Medical Staff, with approval by the Governing Body. Since no clinical privileges are granted. Ambulatory Staff shall not be subject to the requirements for focused professional practice evaluation or ongoing professional practice evaluation.

##### 4.5.2 PREROGATIVES OF AMBULATORY STAFF

Members of the Ambulatory staff may visit their hospitalized patients, and review their patients' medical records, but they exercise no clinical privileges and may not write orders, progress notes, or other notations in the medical record, provide any patient care, or perform any procedures. Members of the Ambulatory staff shall be eligible to vote, hold office within the Medical Staff organization, or serve on any committees.

##### 4.5.3 OBLIGATIONS OF AMBULATORY STATUS

Each member of the Ambulatory Staff shall discharge the basic obligations of staff members as required in these Bylaws; but they shall not provide emergency on-call coverage or perform any other duties for which clinical privileges are required. Each Member of the Ambulatory Staff shall establish appropriate referral and coverage arrangements with an Active or Affiliate Staff Member for the medical care of his/her patients that require Hospital services.

#### 4.6 HONORARY RECOGNITION STAFF

##### 4.6.1 REQUIREMENTS AND PREROGATIVES OF HONORARY RECOGNITION

Honorary Recognition shall be granted to Practitioners retired from professional practice who are recognized for their noteworthy contributions to the health and medical sciences, or previous long-standing service to the Hospital. Due to being retired, Practitioners with Honorary Recognition are not eligible for Medical Staff membership or clinical privileges, and therefore shall not be subject to any credentialing process.

##### 4.6.2 PREROGATIVES OF HONORARY RECOGNITION

Practitioners with Honorary Recognition shall be invited and welcome to attend education and social functions of the Hospital and Medical Staff.

#### 4.7 CHANGES IN STAFF CATEGORY

Pursuant to a written request by the Medical Staff member, upon a recommendation by the Credentials Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a member consistent with the requirements of the Bylaws. The Board shall approve any change in category.

#### 4.8 ADVANCE PRACTICE PROFESSIONALS

The term, “Advanced Practice Professional” (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Board and shall be credentialed through the same processes as a medical Staff Member as described in Article Three, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Three, they are not eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), clinical psychologists (Ph.D.) and advanced registered nurse practitioners (ARNP).

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, Health Care Industry Representatives (HCIRs), operating room nurses and technicians, perfusionists, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. These categories of dependent healthcare professionals are *not considered Allied Practice Professionals*. Although a Medical Staff member may provide employment, sponsorship and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff member, *these Bylaws shall not apply to such dependent healthcare professionals*. Dependent healthcare professionals are listed here only to distinguish them from APPs.

A Medical Staff member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an APP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

##### 4.8.1 REQUIREMENTS FOR ALLIED PRACTICE PROFESSIONALS

4.8.1.1 As permitted by state law, AHPs shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. The terms of the accountability of the APP to the Medical Staff member and the terms for supervision of the APP by a Medical Staff member shall be documented in a sponsorship agreement between the APP and the sponsoring Medical Staff member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

4.8.1.2 Name of the sponsoring Medical Staff member and name of any alternative sponsoring Medical Staff members;

4.8.1.3 Completed sponsoring Medical Staff member’s evaluation;

4.8.1.4 Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff member(s);

4.8.1.5 Signed agreement by the sponsoring Medical Staff member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

4.8.2 PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

4.8.2.1 APPs shall not be eligible to vote, hold office within the Medical Staff organization, or serve on any committees. An APP may attend Medical Staff or Department/Division meetings if invited. No APP may admit patients to the Hospital.

4.8.3 OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS:

4.8.3.1 Each APP shall discharge the basic obligations of Staff members as required in these Bylaws; abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

**5 ARTICLE FIVE: CLINICAL PRIVILEGES**

5.1 EXERCISE OF PRIVILEGES

Every Practitioner or Allied Health Professional providing direct clinical services at these Hospitals, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in the sections below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board. The privileges must be Hospitals-specific, within the scope of the license authorizing the individual to practice in this state or any certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Department or Division. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient. Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

5.2 DELINEATION OF PRIVILEGES

5.2.1 APPLICATION

Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Except for Honorary members who by virtue of their category are not eligible for clinical privileges, every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. An application for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Staff membership. An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Staff appointment, as provided in Article Three, Section 3.5. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to Section 3.7.2, the responsibility for producing a complete application and request for clinical privileges shall be the applicant's.

## 5.2.2 ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.

## 5.2.3 MEDICAL HISTORY AND PHYSICAL EXAMINATION REQUIREMENTS

Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy. A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

## 5.2.4 ADDITIONS TO CLINICAL PRIVILEGES

Determination of a change in clinical privileges shall be based on a Practitioner's subsequent training, experience, and demonstrated competence. A review of each Practitioner's documented professional training and focused professional practice evaluation will be included in the review of such Practitioner's request for a change in privileges. A Practitioner who desires a change in his or her clinical privileges in any department shall make a written request to the CEO and/or the Medical Staff Office. The CPC will process the request by performing verifications of training and/or experience and other queries as outlined in this section. The CEO will then submit the Practitioner's written request and any related information to the Chairperson of the appropriate department for recommendation. The request and the recommendation of the Chairperson of the appropriate department will then be forwarded to the Credentials Committee. The Credentials Committee shall consider the request and will then report recommendations to the MEC. The written comments of the MEC, if any will be forwarded to the Board. Should the Credentials Committee or the MEC make a proposed recommendation against the requested change, the proposed recommendation will be forwarded to the CEO who will notify the Practitioner of the proposed adverse recommendation and the right to a hearing in accordance with the Fair Hearing Procedure. Such notification will be made prior to forwarding the proposed adverse recommendation to the Board. No Practitioner may seek clinical privileges previously requested and denied unless supported by additional training and/or experience.

- 5.2.4.1 Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be verified
- 5.2.4.2 Training and experience related to the new clinical privileges or increased clinical privileges requested shall be verified.
- 5.2.4.3 Evidence of current competence related to the new clinical privileges requested shall be verified. This shall include a review of relevant practitioner specific performance data when available.
- 5.2.4.4 An evaluation provided by peers of the applicant shall be included in deliberations when adding or increasing privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.
- 5.2.4.5 Applicants are required to report malpractice insurance coverage information for the new privileges requested and claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.
- 5.2.4.6 The hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested

5.2.4.7 When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified

5.2.4.8 When revising clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:

5.2.4.8.1 Previously successful or currently pending challenges, or voluntary relinquishment, of licensure or registration.

5.2.4.8.2 Voluntary or involuntary reduction in privileges or termination of privileges or membership.

5.2.4.8.3 Involvement in liability actions, at least final judgments or settlements.

#### 5.2.5 BASIS FOR PRIVILEGE DETERMINATION

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested. Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references and peer recommendations that include written information about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status as related to ability to perform the privileges requested, information from the applicant's current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought. The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients. Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting. The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of performance profiling, as provided for in Article Three of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges, and the applicant's participation in continuing education shall be considered when renewing or revising such privileges. Before clinical privileges are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:

5.2.5.1 For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;

5.2.5.2 For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;

5.2.5.3 The applicant's clinical judgment and technical skills;

5.2.5.4 Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;

5.2.5.5 Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of

medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

5.2.5.6 Relevant practitioner-specific data that are compared to aggregate data;

5.2.5.7 Morbidity and mortality data, when available;

5.2.5.8 Practitioner's performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with core measures protocols.

The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistants at surgery, nursing and administrative personnel. Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board may, in its discretion, obtain assistance with their evaluation, as provided for in Article Three of these Bylaws.

## 5.2.6 DELINEATION

Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Three of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted. The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients whom have been admitted.

## 5.2.7 LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article Three, Section 3.1, who plans to practice within the Hospital on an intermittent or substitute basis. Unless requested, a locum tenens Practitioner shall not be granted medical staff membership. The locum tenens Practitioner shall be credentialed as described in Article Three, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff Member, or for the time of intermittent coverage, but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Section 5.3 of these Bylaws if requesting privileges to provide care, treatment, or services in response to an immediate important patient care need, or after submitting a complete application with no adverse information while the application awaits approval by the Medical Executive Committee and the Board. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, including requirements for focused professional practice evaluation and ongoing professional practice evaluation, and rights to a fair hearing.

## 5.2.8 NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of Trustees, based on this determination of hospital leaders. Any request for clinical privileges that are either new to the Hospitals or that overlaps more than one Department shall initially be reviewed by the Credentials Committee. The Credentials Committee shall review the need for, and

appropriateness of a new procedure or service. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transspecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board shall be based in part on whether the new procedure or service is appropriate to the Hospital.

## 5.2.9 CLOSING/DISCONTINUING A SERVICE OR ENTERING AN EXCLUSIVE CONTRACT

5.2.9.1 From time to time, the Hospital may enter into contract with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. All individual providing clinical services pursuant to such contract will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of these Bylaws.

5.2.9.1.1 To the extent that:

5.2.9.1.1.1 any such contract confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners, or

5.2.9.1.1.2 The Board of Trustees by resolution limits the Practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other Practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized Practitioners are eligible to apply for appointment to the Medical Staff and for the clinical privileges in questions. No other applications will be processed.

5.2.9.1.2 If any such exclusive contract or resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:

5.2.9.1.2.1 The affected member shall be given at least 90 days advance notice of the exclusive contract or Board of Trustees resolution and have the right to meet with the Board of Trustees or a committee designated by the Board of Trustees to discuss the matter prior to the contract in questions being signed by the Hospital or the Board of Trustees resolution becoming effective.

5.2.9.1.2.2 At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board of Trustees resolution.

5.2.9.1.2.3 If, following this meeting, the Board of Trustees confirms its initial determination to enter into the exclusive contract or enact the Board of Trustees resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board of Trustees resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board of Trustees resolution and continues for as long as the contract or Board of Trustees resolution is in effect.

5.2.9.1.2.4 The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board of Trustees' decision or the effect of the decision on his or her clinical privileges, notwithstanding the provision in Article Six of these Bylaws.

5.2.9.1.2.5 The inability of a Practitioner to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the State licensure Board or to the National Practitioner Data Bank.

5.2.9.1.3 Except as provided in the above sections, in the event of any conflict between these Bylaws and the terms of any contract, the terms of the contract shall control.

#### 5.2.10 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions.

5.2.10.1 If the applicant is a telemedicine Practitioner located in a different State, the applicant must also possess current, unlimited, unrestricted, active licensure in that State.

5.10.2.2 Specific to telemedicine providers, due to extraordinary high number of healthcare affiliations, queries will be limited to the top five high volume affiliations and any healthcare organization from which the practitioner was reassigned during the last five years.

#### 5.2.11 USE OF OUTPATIENT DIAGNOSTIC SERVICES BY NON-PRIVILEGED PRACTITIONERS

A Practitioner who is not a Medical Staff member and who has not been granted clinical privileges may order outpatient diagnostic tests and the Hospital may accept and execute orders for outpatient diagnostic tests from Practitioners who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if following requirements are met:

5.2.11.1 The non-privileged Practitioner shall provide proof of current licensure within this State, which shall be verified by the Hospitals or provide proof of being an active duty military Practitioner who is acting within the scope of military duties and providing care to a member of the military or a military dependent ;

5.2.11.2 The Hospital shall ensure that the non-privileged Practitioner is eligible to participate in Federal and State Health Programs by checking the OIG Sanction Report and the GSA List at the time of ordering

5.2.11.3 Per State laws and regulations, must practice only under the supervision or sponsorship of a physician or other licensed independent practitioner (LIP), unless evidence is provided to document the required supervision or sponsorship (e.g., the supervising LIP's countersignature on the non-privileged APP's order).

5.2.11.4 The non-privileged Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, diagnostic cardiopulmonary or electrodiagnostic testing, (e.g., PFT, ECG, and EEG). Examples of orders or types of patient care, treatment or services that can be provided

only by a credentialed Practitioner or APP with clinical privileges, and therefore is *not appropriate for a non-privileged Practitioner* include, but are not limited to:

- 5.2.11.4.1 Admitting a patient, whether for inpatient care or same day procedures;
- 5.2.11.4.2 Serving as a Hospital patient's attending physician;
- 5.2.11.4.3 Performing history & physical examinations, assessing a patient's progress while in the Hospital, performing consultations, or preparing discharge summaries;
- 5.2.11.4.4 Ordering or performing surgery or any other invasive procedures, including any invasive procedures done for diagnostic testing purposes;
- 5.2.11.4.5 Providing on-call coverage for a privileged Practitioner;
- 5.2.11.4.6 Serving as a proctor or trainer, or receiving training or proctoring for professional practice;
- 5.2.11.4.7 Prescribing medications to be administered to a patient by Hospital personnel;
- 5.2.11.4.8 Prescribing medications to be dispensed by the Hospital for a patient to self-administer at home, unless the pharmacy of the Hospital is licensed for retail dispensing;
- 5.2.11.4.9 Issuing orders for therapeutic services; and,
- 5.2.11.5 Performing any other patient care, treatment or services for which The order must be of a type that can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering non-privileged Practitioner.
- 5.2.11.6 The ordering non-privileged Practitioner does not hold himself to be associated or affiliated with the Hospital or its Medical Staff. The non-privileged Practitioner's ordering practices shall be subject to the supervision of the medical director of the Hospital department performing the test or service, or the Chief of Staff. The Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order.
- 5.2.11.7 All diagnostic tests that require an interpretation by a Practitioner with a delineated clinical privilege to do so shall be subject to interpretation by a member of the Medical Staff with such privileges and the interpretation shall be provided to the non-privileged Practitioner.

#### 5.2.12 UNAVAILABLE CLINICAL PRIVILEGES

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the applicant's qualifications or competence, an applicant whose request is so denied shall not be entitled to the Fair Hearing and Appeal rights under these Bylaws and is not subject to reporting to the National Practitioner Data Bank via the state professional licensure agency.

#### 5.3 TEMPORARY PRIVILEGES

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws or to APPs as defined in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or APP exercising such privileges. A Practitioner or APP shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

##### 5.3.1 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this state, a current and unrestricted DEA registration **reflecting an in-state address for Florida** (if the practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary

privileges requested, current competence related to the temporary privileges requested, and documentation of professional liability insurance coverage as required by the Board, except as specified in Section 5.3.2.4 in this Article and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care..

Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source, and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN, and the Hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

### 5.3.2 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from the appropriate Department Chairperson or Chief of Staff under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below. During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by hospital policy. Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

- 5.3.2.1 Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Article Five, Section 5.3.1 may be granted temporary while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days. An applicant waiting for processing of an application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:
- 5.3.2.1.1 There are no current or previously successful challenges to licensure or registration;
  - 5.3.2.1.2 There are no adverse membership actions at another hospital; and,
  - 5.3.2.1.3 Practitioner shall be eligible for privileges if there are no adverse actions against the applicant's privileges at another hospital.
- 5.3.2.2 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner or APP qualified as described in these Bylaws Article Five, may be granted temporary privileges if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever is less. A Practitioner or APP may be granted temporary privileges under this condition for no more than two patients in a twelve-month period. After a Practitioner or APP has been granted temporary privileges under this condition for the care of a second patient within twelve months, he/she shall be required ~~invited~~ to apply for Medical Staff membership or clinical privileges before providing additional patient care, treatment or services at the Hospital.

- 5.3.2.3 Locum Tenens: The locum tenens Practitioner shall not be granted temporary privileges that are in excess of those granted to the Medical Staff member being temporarily replaced. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days or the term of absence of the Medical Staff member, whichever is less.
- 5.3.2.4 Disaster Response and Recovery: Potential disaster situations shall be described in the Hospital Emergency Operations Plan and is defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospitals to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs, temporary disaster privileges may be granted to an appropriately qualified Practitioner qualified as described in Article Five, Section 5.3.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges should be approved by the Hospital Emergency Incident Commander (CEO/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director. All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs. Approvals shall be documented in writing. The Chief of Staff or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review. Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage. Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less. In the event that the disaster creates extreme urgencies as defined in Section 5.4, a Practitioner would be permitted to provide patient care using emergency privileges.
- 5.3.2.4.1 Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and any of the following, and the qualifications required in Section 5.3.1 of this Article shall be verified as soon as the immediate disaster situation is under control, using a process identical to granting temporary privileges for an immediate patient care needs, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.:
- 5.3.2.4.1.1 A current picture hospital ID card from a healthcare organization that clearly identifies professional designation;
  - 5.3.2.4.1.2 A current license to practice in the State of Florida, and a valid picture ID issued by a state, federal or regulatory agency;
  - 5.3.2.4.1.3 Primary source verification of the license.
  - 5.3.2.4.1.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group;
  - 5.3.2.4.1.5 Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity; or,
  - 5.3.2.4.1.6 Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
- 5.3.2.4.2 The following order of preference should be used in granting temporary disaster privileges:

- 5.3.2.4.2.1 Expert Practitioners from government agencies and medical staff members from other HCA hospitals;
- 5.3.2.4.2.2 Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
- 5.3.2.4.2.3 Volunteers from the community or surrounding areas.
- 5.3.2.4.3 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.
- 5.3.2.4.4 Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital, and should be assigned to a Medical Staff member if possible, with whom to collaborate in the care of disaster victims.
- 5.3.2.4.5 The Medical Staff shall oversee the professional practice of volunteer Practitioners either by the direct observation or mentoring provided by the Medical Staff Member assigned to the volunteer Practitioner or when a Medical Staff Member is not available to be assigned, then by medical record review to be performed as designated by the Chief of Staff or MEC.
- 5.3.2.4.6 The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the Chief of Staff or the EOP designated Medical Staff Director. In the event that verification of information results in negative or unsubstantiated information about qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff members can adequately provide care, temporary disaster privileges terminate.
- 5.3.2.4.6.1 Denial, Reduction or Termination of Temporary Clinical Privileges - The CEO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the Department chair, deny, reduce or terminate temporary clinical privileges.
- 5.3.2.4.6.2 Denial, termination or reduction of temporary privileges shall not constitute grounds for a hearing, and the termination shall take effect without hearing or appeal.

#### 5.4 EMERGENCY PRIVILEGES

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

#### 5.5 PRIVILEGES TO SUPPORT POST-RESIDENCE/FELLOWSHIP SURGICAL TRAINING

To support the introduction of a new procedure or new technology at the Hospital, the Board shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offer of training for the procedure/technology fits within the Hospital's operational planning and is appropriate for the Hospital's patient population. Training shall not be conducted until first approved by the Board based on a recommendation from the MEC. The preceptor/trainer and the preceptee/trainee shall be credentialed as

described in these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role, in which the individual shall serve, and the new procedure or new technology to be taught. The preceptor/trainer and the preceptee/trainee shall be subject to the Bylaws, Rules and Regs, and policies, specifically including any relevant requirement related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the preceptee/trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this section, the following definitions apply:

- 5.5.1 Preceptor/trainer: An expert surgeon/physician who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in question. To serve as a preceptor in a specific procedure or technique, the surgeon/physician (preceptor) must be a recognized authority (e.g. through publications, presentations, extensive clinical experience) in the particular field of expertise.
- 5.5.2 Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and or procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be Board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

## **6 ARTICLE SIX: CORRECTIVE ACTIONS**

### **6.1 CRITERIA FOR INITIATION**

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) unprofessional, inappropriate, disruptive or harassing, (as defined in these Bylaws and in Hospital policies, including sexual harassment), (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief of Staff, appropriate Department Chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible

Any Professional Review Body as defined under the Health Care Quality Improvement Act of 1986 shall have the power to conduct an informal inquiry of a Practitioner and conduct a collegial intervention or recommend to the CEO that a formal investigation be conducted-

### **6.2 COLLEGIAL INTERVENTIONS**

These Bylaws encourage the use of progressive steps by medical staff leaders and Hospital management, beginning with collegial and education efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws.

6.2.1 Collegial intervention is a part of the Hospital's professional review activities and may include, but is not limited to, the following:

- 6.2.1.1 Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

- 6.2.2 Informal discussions or formal meetings regarding the concerns raised about conduct or performance; including actions outlined in Article 3. That may be taken to address unprofessional or inappropriate conduct;
- 6.2.3 Proctoring, monitoring, consultation, and letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 6.2.4 Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms
- 6.2.5 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 6.2.6 Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 6.2.7 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 6.2.8 Requirements to seek assistance for a health issue, as provided in these Bylaws.
- 6.2.9 The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.
- 6.2.10 The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

### 6.3 PRECAUTIONARY SUSPENSION OR PRECAUTIONARY RESTRICTION OF CLINICAL PRIVILEGES

#### Grounds for Precautionary Suspension or Restriction:

- 6.3.1.1 Whenever a practitioner or other individual with clinical privileges willfully disregards these Bylaws or the Medical Staff Rules & Regulations or Hospital Policies, or whenever his/her conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the hospital, or to prevent interference with the orderly operation of the Hospital, the Chief of Staff, the chief of a clinical department, the Chief Executive Officer, the Board Chairperson, or the Medical Executive Committee shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.
- 6.3.1.2 A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.
- 6.3.1.3 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.
- 6.3.1.4 A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the Chief of Staff, and shall remain in effect unless it is modified by the Chief Executive

Officer or the Medical Executive Committee. The Department Chairperson for the department to which a suspended or restricted practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the practitioner's patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute practitioner. A suspended or restricted practitioner's elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another practitioner as requested by each patient.

#### 6.3.2 Reporting Requirement:

6.3.2.1 In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual's privileges for more than thirty (30) days.

#### 6.2.2 Medical Executive Committee Procedure:

6.2.2.1 As soon as possible after such precautionary suspension, the Medical Executive Committee shall be convened to review the matter resulting in a precautionary suspension or restriction and consider the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

6.2.2.2 After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee must determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

#### 6.2.3 Reporting Requirement:

6.2.3.1 If the Medical Executive Committee's recommendation is not adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall not be entitled to a hearing and appeal.

6.2.3.2 If the Medical Executive Committee's recommendation is adverse to the practitioner as defined in Article Seven of these Bylaws, the practitioner shall be afforded procedural rights to an appellate review as outlined in Article Seven of these Bylaws. The terms of the precautionary suspension shall remain in effect pending a decision by the Board of Trustees.

### 6.4 FORMAL INVESTIGATION –

The CEO shall consult with the President of the Medical Staff, or the MEC to determine whether a concern about professional competence or conduct should be formally investigated. Whenever it appears that corrective action against a Practitioner or other individual with clinical privileges may be necessary or advisable, the CEO may initiate an investigation by an ad hoc investigation committee. Requests for a formal investigation may be initiated by the CEO, the President of the Medical Staff, by any other officer of the Medical Staff, by the Chairman of any department, by the Chairman of any committee of the Medical Staff, or by any member of the Board of Trustees. Any request for a formal investigation shall be in writing and shall be submitted to the CEO, together with detailed information concerning the specific activities or conduct which constitutes grounds for the request. The initiation of a formal investigation shall not preclude the imposition of suspension or restriction of clinical privileges under these Bylaws. A formal investigation shall begin only after a determination by the MEC or the Board of Trustees to do so.

6.4.1 APPOINTMENT OF AD HOC INVESTIGATION COMMITTEE –A determination is made to investigate formally the necessity or advisability of corrective action against a particular Practitioner, as the result of an informal investigation or otherwise, an Ad Hoc Investigation Committee shall be appointed. In addition, an Ad Hoc Investigation Committee shall be appointed to investigate a Practitioner any time the Licensure Board places a restriction or limitation of any sort on such Practitioner’s license or places such Practitioner on probation, unless the action of the Licensure Board has resulted in automatic termination of the appointment of the Practitioner. It is the explicit intention of the Medical Staff that the Ad Hoc Investigation Committee shall consist of the President of the Medical Staff (or designee), two (2) Practitioners appointed by the CEO and two (2) Practitioners appointed by the President of the Medical Staff. A designee of the Chairperson of the service to which the affected Practitioner is assigned shall serve as a consultant to the Ad Hoc Investigation Committee. The President of the Medical Staff (or designee) shall serve as Chairperson of the Ad Hoc Investigation Committee. The Ad Hoc Investigation Committee shall have no voting members who are in direct economic competition with the Practitioner who is the subject of the investigation. In the event there are not a sufficient number of Practitioners who meet such criteria, the CEO may appoint physicians who are not affiliated with the Hospital who meet such criteria. The Practitioner shall be advised of the names of the Ad Hoc Investigation Committee members within ten (10) days of the appointment of such Ad Hoc Investigation Committee. If the Practitioner who is the subject of the investigation advises the President of the Medical Staff that he or she believes a member of the Ad Hoc Investigation Committee does not meet this criterion, the President of the Medical Staff shall determine the merit of such contention and, if the contention is found to be correct, shall appoint a substitute to serve on the Ad Hoc Investigation Committee. An investigation by an Ad Hoc Investigation Committee shall be considered an administrative matter and not an adversarial proceeding. A Practitioner who is the subject of an investigation shall not be entitled to have legal counsel present during any meetings or discussions between such Practitioner and members of an Ad Hoc Investigation Committee. Testimony and documentary evidence taken informally at the ad hoc investigation stage must be verified under oath at any hearing, if considered.

6.4.2 PRELIMINARY REPORT OF AD HOC INVESTIGATION COMMITTEE –

Upon conclusion of its investigation, the ad hoc investigation committee shall submit a preliminary report to the CEO, to the elected officers of the Medical Staff and to the affected Practitioner. Such report shall contain a statement detailing the preliminary findings, conclusions and recommendation of the ad hoc investigation committee. The CEO, the elected officers of the Medical Staff and to the affected Practitioner shall each be given the opportunity to submit comments on the preliminary report of the ad hoc investigation committee within fifteen (15) days following receipt of the preliminary report.

6.4.3 PROCEDURE OF AD HOC INVESTIGATION COMMITTEE –

The report of the Ad Hoc Investigation Committee shall be forward to the Board of Trustees (i) at such time as a hearing, if requested, is completed and the Hearing Committee’s report is forwarded to the Board of Trustees, (ii) at such time as any hearing right is waived, or (iii) upon its issuance if no hearing right exists. If the Ad Hoc Investigation Committee has made a proposal to recommend an action for which a hearing right is required under Article Six then the affected Practitioner shall be entitled to the procedural rights set forth in the Fair Hearing procedures before final action is taken by the Board of Trustees. If a hearing is requested and the Hearing Committee or, upon appeal, an Authorized Committee of the Board of Trustees recommends a decision in accordance with the proposed recommendation of the Ad Hoc Investigation Committee, then the proposed recommendation shall be deemed to have been made, and the Board of Trustees shall be notified that the proposed recommendation of the Ad Hoc Investigation Committee is a final recommendation of such Committee, and the Board of Trustees shall take final action after reviewing the report of the Committee. If the Ad Hoc Investigation Committee does not propose to recommend any action as to which a hearing right is required under the Fair Hearing Procedure, then the Committee’s report and its recommendation shall be forwarded to the Board of Trustees for final action.

6.5 ACTION ON INVESTIGATION REPORT

As soon as practicable after the conclusion of an investigation, the Medical Executive Committee or the Board of Trustees may:

- 6.5.1 Determine that corrective action is not warranted and dismiss the matter;

- 6.5.2 Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in paragraph 6.2 of these Bylaws; or,
- 6.5.3 Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Seven.

#### 6.6 AUTOMATIC SUSPENSION OR TERMINATION

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, the individual shall be immediately and automatically suspended from practicing in the Hospital by the CEO, and his/her staff membership may be automatically terminated. The CEO shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice. The CEO shall also notify the Chief of Staff and Hospital staff members, and take necessary steps to enforce the suspension.

The following circumstances shall constitute conditions for automatic suspension, and if indicated, automatic termination:

##### 6.6.1 LICENSURE

If an individual's license to practice is revoked or suspended by a state licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the Hospital and his/her staff membership shall be automatically terminated.

##### 6.6.2 CONTROLLED SUBSTANCE REGISTRATION

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, or if an individual fails to maintain a current unrestricted registration, he/she may be automatically suspended from practicing in the Hospital. The individual's prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

##### 6.6.3 LIABILITY INSURANCE

If an individual's professional liability insurance is revoked or the individual fails to maintain ongoing coverage as required in these Bylaws, he/she shall be immediately automatically suspended from practicing in the Hospital.

##### 6.6.4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital:

6.6.4.2 Becoming an Ineligible Person; or,

6.6.4.3 A criminal conviction.

##### 6.6.5 MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. The suspension shall continue until all of the individual's delinquent records are completed.

##### 6.6.6 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, and the misrepresentation or omission is a material or substantive misrepresentation, as judged by the MEC, the individual's membership and clinical privileges shall be automatically terminated. Substantial or material misrepresentation of the applicant's qualifications, competence or character may be grounds for the Board of Trustees to permanently disqualify an individual from applying for

membership or clinical privileges or to set a specific time period after which the applicant may reapply.

#### 6.6.7 Reporting Requirement

6.6.7.2 In compliance with the Health Care Quality Improvement Act of 1996, reports to the National Practitioner Data Bank shall include actions based on professional competence or conduct which adversely affects or could affect the health or welfare of a patient, or the surrender of privileges as a result of, or during, an investigation that affects an individual's privileges for more than thirty (30) days.

### 6.7 COVERAGE DURING SUSPENSIONS

6.7.1 WHEN A PRECAUTIONARY SUSPENSION OR AN AUTOMATIC SUSPENSION HAS BEEN IMPOSED, THE HOSPITAL SHALL ARRANGE FOR COVERAGE FOR ALTERNATIVE COVERAGE. WHEN THE INDIVIDUAL BEING SUSPENDED OR RESTRICTED IS A PRACTITIONER, THE CHIEF OF STAFF OR THE CHAIRPERSON OF THE PRACTITIONER'S DEPARTMENT SHALL ARRANGE FOR ALTERNATIVE MEDICAL COVERAGE OF A SUSPENDED PRACTITIONER'S PATIENTS IN THE HOSPITAL AND FOR COVERAGE OF PATIENT CARE SUBJECT TO A RESTRICTION. THE WISHES OF THE PATIENT SHALL BE CONSIDERED IN THE SELECTION OF AN ALTERNATIVE PRACTITIONER. WHEN THE INDIVIDUAL BEING SUSPENDED OR RESTRICTED IS AN ADVANCED PRACTICE PROFESSIONAL, THE SPONSORING PHYSICIAN SHALL BE RESPONSIBLE FOR ARRANGING ALTERNATIVE COVERAGE FOR THE CARE NORMALLY PROVIDED BY THE INDIVIDUAL. FAILURE TO PROVIDE REQUESTED INFORMATION

Failure of an individual to provide information pertaining to that individual's qualifications for Medical Staff membership or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information within a timeframe specified in the written request, will result in the automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party

### 6.8 CRIMINAL ARREST

In the event that an individual is arrested or indicted for alleged criminal acts, an immediate investigation into the circumstances of the arrest or indictment shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest or indictment and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual subject to such action to notification and the right to a hearing and appeal as set forth in Article Seven.

### 6.9 REINSTATEMENT FOLLOWING A SUSPENSION

6.9.1 Requests for reinstatement will be reviewed by the relevant department chief, the Chair of the Credentials Committee, the Chief of Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board of Trustees for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board of Trustees for review and recommendation.

### 6.10 AUTOMATIC RESIGNATION

#### 6.10.1 RELOCATION

Unless otherwise approved by the Board upon recommendation of the Medical Executive Committee, any member of the staff or other individual with clinical privileges who takes up permanent residence more than 30 miles from the Hospitals shall be deemed to have resigned from the Staff and relinquished all clinical privileges.

6.10.2 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

A term of medical staff membership or the granting of clinical privileges shall be for a period of no more than two years (24 months). In the event that reappointment or a renewal of clinical privileges has not occurred for whatever reason prior to the expiration of the current term of appointment, the membership and clinical privileges of the individual shall be terminated. The individual shall be notified of the termination and the need to submit a new application if continued membership or clinical privileges are desired.

6.10.3 Failure to be Reinstated Following Automatic Suspension

When an individual is automatically suspended due to failure to maintain a current license, a controlled substance registration, liability insurance, or eligibility to participate in Federal programs, or the automatic suspension is due to failure to complete medical records timely, or any other reason for automatic suspension, and the automatic suspension continues for more than 60 days without verified evidence of reinstatement of the expired credential, reinstatement as a participant in Federal programs, or completion of medical records, then the individual shall be deemed to have voluntarily resigned from the Staff, voluntarily relinquished all clinical privileges, and waived any rights to fair hearing or appeal process. The individual shall be notified of the automatic voluntary resignation and the need to submit a new application if reinstatement of membership or clinical privileges is desired.

**7 ARTICLE SEVEN: HEARING AND APPELLATE REVIEW PROCEDURES**

7.1 OVERVIEW

Fair hearing and appellate review procedures shall be used when professional review actions are being taken when it involves an individual applying for Medical Staff membership for existing Medical Staff members, and for other individuals applying for or holding clinical privileges. The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, and after a reasonable effort to obtain the facts of the matter, and in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures and other procedures as are fair to the individual are afforded to the individual subject to professional review actions. Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified. The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Article Seven, Section 7.8 of these Bylaws.

7.2 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

7.2.1 COLLEGIAL ACTIONS

The practitioner does not have a right to a hearing in any of the following circumstances when collegial action(s) is taken, or when an adverse action is recommended by not taken:

- 7.2.1.1 Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- 7.2.1.2 Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 3.21 that may be taken to address unprofessional or inappropriate conduct;
- 7.2.1.3 Proctoring, monitoring, consultation, and letters of guidance;
- 7.2.1.4 Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;
- 7.2.1.5 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

- 7.2.1.6 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 7.2.1.7 Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 7.2.1.8 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 7.2.1.9 Requirements to seek assistance for a health issue, as provided in these Bylaws.
- 7.2.1.10 A request for an adverse action involving the practitioner that has been recommended but denied.

#### 7.2.2 AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

The hearing and appeal rights under these Bylaws do not apply to an individual whose application or request for extension of privileges was declined on the basis that the clinical privileges being requested are not able to be supported with available facilities or resources within the Hospital, or are not granted due to closed staff or exclusive contract or in accord with a Medical Staff development plan. The hearing and appeal rights under these Bylaws do not apply to an individual who has clinical privileges retracted or automatically terminated due to the Hospital closing or discontinuing a service, or entering into an exclusive contract.

#### 7.2.3 MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

The terms of any written contract between the Hospital and a Contract Practitioner or Contractor shall take precedence over these Bylaws as now written or hereafter amended. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges, which are independent of the individual's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

#### 7.2.4 AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws for reasons not related to the Practitioner's qualifications, competence or professional conduct.

#### 7.2.5 REMOVAL FROM EMERGENCY CALL PANEL

Participation on the emergency on-call panel is not a benefit or privilege of Staff membership, but rather is an obligation. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

#### 7.2.6 HOSPITAL POLICY DECISION

The hearing and appeal rights of these Bylaws are not available if the Hospital makes a policy decision (e.g., closing a department or service, or a physical plant change) that adversely affects the Staff membership or clinical privileges of any Staff member or other individual.

#### 7.2.7 ADMINISTRATIVE ACTIONS

A practitioner does not have the right to a hearing in any of the following circumstances:

- 7.2.7.1 Change to specific medical staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;
- 7.2.7.2 Denial, termination or reduction of temporary privileges if the reasons are unrelated to professional competence or conduct;

7.2.7.3 Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;

7.2.7.4 Any other actions except those listed in Section 7.3.

### 7.3 HEARING RIGHTS

#### 7.3.1 ADVERSE RECOMMENDATIONS OR ACTIONS

Only individuals who are subject to an adverse recommendation or action are entitled to a hearing under these Bylaws if recommended by the MEC, or if taken by the Board contrary to a favorable recommendation by the MEC under circumstances where a right to hearing exists. The following recommendations or actions shall be deemed adverse and entitle the individual affected thereby to a hearing:

7.3.1.1 Denial of initial staff appointment;

7.3.1.2 Denial of reappointment;

7.3.1.3 Suspension of staff membership;

7.3.1.4 Revocation of staff membership;

7.3.1.5 Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations;

7.3.1.6 Denial of requested clinical privileges;

7.3.1.7 Involuntary reduction in clinical privileges;

7.3.1.8 Precautionary suspension or restriction of clinical privileges, as defined in Article Six, Section 6.3;

7.3.1.9 Revocation of clinical privileges; or,

7.3.1.10 Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to provisional status or the granting of new privileges).

#### 7.3.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to these Bylaws shall promptly be given special written notice of such action. Such notice shall:

7.3.2.1 State the reasons for an adverse recommendation or action, with enough specifics to allow response;

7.3.2.2 Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.

7.3.2.3 Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.

7.3.2.4 State that failure to request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.

7.3.2.5 State a summary of the Practitioner's rights at the hearing.

7.3.2.6 State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

### 7.3.3 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 7.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief Executive Officer either in person or by certified mail..

### 7.3.4 FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 7.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

- 7.3.4.1 An adverse recommendation by the MEC shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board.
- 7.3.4.2 An adverse action by the Board shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board.

## 7.4 HEARING PREREQUISITES

### 7.4.1 SPECIAL WRITTEN NOTICE

Upon receipt of a timely request for a hearing, the Chief Executive Officer shall deliver such request to the Chief of Staff or to the Trustees, depending on whose recommendation or action prompted the request for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent a special written notice stating the following:

- 7.4.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;
- 7.4.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;
- 7.4.1.3 The Practitioner involved has the right:
  - 7.4.1.3.1 To be present at the hearing;
  - 7.4.1.3.2 To representation by an attorney or other person of the Practitioner's choice;
  - 7.4.1.3.3 To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
  - 7.4.1.3.4 To call, examine, and cross-examine witnesses;
  - 7.4.1.3.5 To present evidence determined to be relevant by the chairman of the hearing committee, regardless of its admissibility in a court law; and,
  - 7.4.1.3.6 To submit a written statement at the close of the hearing.
  - 7.4.1.3.7 Upon completion of the hearing, the Practitioner involved has the right: To receive a record of the proceedings upon payment of a reasonable charge.
  - 7.4.1.3.8 To receive a written decision of the Board of Trustees, including a statement of the basis for the decision.
  - 7.4.1.3.9 during a hearing, each parties shall have the right to conduct discovery only in accordance with these bylaws.
- 7.4.1.4 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

#### 7.4.2 APPOINTMENT OF HEARING PANEL

7.4.2.1 By Medical Staff: A hearing occasioned by an adverse recommendation of the MEC shall be conducted by an ad hoc hearing committee appointed by the Chief of Staff.

7.4.2.2 By Board of Trustees: A hearing occasioned by an adverse action of the Board shall be conducted by a hearing panel appointed by the Chairperson of Board.

7.4.2.3 Composition of Hearing Panel: The Hearing Panel shall be composed of at least three members. One of the members so appointed will be designated as the Chairperson. The Chairperson will preside over the hearing. No member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a member from serving. No member shall be appointed who is in direct economic competition with the Practitioner, or is a member of the Medical Executive Committee or Board of Trustees. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the hearing panel, the medical Executive Committee or the Board may appoint Practitioners who are not members of the Medical Staff.

7.4.2.4 Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any member of the hearing committee for any cause, which would indicate bias or predisposition. The Chairperson, or if challenged, the Chief of Staff, shall decide the validity of such challenges. His/her decision shall be final.

#### 7.5 HEARING PROCEDURE

##### 7.5.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 7.3.4.

##### 7.5.2 PRESIDING OFFICER

The Chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

##### 7.5.3 APPOINTMENT OF A HEARING OFFICER OR LEGAL CONSULTANT

The use of a hearing officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Chief of Staff or by the Chairman of the Board of Trustees. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/she shall act as the presiding officer of the hearing. Alternatively, the Chief of Staff may appoint an attorney to be a legal consultant to the Hearing Panel. The hearing officer or legal consultant may be present during deliberations, but shall not vote. Once a hearing officer has been appointed, he or she may only be removed for cause by the Chief of Staff with CEO approval.

##### 7.5.4 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice. The MEC or the Board, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

##### 7.5.5 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

- 7.5.5.1 Call and examine witnesses;
- 7.5.5.2 Introduce exhibits;
- 7.5.5.3 Cross-examine any witness on any matter relevant to the issues;
- 7.5.5.4 Impeach any witness;
- 7.5.5.5 Rebut any evidence
- 7.5.5.6 Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

#### 7.5.6 PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing panel is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The hearing panel shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the hearing panel Chairperson's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

#### 7.5.7 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of their recommendation or action, but the Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the recommendation or action lacks any substantial factual basis or that the adverse recommendation or action is either arbitrary, unreasonable, or capricious.

#### 7.5.8 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit a valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A court reporter shall be present if requested by any party (at the expense of the requesting party).

#### 7.5.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairperson to a date agreeable to the hearing panel only by stipulation between the parties or upon a showing of good cause.

#### 7.5.10 PRESENCE OF HEARING PANEL MEMBERS AND VOTE

A majority of the hearing panel but in no event less than three members, must be present throughout the hearing and deliberations. If a panel member is absent from any part of the proceedings, that member shall not be permitted to participate in the deliberations or to vote.

#### 7.5.11 RECESSES AND ADJOURNMENT

The hearing panel may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

## 7.6 HEARING PANEL REPORT AND FURTHER ACTION

### 7.6.1 HEARING PANEL REPORT

Within fourteen (14) days after the final adjournment of the hearing, the hearing Panel shall make a written report of its findings and recommendations in the matter, as decided by a majority of the entire hearing panel, and shall forward the same, together with the hearing record and all other documentation considered by it, to the CEO for distribution to the Medical Executive Committee and the Practitioner.

### 7.6.2 ACTION ON HEARING PANEL REPORT

Within 30 days after receipt of the written report of the Hearing Panel, the MEC or Board, as the case may be, shall consider the report and affirm, modify or reverse its recommendations or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing panel and all other documentation considered, to the Chief Executive Officer. The MEC or Board, as the case may be, may also request a status report by the Chairperson of the hearing panel during the 30-day review period.

### 7.6.3 NOTICE AND EFFECT OF RESULT

7.6.3.1 Notice: The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by special notice, to the Chief of Staff, to the MEC and to the Board.

#### 7.6.3.2 Effect of Favorable Result:

7.6.3.2.1 Adopted by the MEC: If the MEC's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereupon by adopting, rejecting, or modifying the MEC's recommendation in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall within 31 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

7.6.3.2.2 Adopted by the Board: If the Board's initial hearing action is favorable to the Practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

7.6.3.3 Effect of Adverse Result for Practitioner: If the result of the MEC or of the Board continues to be adverse to the Practitioner in any of the respects listed in Section 7.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 7.7.1.

## 7.7 APPELLATE REVIEW

### 7.7.1 Time for Appeal

7.7.1.1 Within 10 days after receipt of notice of the Hearing Panel's recommendation either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. 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.

7.7.2 Grounds for Appeal:

7.7.2.1 The grounds for appeal shall be limited to the following:

7.7.2.1.1 There was substantial failure to comply with the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

7.7.2.1.2 The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.7.3 Time, Place and Notice

7.7.3.1 Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson 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.

7.7.4 Nature of Appellate Review

7.7.4.1 The Board may consider the appeal as a whole body, or the Chairperson of the Board may appoint a Review Panel composed of no less than three persons, either members of the Board or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

7.7.4.2 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 ten days to respond. In its sole discretion, the Board (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

7.7.4.3 The Board (or 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 Board (or Review Panel).

7.7.5 Appellate Review in the Event of Board Modification or Reversal of Hearing Panel Recommendation

7.7.5.1 If the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board has the final say in the matter, regardless of what the Hearing Panel recommends, as long as the decision of the Board reasonably relates to the operation of the hospital and is administered fairly.

7.7.6 Final Decision of the Board

7.7.6.1 Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

7.7.6.2 The Board may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further

review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

- 7.7.6.3 The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

#### 7.7.7 Further Review

- 7.7.7.1 Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board 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.

### 7.8 RIGHT TO ONE HEARING AND ONE APPEAL ONLY

No member of the Medical Staff 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, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

### 7.9 CHAIR PERSON GENERAL PROVISIONS

#### 7.9.1 NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to a specific adverse recommendation or action.

#### 7.9.2 RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article Twelve in these Bylaws relating to immunity from liability in all matters relating thereto.

#### 7.9.3 CONFIDENTIALITY

The investigations, proceedings and records conducted or created for the purpose of carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected by State and Federal Law.

#### 7.9.4 HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

Individuals with clinical privileges who are not eligible for Medical Staff membership and who are not Medical Staff members (i.e., Advanced Practice Professionals - APPs) are afforded a fair hearing and appeal process but that process shall be a modification of that for Medical Staff members or applicants for Medical Staff membership. The following procedures shall be used for APPs:

- 7.9.4.1 Notice: Written notice of an adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has 30 days in which to request a hearing. If the APP does not request a hearing within 30 days, the APP shall have waived right to a hearing.

- 7.9.4.2 Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, the Chief of Staff or another officer of the Medical Staff, and a peer of the APP. None of the panel members shall have had a role in the adverse recommendation or action.

7.9.4.3 Rights: The APP subject to the adverse recommendation or action shall have the right to present information, but cannot have legal representation or call witnesses.

7.9.4.4 Hearing Panel Determination: Following presentation of information and panel deliberations, the panel shall make a determination:

7.9.4.4.1 A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

A. A determination adverse to the APP shall result in notice to the APP of the right to appeal the decision to the Chairperson of the Board

B. Final Decision: The decision of the Chairperson of the Board shall be final.

#### 7.9.5 EXTERNAL REPORTING REQUIREMENTS

The individual consents to the reporting by any Hospital Representative of Information to the National Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 and to other Federal agencies or to State agencies as required by laws, statutes or regulation, which such Hospital representative believes in good faith is required by law to be reported.

### 8 ARTICLE EIGHT: MEDICAL STAFF OFFICERS

#### 8.1 ELECTED OFFICERS OF THE STAFF

##### 8.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the Chief of Staff, the Chief of Staff-Elect, the Secretary-Treasurer, and the Immediate Past Chief of Staff.

##### 8.1.2 QUALIFICATIONS

Officers must be members of the active staff in good standing at the time of nomination and election and must continuously maintain such status during their terms of office. To qualify for the position of Chief of Staff or Chief of Staff-Elect, a member of the Medical Staff must be a doctor of medicine or osteopathy. No Medical Staff member actively practicing in the Hospital is ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

8.1.2.1 To have membership in good standing on the Medical Staff, and to have served on the Medical Staff for at least two years;

8.1.2.2 To not be under investigation by the Medical staff or any local, state or Federal agency with regard to professional practice, and to have no adverse recommendations concerning Medical Staff appointment or clinical privileges;

8.1.2.3 Be willing to faithfully discharge the duties and responsibilities of the position;

8.1.2.4 Have experience in a leadership position for at least two years, or other involvement in performance improvement functions;

8.1.2.5 Attend continuing education relating to medical staff leadership and/or credentialing functions during the term of the office.

#### 8.2 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

##### 8.2.1 TERM OF OFFICE

Each officer shall serve a two (2) year term. The term of office shall commence on the first day of the medical staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of

the Chief of Staff's term, the Chief of Staff-Elect shall automatically assume that office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

### 8.3 ATTAINMENT OF OFFICE

#### 8.3.1 NOMINATION

Within THIRTY (30) days of the last meeting of the year, the Nominating Committee shall notify the Medical Staff in writing of the nominees selected. The Medical Staff shall be given the opportunity during those THIRTY(30) days to write in additional nominees. Ballots shall list those names selected by the Nominating Committee, as well as those write-in nominees who have accepted the nomination.

#### 8.3.2 ELECTION

Voting at the annual meeting shall be by secret written ballot, and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority vote, a runoff election between the two candidates receiving the highest number of votes shall be held at the meeting by secret written ballot. If a tie results, the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.

#### 8.3.3 BOARD RATIFICATION/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Division officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities. The Board's ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:

- 8.3.3.3 The activities such leaders undertake shall be performed on behalf of the Hospital;
- 8.3.3.4 The activities shall be performed in good faith,
- 8.3.3.5 That any professional review action shall be taken:
  - 8.3.3.5.1 In the reasonable belief that the action was in the furtherance of quality health care;
  - 8.3.3.5.2 After a reasonable effort to obtain the facts of the matter;
  - 8.3.3.5.3 After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,
  - 8.3.3.5.4 In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.
- 8.3.3.6 The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies;
- 8.3.3.7 Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

## 8.4 VACANCIES

### 8.4.2 WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active staff status in good standing.

### 8.4.3 OFFICE OF THE CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff, then the Chief of Staff-Elect shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of Chief of Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Chief of Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the Board shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

When a vacancy occurs in the office of the Chief of Staff-Elect, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election, when both a Chief of Staff and Chief of Staff-Elect shall be elected. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election.

## 8.5 RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

### 8.5.2 RESIGNATION

Any medical staff officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

### 8.5.3 REMOVAL

Any elected Medical Staff officer or member of the Medical Executive Committee may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

- 8.5.3.3 Failure to perform the duties of office;
- 8.5.3.4 Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
- 8.5.3.5 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 8.5.3.6 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,
- 8.5.3.7 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

#### 8.5.4 RECALL FROM OFFICE

Any elected Medical Staff officer or a member of the Medical Executive Committee may be recalled from office, with or without cause. Recall of a Medical Staff officer or a member of the Medical Executive Committee may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in medical Staff-Elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

### 8.6 RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS

#### 8.6.2 PRESIDENT/CHIEF OF STAFF

The President/Chief of Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the Chief of Staff are to:

- 8.6.2.3 Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;
- 8.6.2.4 Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- 8.6.2.5 Serve as ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;
- 8.6.2.6 Appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, except when these memberships are designated by position or by specific direction of the Board;
- 8.6.2.7 Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;
- 8.6.2.8 Be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;
- 8.6.2.9 Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the CEO and the Board, and serve as an ex-officio member of the Board, with a vote;
- 8.6.2.10 Receive and interpret the opinions, policies, and directives of the Administration and the Board to the Medical Staff;
- 8.6.2.11 Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,
- 8.6.2.12 Perform all other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board.
- 8.6.2.13 Recommend clinical privileges for each member of the Medical Staff or other individual requesting clinical privileges. If the Chief of Staff is in direct economic competition with the applicant, then the Chief of Staff should not participate in the decision, but should delegate this responsibility to the Chief of Staff Elect.
- 8.6.2.14 Conduct surveillance of the professional performance of all individuals who have clinical privileges.

8.6.3 PRESIDENT/CHIEF OF STAFF-ELECT

The Chief of Staff-Elect shall perform the duties of the Chief of Staff in the absence or temporary inability of the Chief of Staff to perform. The Chief of Staff-Elect shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the Chief of Staff or the Board.

8.6.4 SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer are to:

- 8.6.4.3 Maintain a roster of Medical Staff members;
- 8.6.4.4 Keep accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;
- 8.6.4.5 Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff;
- 8.6.4.6 Be custodian of Staff records and attend to all appropriate correspondence and notices on behalf of the Medical Staff; and,
- 8.6.4.7 Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority.

8.6.5 IMMEDIATE PAST PRESIDENT/CHIEF OF STAFF

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Chief of Staff shall serve as an advisor and mentor to the Chief of Staff, shall participate as a member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Chief of Staff.

8.7 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the medical staff affairs of the Hospital. The Chief Medical Officer is not elected by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Article Three, Section 3.16 of these Bylaws apply.

8.7.2 QUALIFICATIONS

The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership.

8.7.3 RESPONSIBILITIES AND AUTHORITY

The Chief Medical Officer shall serve as an advisor to the officers of the Medical Staff and as a liaison between the Medical Staff and the Administration of the Hospital. The authority of the Chief Medical Officer shall be that of an administrator of the Hospital, as assigned by the Chief Executive Officer. Specific responsibilities include, but are not limited to:

- 8.7.3.3 Administratively oversee the Medical Staff Services in performance of the credentialing function;
- 8.7.3.4 Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;
- 8.7.3.5 Serve as an ex-officio Member of all Medical Staff committees, without vote;
- 8.7.3.6 Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

8.7.4 APPOINTMENT

After having received input from the Medical Executive Committee, Chief Medical Officer shall be appointed by the Chief Executive Officer and approved by the Board.

8.7.5 VACANCY

In the event of a vacancy in the position of Chief Medical Officer, the Chief of Staff shall ensure that any Medical Staff functions associated with the position are performed.

**9 ARTICLE NINE: CLINICAL DEPARTMENTS AND SPECIALTY DIVISIONS**

9.1 DESIGNATION

9.1.2 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be organized into clinical Departments. The Medical Staff Departments are:

9.1.2.3 Medicine/Family Practice Department

9.1.2.4 Surgery Department

9.1.2.5 GYN Department

9.1.1.4 Trauma Department

9.1.3 SPECIALTY DIVISIONS WITHIN A DEPARTMENT

Each Department may be further subdivided into specialties:

9.1.3.3 DEPARTMENT OF MEDICINE:

Allergy & Immunology	Geriatric Psychiatry	Nuclear Cardiology
Cardiology	Geriatrics	Pediatrics
Cardiology, Interventional	Hematology/Oncology	Phlebology
Critical Care	Hyberbaric Medicine	Physician Medicine & Rehab
Dermatology	Infectious Diseases	Psychiatry
Emergency Medicine	Internal Medicine	Pulmonary Diseases
Endocrinology/Metabolism	Nephrology	Rheumatology
Family Practice	Neurology	

9.1.3.4 DEPARTMENT OF SURGERY:

Anesthesiology	Oral and Maxillofacial Surgery	Radiology
Cardio-Thoracic Surgery	Orthopedic Surgery	Spine Surgery
Colon and Rectal Surgery	Otorhinolaryngology	Thoracic-Vascular Surgery
Dentistry	Pain Management	Urological Surgery
General Surgery	Pathology	Vascular Surgery
Neurological Surgery	Plastic Surgery	Thoracic-Vascular Surgery
Ophthalmology	Podiatry	

9.1.3.5 DEPARTMENT OF GYNECOLOGY

Gynecology

9.1.3.6 Department of Trauma

Trauma Surgery

## 9.2 CRITERIA TO QUALIFY AS A DEPARTMENT

The Medical Executive Committee may create, eliminate, subdivide or combine Departments, subject to approval by the Board, based on the evolving scope of clinical services of the Hospitals and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Department is to be responsible for the quality of patient care provided by the members of the Department, the primary criteria for creating or subdividing a Department, or in eliminating or combining a Department shall be whether the Department has a sufficient number of active staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department.

## 9.3 REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS

Each Medical Staff member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A Medical Staff member or other individual with clinical privileges may be assigned to a Division if one exists related to the member's or individuals clinical specialty. A member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of the Department and the authority of the Department Chairperson.

## 9.4 PERFORM PEER REVIEW AND QUALITY ASSESSMENT ACTIVITIES RELATIVE TO THE PERFORMANCE OF INDIVIDUALS WITH CLINICAL FUNCTIONS OF DEPARTMENTS

The Departments shall meet at least quarterly to perform the following functions:

### 9.4.2 CLINICAL FUNCTIONS

- 9.4.2.3 Serve as a forum for the exchange of clinical information regarding services provided by Department members;
- 9.4.2.4 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;
- 9.4.2.5 Provide recommendations to the Department Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board that patients shall receive quality care. The recommendations shall include:
  - 9.4.2.5.1 Criteria for granting, withdrawing and modifying clinical privileges;
  - 9.4.2.5.2A procedure for applying these criteria to individuals requesting privileges.
- 9.4.2.6 Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;
- 9.4.2.7 Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;
  - 9.4.2.7.1 By establishing uniform patient care processes;
  - 9.4.2.7.2 By establishing similar clinical privileging criteria for similar privileges;
  - 9.4.2.7.3 By using similar indicators in performance improvement activities.
- 9.4.2.8 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;
- 9.4.2.9 Ensure effective mechanisms for the clinical supervision of Advanced Practice Professionals, and House Staff practitioners, if any.

#### 9.4.3 ADMINISTRATIVE FUNCTIONS

- 9.4.3.3 Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the Department;
- 9.4.3.4 Ensure that individuals within the Department who admit patients have privileges to do so, and that all individuals within the Department with clinical privileges only provide services within the scope of privileges granted.
- 9.4.3.5 Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff Policies;
- 9.4.3.6 Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Department members.
- 9.4.3.7 Privileges in the Department and report such activities to the Medical Executive Committee on a regular basis;
- 9.4.3.8 Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.
- 9.4.3.9 Ensure appropriate quality control is performed, if applicable to the Department;
- 9.4.3.10 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

#### 9.4.4 COLLEGIAL AND EDUCATIONAL FUNCTIONS

- 9.4.4.3 Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, and the results of Departmental performance improvement activities.

### 9.5 OFFICERS OF DEPARTMENTS

#### 9.5.1 IDENTIFICATION

The officers of the Departments shall be the Department Chairperson.

#### 9.5.2 QUALIFICATIONS

The officers of the Departments shall be active staff members in good standing. Each Department Chairperson shall have demonstrated ability in at least one of the clinical areas of the Department. All officers of the Departments shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.

##### 9.5.2.1 Each Department Chairmen shall:

9.5.2.1.1 Be an Active Staff member;

9.5.2.1.2 Be certified by an appropriate specialty board or equivalent, as determined through the credentialing and privileging process; and

Satisfy the eligibility criteria set forth for Medical Staff Officers

#### 9.5.3 ATTAINMENT OF OFFICE

Department officers shall be elected by a majority vote of the Department members eligible to vote and in attendance at the last meeting of the Department of each even numbered year. The officers selected during the election shall be subject to ratification by the Board and shall take office at the beginning of the subsequent medical staff year.

#### 9.5.4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

The Department Chairperson shall serve a term of office of two years. No person may serve in the same position for more than two consecutive terms.

#### 9.5.5 RESIGNATION

Any Department Chairperson may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

#### 9.5.6 REMOVAL

Any Department Chairperson may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether sufficient evidence exists for grounds for removal, with approval by the Board, or with the majority vote of the Board. Grounds for removal may include any one or more of the following causes, without limitations:

- 9.5.6.1 Failure to perform the duties of office;
- 9.5.6.2 Failure to comply with or support the enforcement of the Hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
- 9.5.6.3 Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 9.5.6.4 Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing and/or failure to maintain specialty board certification or comparable competence; and/or,
- 9.5.6.5 Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.

At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

#### 9.5.7 RECALL

Any Department officer may be recalled from office, with or without cause. Recall of a Department officer may be initiated by a petition signed by at least one-third of the Department members eligible to vote in medical Staff-Elections. Recall shall be considered by the members of the Department at a special meeting of the Department called for that purpose. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. Sealed, authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

#### 9.5.8 VACANCY

In the event of a vacancy in one of the Department officer positions, the President/Chief of Staff shall appoint an interim officer until an election can be held at the next Medical Staff meeting.

#### 9.5.9 RESPONSIBILITY AND AUTHORITY

- 9.5.9.1 Department Chairperson: Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the Department shall be responsible to the Department Chairperson. Each Department Chairperson shall be responsible for the following duties:

- 9.5.9.1.1 Presiding at all meetings of the Department;
- 9.5.9.1.2 Appointing Department members to the positions of Director of MICU, SICU and CVICU and to membership positions on departmental committees, if any; Serving as an ex-officio

member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;

- 9.5.9.1.3 Serving as an ex-officio member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;
- 9.5.9.1.4 Serving as a member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;
- 9.5.9.1.5 Conducting all clinically related activities of the Department;
- 9.5.9.1.6 Conducting all administratively related activities of the Department, unless otherwise provided by the Hospitals;
- 9.5.9.1.7 Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;
- 9.5.9.1.8 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;
- 9.5.9.1.9 Recommending clinical privileges for each member of the Department;
- 9.5.9.1.10 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;
- 9.5.9.1.11 Integrating the Department into the primary functions of the Hospital; Coordinating and integrating interdepartmental and intradepartmental services;
- 9.5.9.1.12 Coordinating and integrating interdepartmental and intradepartmental services;
- 9.5.9.1.13 Developing and implementing policies and procedures that guide and support the provision of services;
- 9.5.9.1.14 Recommending a sufficient number of qualified and competent persons to provide care or services;
- 9.5.9.1.15 Determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services; Ensuring the continuous assessment and improvement of the quality of care and services provided;
- 9.5.9.1.16 Ensuring the continuous assessment and improvement of the quality of care and services provided;
- 9.5.9.1.17 Maintaining quality control programs, as appropriate;
- 9.5.9.1.18 Ensuring the orientation and continuing education of all persons in the Department;
- 9.5.9.1.19 Recommending appropriate space and other resources needed by the Department.

## **10 ARTICLE TEN: FUNCTIONS AND COMMITTEES**

### **10.5 FUNCTIONS OF THE STAFF**

Individual members of the Medical Staff and others with clinical privileges care for patients within an organization context. Within this context, members of the Medical Staff and those individuals with clinical privileges, as individuals and as a group, interface with, and actively participate in important organization functions. Key functions of the Medical Staff are outlined below, and are performed through the Departments, and committees that compose the Medical Staff structure.

#### 10.5.1 GOVERNANCE

Although the Medical Staff is an integral part of the Hospitals and is not a separate legal entity, the Medical Staff is organized to perform its required functions. The Medical Staff organization shall:

- 10.5.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board.
- 10.5.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital

#### 10.5.2 PLANNING

The leaders of the Hospital include members of the Board, the CEO and other senior managers, Department leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Departments and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders. Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

- 10.5.2.1 Planning patient care services;
- 10.5.2.2 Planning and prioritizing performance improvement and patient safety activities;
- 10.5.2.3 Budgeting;
- 10.5.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;
- 10.5.2.5 Recruitment, retention, development, and continuing education of all staff;
- 10.5.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.
- 10.5.2.7 Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department.
- 10.5.2.8 When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.
- 10.5.2.9 If emergency services are not provided at the Hospital, the Medical Staff shall have written policy and procedures for appraisal of emergencies, initial treatment, and referral of patients when needed.
- 10.5.2.10 The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest.
- 10.5.2.11 The Medical Staff, specifically the attending physician, shall be informed of autopsies that the Hospital intends to perform.

#### 10.5.3 CREDENTIALING

The Medical Staff is fully responsible to the Board for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of clinical privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

- 10.5.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.
  - 10.5.3.2 Establish professional criteria for membership and for clinical privileges.
  - 10.5.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.
  - 10.5.3.4 Submit recommendations to the Board regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.
  - 10.5.3.5 Establish a mechanism for fair hearing and appellate review.
  - 10.5.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.
- 10.5.4 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT/PATIENT SAFETY/OPPE/FPPE
- The Board requires that the Medical Staff is accountable to the Board for the quality of care provided to patients.
  - All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospitals' quality assessment and performance improvement activities.
  - All organized services related to patient care shall be evaluated.
  - The Hospitals' utilization management quality assessment and performance improvement shall be described in detail in the Utilization Management Plan and Performance Improvement Plan.
  - Through the activities of the Medical Staff Departments, the Utilization Management the Medical Staff Quality/Peer Review Committee, and Performance Improvement Committees, and representation of the Medical Staff on Hospitals performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below. The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees.
- 10.5.4.1 The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:
- 10.5.4.1.1 That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
  - 10.5.4.1.2 That the results of Hospital-wide quality assessment and performance improvement are, utilized for ongoing professional practice evaluation (OPPE), and focused professional practice evaluation (FPPE), and peer review activities.
  - 10.5.4.1.3 That clear expectations for safety are established.
  - 10.5.4.1.4 That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.
  - 10.1.4.1.5 That the determination of the number of distinct improvement projects is conducted annually.
- 10.5.4.2 Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital's quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of

one or more individuals with clinical privileges. Such activities shall include, but are not limited to a review of the following:

- 10.5.4.2.1 Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;
  - 10.5.4.2.2 Root cause analysis, investigation and response to any unanticipated adverse events;
  - 10.5.4.2.3 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;
  - 10.5.4.2.4 Review and analysis of performance based on the results of core measures and other publicly reported performance information;288
  - 10.5.4.2.5 Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;289
  - 10.5.4.2.6 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;
  - 10.5.4.2.7 Use of blood and blood components, including the review of any significant transfusions reactions
  - 10.5.4.2.8 Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses
  - 10.5.4.2.9 Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;
  - 10.5.4.2.10 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff.
  - 10.5.4.2.11 Use of developed criteria for autopsies
- 10.5.4.3 Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes. Such activities shall include, but are not limited to a review of the following:
- 10.5.4.3.1 Analyzing and improving patient satisfaction; Education of patients and families;
  - 10.5.4.3.2 Education of patients and families
  - 10.5.4.3.3 Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and,
  - 10.5.4.3.4 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates.
  - 10.5.4.3.5 The quality of history and physical exams;
  - 10.5.4.3.6 Surveillance of nosocomial infections.
- 10.5.4.4 Medical Staff Peer Review: Findings relevant to an individual are used in an ongoing professional practice evaluation (OPPE) to verify continued competence for the privileges granted, and focused professional practice evaluation (FPPE) for both the initial appraisal of the individuals competence and when indicated for-cause. When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in FPPE, OPPE or peer review. In accordance with these Bylaws, clinical privileges are renewed or revised appropriately as determined by the Medical Staff or Board based on OPPE or FPPE findings.

#### 10.5.5 CONTINUING EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education. In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Company policy. The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

10.5.5.1 The type and nature of care offered by the hospital; and,

10.5.5.2 The findings of performance improvement activities.

#### 10.5.6 BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

10.5.6.1 Remain consistent with the Bylaws of the Board of Trustees;

10.5.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;

10.5.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities; and,

10.5.6.4 Remain consistent with Hospital policies.

#### 10.5.7 MEDICAL STAFF LEADERSHIP DEVELOPMENT AND NOMINATING

The Medical Staff shall provide a mechanism for developing future medical staff leaders by defining desired leadership characteristics, identifying and recruiting future potential medical staff leaders from among the Members of the Medical Staff, and determining the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.

#### 10.6 PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the standing committees, the Medical Executive Committee or the President/Chief of Staff may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

#### 10.7 DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Utilization Management Committee, the Quality Peer Review Committee, Infection Control Committee, Pharmacy and Therapeutics Committee, Cancer Quality and Assessment

Committee, the CME Committee, the Bylaws Committee, Bioethics Committee and the Nominating Committee.

## 10.8 OPERATIONAL MATTERS RELATING TO COMMITTEES

### 10.4.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation. Medical Staff representatives for a Hospital committee shall be appointed by the President/Chief of Staff with input from the CEO or CMO.

### 10.4.2 EX OFFICIO MEMBERS

The CEO and CMO shall serve as ex-officio member of all Medical Staff committees. The CEO may designate another senior administrative member to attend any meeting in his/her place. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

### 10.4.3 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Prior to the end of each Medical Staff year, the President – Elect will make recommendations to the Medical Executive Committee of staff members to committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Performance Improvement Committee, and any other committee performing a professional review activity shall be subject to ratification by the Board per these Bylaws. The CEO, in consultation and with the approval of the President/Chief of Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

### 10.4.4 TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee member shall be two (2) years. If a chairperson or member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the President/Chief of Staff, the Medical Executive Committee, or the Board may remove that member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

### 10.4.5 NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and may be given not less than three (3) days before the meeting.

### 10.4.6 MEETINGS

The frequency of meeting shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Departments, and Divisions shall be held on the campus of the Hospital. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being

presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported voting system, fax, or email as approved by the Hospital.

#### 10.4.7 QUORUM FOR COMMITTEES

Fifty percent (50%), but not less than TWO (2) committee members present or by proxy, shall constitute a quorum for any Medical Staff committee.

#### 10.4.8 MANNER OF ACTING

Once a quorum has been established, a committee shall take action with a majority of the votes by those who are present or represent a proxy and who have voting rights. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

#### 10.4.9 ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee.

#### 10.4.10 MINUTES

Each committee and subcommittee shall record minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for perpetuity.

#### 10.4.11 PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

#### 10.4.12 REPORTS

Each standing and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part.

#### 10.4.13 COMMITTEES, AND DEPARTMENTS WITH PEER REVIEW RESPONSIBILITIES

Peer review is the concurrent or retrospective review of an individual's professional qualifications professional competence, or professional conduct, including through clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.

10.4.13.1 Purpose of Peer Review: The purpose of the Hospital's peer review processes, programs, and proceedings are to encourage candid discussions in a private and confidential setting among Practitioners, other individuals with clinical privileges and other health care personnel to accomplish the following objectives:

10.4.13.1.1 To improve the quality of health care provided to patients;

10.4.13.1.2 To reduce morbidity and mortality at the Hospital;

- 10.4.13.1.3 To improve the credentialing process in an effort to monitor the competence, professional conduct and patient care activities of Practitioners, other individuals with clinical privileges, and other health care professionals who provide care to patients at the Hospital; and,
- 10.4.13.1.4 To maintain confidentiality of information generated during the course of peer review processes, programs and proceedings.
- 10.4.13.2 Peer Review Information: All peer review information shall be kept private and confidential. A Practitioner, other individual with clinical privileges, or other Hospital staff member who participates or has participated in a peer review process at the Hospital shall treat all peer review information as private, confidential and privileged and shall not disclose peer review information obtained, generated or compiled during a peer review process in which he/she participates unless specifically and expressly authorized by the Hospitals to do so or as required by law.
- 10.4.13.3 Hospital Committees or Functions: A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: process improvement, utilization management, credentialing, infection control, use of medications, use of blood and blood components, clinical risk management, quality assessment, and fair hearings conducted pursuant to the Medical Staff Fair Hearing Plan.
- 10.4.13.4 Circumstances for Peer Review: The primary purpose of peer review activities shall be to improve an individual's performance. Peer review analysis shall be conducted whenever data comparisons indicate that the level of an individual's performance patterns or trends vary substantially from the expected. Peer review shall also be conducted for unanticipated adverse events when root cause analysis indicates human factors related to an individual's performance are possibly significant to the cause of the event. Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, or failure to comply with Hospital policies and procedures, or in any other circumstance deemed necessary by the Chief of Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review or evaluate an individual's performance, or the Board of Trustees. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, or when there is a question of conflict of interest, or when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the Chief of Staff, Chief Executive Officer, Medical Executive Committee, or any other committee authorized to review or evaluate an individual's performance, or the Board of Trustees.
- 10.4.13.5 Peer Review Panel: Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a Member or staff to a professional review body, or any person under contract with a professional review body. Ad hoc peer review panels may be selected for specific focused review by the Chief of Staff, Chief Executive Officer, Medical Executive Committee, any other Medical Staff committee authorized to review or evaluate care, or the Board of Trustees.
- 10.4.13.6 Timeframes for Review: Focused peer review activities shall be conducted and the results reports within a timeframe of **90 days**. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.
- 10.4.13.7 Participation in Review: The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual.

- 10.4.13.8 Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION. The names of individuals who present or provide information during a peer review process should be documented.
- 10.4.13.9 Custody: Peer review information, including Medical Staff records, shall be maintained under the custody of the Chief of Staff and the CEO.
- 10.4.13.9.1 . A Practitioner or other individual with clinical privileges shall be permitted access to further information in his or her own credentials and peer review file only if, following a written request by the individual, the CEO, in consultation with the Chief of Staff and legal counsel, finds that the individual has a compelling need for such information and grants written permission. A Practitioner or other individual with clinical privileges shall be permitted access to further information in that credentials file only if, following a written request by the individual, the Medical Executive Committee and the Board find that the individual has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee or the Board may enforce restrictions or conditions if access is permitted.
- 10.4.13.10 Medical Staff Officers: Members of the Board, licensing agencies, accreditation and regulatory authorities, the CEO, counsel to the Hospital, authorized Hospital staff members participating in utilization management functions or in performance improvement activities, may be afforded limited access to Medical Staff files and records, as appropriate. Medical Staff committee members who are members of the Medical Staff may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and official functions. The Board and the CEO and their properly designated representatives shall have access to Medical Staff records to the extent necessary to perform their responsibilities and official functions.
- 10.4.13.11 Outside Requests for Information: The Medical Staff Office and the Chief of Staff (or his designee) may release information contained in Medical Staff files in response to a proper request from another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with clinical privileges is a member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested.
- 10.4.13.12 Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for reporting and compliance purposes.
- 10.4.13.13 Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff records on the Hospital premises in the presence of Medical Staff personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the

premises, except pursuant to court or administrative order or subpoena or other legal requirements, (b) access is provided only with the concurrence of the CEO (or his/her designee) and the Chief of Staff (or his/her designee), and (c) the surveyor demonstrates the following to the satisfaction of the CEO or Chief of Staff:

- 10.4.13.13.1 Specific statutory, regulatory or other appropriate authority to review the requested materials;
- 10.4.13.13.2 The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;
- 10.4.13.13.3 The materials sought are the most direct and least intrusive means to accomplish the purpose;
- 10.4.13.13.4 Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital;
- 10.4.13.13.5 If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.
- 10.4.13.14 Subpoenas: All subpoenas of Medical Staff records shall be referred to the CEO and the Chief of Staff.
- 10.4.13.15 Legal Counsel: Legal counsel to the Hospital may have access to information in Medical Staff records related to peer review proceedings, litigation, potential litigation or threatened litigation.
- 10.4.13.16 Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the CEO and the Chief of Staff for evaluation.
- 10.4.13.17 Peer Review Meetings: All peer review functions shall be performed only at meetings held on the campus of the Hospital.

## 10.5 MEDICAL EXECUTIVE COMMITTEE

### 10.5.1 COMPOSITION

The Medical Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff; the chairperson of each department, two representatives of the Hospital Based Physicians, and no more than three members-at-large to be appointed by the President of the Medical Staff, of which a majority of voting members shall be fully licensed physician members of the Medical Staff actively practicing in the Hospitals. The Chief Executive Officer and/ shall attend each meeting on an ex-officio basis without vote. The President of the Medical Staff shall act as Chairman for the Medical Executive Committee and will have full voting rights on that committee. No Medical Staff member actively practicing in the Hospitals is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, or practice as a hospital-based physician.

### ~~10.5.2~~ DUTIES AND RESPONSIBILITIES

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Section 10.1.2 and .1.1.2 and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

- 10.5.2.1 To periodically review the Medical Staff Bylaws, Rules and Regs and make recommended revisions thereto in order to reflect the Hospital's current policies with respect to Medical Staff organization and function
- 10.5.2.2 Providing liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services.
- 10.5.2.3 Collaborate with other leaders of the organization in Hospital planning.
- 10.5.2.4 Review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, staff category, assignment to Departments and Divisions, clinical privileges, and any disciplinary actions.
- 10.5.2.5 Organizing the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities.  
  
Request evaluations of practitioners privileged through the Medical Staff Process in instances where there is a doubt about an applicant's ability to perform the privileges requested.
- 10.5.2.6 Conduct and supervise Medical Staff peer review activities.
- 10.5.2.7 Receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities.
- 10.5.2.8 Make recommendations directly to the Board with regard to all of the following:
  - 10.5.2.8.1 The Medical Staff structure;
  - 10.5.2.8.2 The mechanism used to review credentials and to delineate individual clinical privileges;
  - 10.5.2.8.3 Recommendations of individuals for Medical Staff membership;
  - 10.5.2.8.4 Recommendations for delineated clinical privileges for each eligible individual;
  - 10.5.2.8.5 The participation of the Medical Staff in organization performance improvement activities;
  - 10.5.2.8.6 Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;
  - 10.5.2.8.7 The mechanism by which Medical Staff membership may be terminated; and,
  - 10.5.2.8.8 The mechanism for fair hearing procedures.
- 10.5.2.9 Report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff.
- 10.5.2.10 Implement policies of the Medical Staff not otherwise the responsibility of the departments;
- 10.5.2.11 To make recommendations to the CEO on matters of medico-administrative nature;
- 10.5.2.12 Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
- 10.5.2.13 To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
- 10.5.2.13 To review the recommendations from the Credentials Committee regarding establishment of written criteria, make recommendations from the MEC and forward to the Board for final approval;
- 10.5.2.14 To review the recommendations of the Credentials Committee concerning all applications, and to make written comment to the Board of Trustees on the recommendations from the Credentials Committee regarding appointment, assignments to services, and delineation of clinical privileges;

- 10.5.2.15 To review periodically all information of Medical Staff appointees and other Practitioners with clinical privileges, including, but not limited to focused professional practice evaluation data, ongoing professional practice evaluation data, peer review information and credentialing data, and, as a result of such reviews, make recommendations for reappointments and renewal or changes to clinical privileges;
- 10.5.2.16 To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all appointees of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
- 10.5.2.17 To organize the Medical Staff's quality assessment performance improvement activities (add including the review of the safety effectiveness, patient-centeredness, equitability, efficiency, and timeliness of medical and surgical care
- 10.5.2.18) To fulfill the Medical Staff's accountability to the Board of Trustees for the medical care rendered to patients in the Hospital.

### 10.5.3 MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least monthly, except for the month of December, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board.

## 10.6 CREDENTIALS COMMITTEE

### 10.6.1 COMPOSITION

The Credentials Committee may consist of at least five (5) members of the Active Staff. Members shall include past presidents of the Medical Staff. The Chief of Staff-Elect shall serve as chairperson. Non-physician membership will include CMO, Administration, Quality Resources, Risk Management, and the Medical Staff Office.

### 10.6.2 DUTIES AND AUTHORITY

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

- 10.6.2.1 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;
- 10.6.2.2 Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;
- 10.6.2.3 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;
- Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.
- 10.6.2.4 Investigate the credentials of all applicants for Medical Staff appointment or clinical privileges;
- 10.6.2.5 Make recommendations to the MEC concerning applications for initial appointment, granting of clinical privileges, applications for reappointment, changes in clinical privileges, and changes in Medical Staff category.
- 10.6.2.6 Solicit recommendations from the clinical Departments concerning written criteria for the granting of clinical privileges within each Department and/or Division. The Credentials

Committee shall take such departmental recommendations and prepare its own recommendation. Recommendations from the Credentials Committee regarding establishment of written criteria shall be forwarded to the MEC for their recommendations and to the Board of Trustees for final approval;

- 10.6.2.7 Determine whether a reduction in Medical Staff category for a Medical Staff member is warranted because of failure to meet the patient care requirements set forth in the Medical Staff Bylaws is not warranted due to extraordinary circumstances;
- 10.6.2.8 Whenever an applicant's or Medical Staff member's practice is in direct economic competition with the practice of a member of the Credentials Committee, such member of the Credentials Committee who is in direct economic competition with the Applicant or Medical Staff member shall abstain from voting during proceedings involving the applicant or Medical Staff member. Such abstention shall be recorded in the minutes of the meeting.

### 10.6.3 MEETINGS AND REPORTING

The Credentials Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.

## 10.7 QUALITY/PEER REVIEW COMMITTEE

### 10.7.1 COMPOSITION

The Quality/Peer Review Performance Improvement Committee shall be composed of (as written below) voting members who shall be active staff members in good standing. The voting membership shall include three (3) active staff representatives of each of the Medical Staff Departments.

The Quality/Peer Review Committee shall be composed of President-elect who shall act as chair of the meeting, the current President, and the chiefs of all departments. In addition the Director of Quality Resources, the Risk Manager and CMO will serve as an ex-officio member without vote. The Committee shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the President/Chief of Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee. Ad hoc members of the committee shall not have voting rights on the committee.

### 10.7.2 DUTIES AND AUTHORITY

The Quality/Peer Review Committee shall perform the key function of Quality Assessment/Performance Improvement, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Performance Improvement/Peer Review Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital's performance improvement program through the activities of the Medical Staff Departments, committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Quality/Peer Review Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual's performance, the committee shall conduct peer review or an ongoing evaluation of the individual's competence and make recommendations accordingly. In addition, the Performance Improvement/Peer Review Committee shall perform the following specific functions:

- 10.7.2.1 Participate in an annual evaluation of the Hospital's Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.

10.7.2.2 Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

#### 10.7.3 MEETINGS AND REPORTING

The Quality/Peer Review Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.

### 10.8 MEDICAL EDUCATION COMMITTEE

#### 10.8.1 COMPOSITION

The CME Committee shall be composed of at least five (5) voting members including the President/Chief of Staff who shall be active staff members in good standing. The ex-officio members without vote shall also include the CMO and Medical Staff Services Coordinator.

#### 10.8.2 DUTIES AND AUTHORITY

The Medical Education Committee shall perform the key function of Continuing and Graduate Medical Education, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Medical Education Committee shall plan, implement, coordinate and promote ongoing clinical and scientific education programs for Medical Staff members and other individuals with clinical privileges. In addition, the committee shall perform the following specific duties:

10.8.2.1 Establish liaison with the quality assessment and performance improvement program to identify the need for education based on the findings from the program;

10.8.2.2 Assist in prioritizing plans for hospital-sponsored education;

10.8.2.2.1 Mandatory Education Requirements by the State of Florida.

10.8.2.3 Select appropriate teaching methods and knowledgeable faculty for each education program;

10.8.2.4 Promote and document attendance at each program, and assess the effectiveness of each program;

10.8.2.5 Make recommendations regarding the library needs of the Medical Staff;

10.8.2.6 Make recommendations regarding the financial needs of the continuing education program;

10.8.2.7 Provide liaison and oversee the affiliation with any graduate medical education programs, including overseeing the safety and quality of care provided by program participants, and related educational and supervisory needs.

#### 10.8.3 MEETINGS AND REPORTING

The CME Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee. The Medical Education Committee shall communicate periodically with the Medical Executive Committee and the Board about the educational needs and performance of the participants in professional graduate education programs.

### 10.9 BYLAWS COMMITTEE

#### 10.9.1 COMPOSITION

The Bylaws Committee shall be composed of the President-Elect who is the Committee Chair, the Medical Staff President, the Past-president, and the Department Chiefs with CMO and Administrative representation as ex-officio members without voting rights if it is

determined that the Bylaws need revision. The Bylaws committee shall meet as needed to review these Bylaws and the Rules and Regulations and recommend to the Executive Committee any needed additions, revisions, modifications, amendments or deletions.

#### 10.9.2 DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws and the Rules and Regulations and recommend any needed additions, revisions, modifications, amendments or deletions.

#### 10.9.3 MEETINGS AND REPORTING

The Bylaws Committee shall meet at least annually, and shall report their recommendations and activities to the Medical Executive Committee.

### 10.10 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING COMMITTEE

#### 10.10.1 COMPOSITION

The Medical Staff Leadership Development & Nominating Committee shall be composed of President-Elect who shall chair the meeting, the current chiefs of each department, three past presidents and one Board member. The CEO and his/her designees shall serve as ex-officio members without vote. No candidate for election may serve as a member of the Medical Staff Leadership Development Nominating Committee.

#### 10.10.2 DUTIES AND AUTHORITY

The Medical Staff Leadership Development & Nominating Committee shall perform the key function of Nominating, as described in these Bylaws, under the oversight and direction of the Medical Executive Committee. The Medical Staff Leadership Development & Nominating Committee shall define desired leadership characteristics, identify and recruit future potential medical staff leaders from among the Members of the Medical Staff, and shall advise the Chief Executive Officer, the Chief Medical Officer], and the Medical Executive Committee of the education and development needs of potential medical staff leaders so as to be successful in future roles. The Medical Staff Leadership & Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

#### 10.10.3 MEETINGS AND REPORTING

The Medical Staff Leadership Development & Nominating Committee shall meet at least every two years during even-numbered years, and shall report their recommendations and activities to the Medical Executive Committee.

### 10.11 UTILIZATION MANAGEMENT COMMITTEE

#### 10.11.1 COMPOSITION

The Utilization Management Committee will be comprised of two or more physician members appointed by the President of the Medical Staff, and assisted by other professional personnel consisting of representatives from Administration, Quality Resources/Case Management, Nursing and Health Information Management. A Physician Liaison shall serve as an Ad Hoc Committee member to support the hospital/Medical Staff strategies that will bring about the desired improvements. The chairperson shall be appointed by the President of the Medical Staff, and shall serve for a period of TWO (2) years.

#### 10.11.2 DUTIES AND AUTHORITY

The Committee is responsible for conducting an ongoing Utilization Review program designed to evaluate the appropriateness of admissions to the hospital, lengths of stay,

discharge practices, use of inpatient and outpatient medical and hospital services and resources, the quality of medical record documentation, the timeliness of medical record completion, and all related factors which may contribute to the effective utilization of hospital and physical services, including:

1. The analysis of under/over utilization of each of the hospital's services and how it impacts on the quality of patient care provided;
2. The study of patterns of care and their relationship to average or normal (usual) lengths of stay.
3. The evaluation and approval of systems for utilization review employing such criteria.
4. Working with Quality Resources/Case Management toward the assurance of early discharge planning and the proper continuity of care upon discharge;
5. Communicating the findings and other pertinent data to the appropriate hospital and Medical Staff departments, the Medical Executive Committee, and the Board of Trustees.
6. Making recommendations for the optimum utilization of hospital resources and facilities commensurate with quality of patient care and safety; and
7. The review of the quality of documentation in the medical record, including a review of summary information regarding clinical pertinence and timely completion. The Committee will be responsible for assuring that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge. The Committee will recommend the format of the record and the forms used in it.
8. The effect of the actions taken is assessed and, when the actions taken are successful, the improvements are maintained. When initial actions are not effective, new actions are designed and implemented and the effectiveness of those actions is assessed.
  - Results are trended to identify opportunities to improve or problems related to individual practitioners. When an individual has performance problems that result in an inability or unwillingness to improve, modifications are made in clinical privileges, or other appropriate actions are taken.
9. Formulating written utilization review plan for the hospital. Such plan, as approved by the Medical Staff and Governing board, must be in effect at all times and must include all the following elements:
  - Authority: The organization and composition of committee(s) that will be responsible for the utilization review functions.
  - Purpose of the Utilization Review Program.
  - The Utilization Review Committee will meet quarterly.
  - The method to be used in selecting cases for review, and the criteria that will be utilized in determining appropriateness for admission and continued stay.
  - The method to be used in the denial and appeal processes.
  - The relationship of the utilization review plan, to claim administration, by a third party.

10. Formulating written utilization review plan for the hospital. Such plan, as approved by the Medical Staff and Governing board, must be in effect at all times and must include all the following elements:
  - Authority: The organization and composition of committee(s), which will be responsible for the utilization review functions.
  - Purpose of the Utilization Review Program.
  - The Utilization Review Committee will meet quarterly.
  - The method to be used in selecting cases for review, and the criteria that will be utilized in determining appropriateness for admission and continued stay.
  - The method to be used in the denial and appeal processes.
  - The relationship of the utilization review plan, to claim administration, by a third party.
11. No physician shall have review responsibility for any cases in which he/she is professionally involved.
12. All decisions that admission and/or continued inpatient stay is medically necessary, shall be made by physician members of the Committee, and only after opportunity for consultation has been given the attending physician, by the Physician Advisor.
13. If the Physician Advisor considers the admission to be inappropriate, he/she shall contact the attending physician and discuss the case. If the attending physician agrees with the Physician Advisor, an initial determination will be reached and the Physician Advisor shall deny the admission. All findings/decisions shall be documented by the Physician Advisor on the Admission Review Referral form and will be kept on file by the Quality Resources Department.
14. When the Physician Advisor considers the admission to be inappropriate and the attending physician disagrees with the Physician Advisor's opinion, the case automatically is referred to the assigned external "Professional Review Organization (PRO)". The PRO will be telephoned with this information and a PRO Physician Advisor will review the chart onsite, or request that the record be copied and sent to the PRO office for review. The PRO will notify the hospital/physician within FORTY-EIGHT (48) hours of his/her determination (excluding weekends and holidays).
15. The procedure for handling utilization or quality related referrals from the nursing departments, when a Physician Advisor is needed, is as follows: The Nursing Director or Nursing Shift Supervisor will evaluate the situation and take action. If the director or supervisor feels that a problem warrants further investigation, he/she will contact the Physician Unit Director, who may contact the Quality Resources Department. In this case, the Quality Resources representative will refer the case to a Physician Advisor for review.

If there is not an assigned Physician Unit Director for the clinical area, the Nursing Director or supervisor may contact the Quality Resources department for assistance in obtaining a Physician Advisor to review the case.

## 10.12 INFECTION CONTROL COMMITTEE

### 10.12.1 COMPOSITION

The Infection Control Committee is a hospital-wide, multi-disciplinary medical staff committee composed of a Medical Staff Chairperson, representatives from the Medical Staff, Administration, Infection Control Coordinator, Quality Resources, Risk Management, Nursing, Employee Health, Public Health Unit, Wound Care Center, Safety Officer, Environmental Services, Plant Management, Surgery/Sterile Supply. The Committee members will have equal voting rights.

### 10.12.2 DUTIES AND AUTHORITY

To prevent, identify, investigate, and control infections acquired in the hospital or brought into the hospital from the community

1. Maintain surveillance of hospital infection potentials;
2. Identify and analyze the incident and cause of all infections;
3. Develop and implement a preventive and corrective program designed to minimize infection hazards;
4. Supervise infection control in all phases of the hospital's activities;
5. Act upon recommendations related to infection control received from the Chief of Staff, Executive Committee, the Board of Trustees, and other staff/hospital committees;
6. Maintain a permanent record of all activities relating to Infection Control and submit quarterly reports to Medical/Surgical Assessment and Improvement Committees, appropriate hospital departments, Executive Committee, Board of Trustees and Medical Staff;
7. Documentation of the performance of this function shall be reflected in the appropriate committee minutes at least quarterly

### 10.12.3 MEETINGS

The Infection Control Committee will meet at least quarterly.

## 10.13 PHARMACY AND THERAPEUTICS COMMITTEE

### 10.13.1 COMPOSITION

The multi-disciplinary Pharmacy and Therapeutics Committee shall consist of medical representation as appointed by the President of the Medical Staff and shall have representation from: Medical Staff, Pharmacy, Microbiology, Dietary, Quality Resources, Administration, Nursing and Laboratory. The Chairperson shall be appointed by the President of the Medical Staff and shall serve for a period of TWO (2) years Non-voting ad hoc representation will include any department of the hospital designated by the Committee.

The Chairperson shall be appointed by the President of the Medical Staff and shall serve for a period of TWO (2) years.

### 10.13.2 DUTIES AND AUTHORITY

The duties involved in developing and maintaining surveillance over drug utilization policies and practices are to:

1. Assist in the formulation of professional policies regarding the evaluation, appraisal, use, safety procedures and all other matters relating to drugs in the hospital.
2. Make recommendations concerning drugs to be stocked on the nursing unit and by other services.

3. Develop and review periodically, a formulary or drug list for use in the hospital;
4. Monitor all reported adverse drug events and make recommendations for the prevention of adverse events and the continual improvement in medication safety.
5. Review all data relative to drug effectiveness, side effects and new drugs or uses, and disseminate such information as needed.
6. Prepare a quarterly report, consisting of statistical data involving drug reactions and drug errors, their probable courses and actions taken to resolve problems, and follow-up action to assure the resolution of problems.
7. Establish standards concerning the use and control of investigational drugs and of research in use of recognized drugs.
8. Perform such other duties as assigned by the Chief of Staff or the Executive Committee.
9. Documentation of the performance of this function shall be reflected in the appropriate committee minutes at least quarterly.

#### 10.13.3 DRUG USAGE EVALUATION

Drug usage evaluation is the responsibility of the Pharmacy and Therapeutics Committee. The Medical Staff will evaluate its prescribing practices with regard to all major classes of drugs, including antibiotics and all other kinds of drugs used in the hospital.

1. The purpose of the review is to determine that drugs are used appropriately, safely and effectively, in accordance with these definitions:
  - Appropriately: The presence of valid clinical indications for the use of the drug.
  - Safety: The identification of all significant risk/factors for patients receiving the drug.
  - Effectiveness: The selection of the proper drug in its class; the prescription of the right dose, frequency, route, etc.; and the use of appropriate monitoring needed to enable the identification of the effective dose level.
2. Drugs are to be reviewed for their empiric, therapeutic, and prophylactic uses. The scope of the drug usage review should reflect all areas in the hospital where the drug is prescribed, including the inpatient, outpatient, and urgent room areas.
3. The performance of drug usage review is the responsibility of the Medical Staff, but is performed in cooperation, as may be necessary, with Quality Resources, Pharmacy, Nursing, Ancillary, and Administrative personnel.
4. The duties involved in the review of Drug Usage Evaluation are:
  - Develop a planned and systematic ongoing drug review plan;
  - Select drugs for review that encompass all clinical services, and address issues of high risk, high volume, or problem prone areas;
  - Develop and approve criteria that adequately defines the safe and effective use of a particular drug;
  - Review medical records of patients who have failed the screens;
  - Report findings, conclusions, recommendations, actions, and follow-up to the Medical Staff, Executive Committee and the Board; and, the Infection Control Committee, as appropriate; and

- Document the performance of function in committee minutes at least quarterly.

#### 10.13.4 MEETINGS

The Pharmacy and Therapeutics Committee will meet at least quarterly.

### 10.14 CANCER COMMITTEE

#### 10.14.1 COMPOSITION

The multi-disciplinary Cancer Committee shall consist of Medical Staff representation as appointed by the President of the Medical Staff. Within the limits of the institution, the Committee will include at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology, and will include the Cancer Liaison Physician. A physician or specialist representing pain control palliative care is also a member of the committee. Non-physician membership will include Administration, Nursing, Case Management, Cancer Registry, and Quality Resources. Other physician and non-physician representatives will be included based on the cancer experience of the institution. Physician representatives from the five major sites of cancer seen at the institution will be included. The Chairperson shall be appointed by the President of the Medical Staff and shall serve for a period of TWO (2) years. The chairperson can only serve two (2) consecutive terms.

#### 10.14.2 FUNCTIONS

The Cancer Committee will execute the following staff functions:

- Develops and evaluates the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.
- Promotes a coordinated, multi-disciplinary approach to patient management.
- Provides consultation services.
- Sponsors educational cancer conferences, during which actual case studies of current diagnosed cancers will be discussed.
- Ensures that educational and consultative cancer conferences cover all major sites and related issues.
- Ensures that an active supportive care system is in place for patients, families and staff.
- Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
- Generates criteria concerning diagnoses and treatment and evaluates concepts of treatment, follow-up, and rehabilitation of cancer patients.
- Promotes clinical research.
- Upholds medical ethical standards.
- Monitors the quality of oncology services provided by external entities.
- Provides program leadership with duties as described in the current Cancer Program Standards provided by the Commission on Cancer.

#### 10.14.3 DUTIES

The Cancer Committee is responsible for establishing the quality improvement priorities of the institution's cancer program and monitoring the effectiveness of quality management activities. The duties involved in assessing the quality and appropriateness of cancer care are:

- The quality of cancer patient care is measured, evaluated and improved.
- Striving to improve site-specific patient survival rates as one of the improvement priorities.
- At least annually, assessing the effectiveness of quality management activities in achieving its priorities for improvement related to cancer patient care.
- Selecting measures of quality to evaluate compliance with current treatment guidelines.
- Defining measures of outcome process indicators for each of the priorities for improvement.

- Evaluating or referring criteria regarding appropriateness of treatment guidelines to the appropriate oncology specialist, as it related to Cancer Committee, or other medical staff committees as applicable prior to implementation.
- (Note: no physician shall review a case in which he/she is professionally involved.)
- Evaluating variances from treatment guidelines at least annually to identify future improvement priorities.
- Evaluating the results of measurement activities to determine current performance levels, assess the need for interventions aimed at reducing or eliminating undesirable performance, and/or identify opportunities for refining existing processes.
- When undesirable levels of performance or patient outcomes are identified or when there is an opportunity to improve already acceptable performance, actions are taken to bring about desired changes. Any adverse recommendations, defined in the Medical Staff By-Laws, will be referred to the appropriate Medical Staff Department Chairman for review and recommendation and/or further action.
- Recommending focus reviews by Cancer Committee when additional information/further investigation is needed before problem resolution can occur, or when acceptance thresholds (norms) have been exceeded. Focus reviews may include medical, surgical and/or multi-disciplinary studies, as well as clinical service studies designed to evaluate the quality and appropriateness of cancer patient care within the clinical services. Committees may recommend the establishment of a PI team or as a Focus Measurement Project.
- The use of non-physician personnel in those activities not requiring medical judgment shall be used to the greatest extent possible.
- Comparing site-specific patient survival rates with National Cancer Data Base (NCDB) data and other relevant published literature, as appropriate.
- Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting.
- Performs quality control of registry data.
- Ensures data is analyzed and disseminated annually, content of the report meets ACS requirements and includes an evaluation of the Cancer Program.
- Ensures that the documentation of the performance of this function is reflected in the Cancer Committee minutes.

#### 10.14.4 MEETINGS

The Cancer Committee meets quarterly and minutes are maintained. The Committee will submit a summary of results of significant cancer findings and or pertinent criteria or data to the appropriate hospital departments, the Executive Committee, Board of Trustees, Medical Staff and Administration.

### 11 ARTICLE ELEVEN: MEETINGS

#### 11.4 MEDICAL STAFF YEAR

The Medical Staff year shall be the period from January 1 to December 31 of each year.

#### 11.5 MEDICAL STAFF MEETINGS

##### 11.5.1 REGULAR MEETINGS

The regular meeting of the Medical Staff shall be held quarterly at a time and place designated by the Medical Executive Committee, for the purpose of receiving reports from officers and committees, electing officers, and transacting other such business as may properly come before the meeting of the Medical Staff.

##### 11.5.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the President/Chief of Staff and shall be called by the President/Chief of Staff at the request of the Medical Executive Committee or any ten members of the active staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be

transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.6 DEPARTMENT MEETINGS

11.6.1 REGULAR MEETINGS

Meetings of each Department shall be held as necessary to perform the functions of Departments as specified in Article Nine of these Bylaws.

11.6.2 SPECIAL MEETINGS

Special meetings of a Department may be called at the direction of the Chairperson of the Department and shall be called by the Chairperson or any three members of the active staff of the Department by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

11.6.3 ATTENDANCE REQUIREMENTS

Medical Staff membership shall not be contingent upon attendance at medical staff meetings. However, all members of the Active and Provisional/Active Medical Staff are encouraged to attend and participate in medical staff and department meetings in order to participate in the functions and responsibilities of the departments as described in these Bylaws, and to provide feedback regarding the continual improvement in patient care and hospital operations.

Alternative means for communication to the medical staff of performance improvement data and information and other information pertinent to the delivery of quality healthcare within the hospitals will be provided.

Alternative means for feedback from the medical staff include communication to the Department Chief, the MEC and the Hospitals' administration.

11.7 MEETING PROCEDURES

11.7.1 NOTICE OF MEETINGS

11.7.2 Written or oral notice stating the place, day and hour of any special meeting, or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee or service not less than Three (3) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting. Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting. QUORUM FOR FULL MEDICAL STAFF

11.7.3 At least TEN (10) percent of the non-provisional staff members present in person or by absentee ballot shall constitute a quorum for purposes of amendment of these Bylaws. Voting by proxy shall not be permitted MANNER OF ACTION

The act of a majority of the voting members present at a general Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the majority of voting Department members present at a Medical Staff meeting at which a quorum is present shall be the act of the Department.

11.7.4 VOTING RIGHTS

Only non-provisional status active staff members have the right to vote. A non-physician Member of the Medical Staff may vote on credentialing matters (such as procedures for appointment, reappointment, granting clinical privileges and discipline) only when such matters involve practitioners who hold the same professional license as the non-physician.

#### 11.7.5 RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided.

#### 11.7.6 MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the Executive Committee for approval. Each committee and service shall maintain a permanent file of the minutes of each meeting. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information.

#### 11.7.7 PROCEDURAL RULES

The President/Chief of Staff, or in his/her absence, the Chief of Staff-Elect, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert's Rules of Order, as may be modified by the Medical Staff.

### **12 ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASE**

#### 12.4 AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every member of the Medical Staff or individual with clinical privileges shall agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

#### 12.5 CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the CEO, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a member of the Medical Staff, authorized representatives of the Staff, the Administration or the Board.

#### 12.6 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment /performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

#### 12.7 IMMUNITY FROM LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

- 12.7.1 Applications for appointment to the Medical Staff or for clinical privileges;
- 12.7.2 Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;
- 12.7.3 Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;
- 12.7.4 Hearing and appellate review;
- 12.7.5 Medical care evaluations;
- 12.7.6 Peer review evaluations;
- 12.7.7 Utilization review and resource management; and,
- 12.7.8 Any other Hospital, departmental, service or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards or any other matter that may or might have an effect or bearing on patient care.

#### 12.8 RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff member or individual with clinical privileges shall, by requesting or accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon the request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

#### 12.9 SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

#### 12.10 NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

### **13 ARTICLE THIRTEEN: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS**

#### 13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its medical staff functions.<sup>390</sup> The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards.<sup>391</sup> The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon approval by the Board. The Medical Staff Rules and Regulations and Policies shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the

Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. “Associated details” are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.<sup>392</sup>

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.<sup>393</sup>

### 13.2 EXCLUSIVE MECHANISM

The mechanism described herein shall be the sole method for initiation, adoption, amendment or repeal of the Medical Staff Bylaws.

### 13.3 METHODOLOGY

#### 13.3.1 MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the President/Chief of Staff, or the Bylaws Committee after approval by the Medical Executive Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. If the proposed revision is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the revision via written notice of the proposed change to all voting members of the medical staff no less than twenty (20) days prior to the meeting at which the Bylaws changes are to be voted upon.<sup>394</sup> If the proposed revision is made by written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the revision via written notice of the proposed change to all members of the Medical Executive Committee no less than twenty (20) days prior to the meeting upon which the Bylaws changes are to be voted.<sup>395</sup> The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). If a quorum is present as described in Article Eleven, Section 11.6.1, for the purpose of enacting a bylaw change, the change shall require an affirmative vote of greater than fifty percent (50%) of the members voting in person or by written ballot. In the event of a conflict within the Medical Staff regarding Medical Staff Bylaws, the Medical Staff process for conflict management shall be implemented. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text.<sup>396</sup>

In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.<sup>397</sup>

Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below. As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the Medical Executive Committee are incapable of, or refuse to amend the Medical

Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally amend the Medical Staff Bylaws or Rules & Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the Medical Executive Committee's or Medical Staff's approval, including using the conflict management process as set out below in Section 13.5.9. In such a situation, the Board's amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

### 13.3.2 RULES AND REGULATIONS

13.3.2.1 To implement the Medical Staff Bylaws, the Medical Staff shall develop administrative procedures, which shall be described in documents that supplement the Bylaws, such as Rules and Regulations, and Policies

Medical Staff Rules and Regulations: Subject to approval by the Board, the Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement these Bylaws. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

### 13.4 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations.

### 13.5 GENERAL PROVISIONS

#### 13.5.1 SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board or its successor in interest. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

#### 13.5.2 AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

#### 13.5.3 NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of the internal affairs of the Hospital. No person is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided.

#### 13.5.4 NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered

personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

#### 13.5.5 NO CONTRACT INTENDED

Notwithstanding anything herein to the contrary, it is understood that these Bylaws and the Rules and Regulations do not create, nor shall they be construed as creating, in fact or by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Medical Staff and any member of the Medical Staff or any person granted clinical privileges. Any clinical or other privileges are simply privileges which permit conditional use of the Hospital facilities, subject to the terms of these Bylaws and the Rules and Regulations.

Notwithstanding the forgoing, the provisions of Article Thirteen and other provisions containing undertakings in the nature of an agreement or an indemnity or a release shall be considered contractual in nature, and not a mere recital and shall be binding upon Medical Staff applicants and members and individuals applying for or those granted clinical privileges in the Hospital.

#### 13.5.6 CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as defined by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, this provision does not prohibit any person from voting for himself/herself

13.5.6.1 When performing a function outlined in the Bylaws, applicable policies, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.

13.5.6.2 Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Chief of Staff (or to the Vice Chief if the Chief of Staff is the person with the potential conflict), or the applicable Department Chairperson or Committee Chair. The Chief of Staff or the applicable Department Chairperson or Committee Chair will make a final determination as to whether the provisions in this Article should be triggered.

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

13.5.6.4 The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

#### 13.5.7 NO AGENCY

13.5.8 Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital. Conflict in the event that these Bylaws, including provisions for Fair

Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

### 13.5.9 CONFLICT MANAGEMENT/RESOLUTION

#### 13.5.9.1 CONFLICTS BETWEEN THE BOARD AND THE MEDICAL EXECUTIVE COMMITTEE

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the Medical Executive Committee, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

To address Board-Medical Staff conflicts, the Joint Conference Committee shall be composed of:

- Three officers of the Medical Staff
- One other Medical Executive Committee member
- The Chairperson, Vice-Chairperson, and Secretary of the Board or other designees of the Board
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Board within 30 days of the initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party. The Medical Executive Committee and Board shall together select the third-party mediator, the costs for which shall be shared equally by the Hospital and the Medical Staff. The Medical Executive Committee and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the Medical Executive Committee shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the Medical Executive Committee and the Board, in accordance with the provisions of Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital. If, after 90 days from the date of the initial request for mediation from an outside party, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

In addition to the formal conflict resolution process herein described, the Chairperson of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board, or Administration.

13.5.10 ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.