Status **Active** PolicyStat ID **12303947**

Origination	08/2022	Owner	Bonnie Stephens
Last Approved	09/2022	Area	Medical Staff
Effective	08/2022	Applicability	Community Medical Center
Last Revised	09/2022		
Next Review	09/2023		

Medical Staff Bylaws

DEFINITIONS

1. "Active Staff" members shall be those physicians (D.O. s and M.D.s) licensed in the state of Montana that may have the privilege of admitting patients, holding office and voting.
2. "Advanced Practice Provider" or "APP" means an individual, other than a physician, who is qualified to render direct or indirect medical or surgical care who has been afforded privileges within their scope of practice to provide such care in the Hospital in accordance with state licensure regulations. The authority of an APP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.
3. "APP Staff" means the formal organization of APPs who are eligible to be granted clinical privileges pursuant to these Bylaws.
4. "Board" means the Board of Trustees of the Hospital.
5. "Board Certification" shall mean certification in one of the Member Boards of the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). The National Board of Physicians & Surgeons (NBPAS) may be used for recertification if initial certification was granted by one of the Member Boards of the ABMS or the Bureau of Osteopathic Specialists certifying boards of the AOA. For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).

1. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.
2. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.
3. "Clinical Privileges" means the Board's recognition of an individual's competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

1. "Corporation" means LifePoint Health

1. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

1. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

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

1. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's or dentists clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence.

1. "Hospital" means RCHP Billings – Missoula, LLC DBA Community Medical Center

1. "Licensed Independent Practitioner" means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

1. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

1. "Medical Staff" or "Organized Medical Staff" means the formal organization of practitioners who are eligible to be granted privileges by the Board to attend patients in the Hospital.

1. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan, policies and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

1. "Medical Staff Year" means calendar year

1. "Member" means a practitioner who has been granted Medical Staff membership and is eligible to be granted clinical privileges pursuant to these Bylaws.

1. "Professional Performance Review Policy" means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix "E" hereto.[6]

1. "Provider" means physicians, dentists, podiatrists, LIPs and APPs with clinical privileges at the Hospital.

1. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Montana

1. "Practitioner" means a physician, dentist, or podiatrist who has been granted clinical privileges at the Hospital.

1. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other hospital and Medical Staff policies.

1. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

1. "Telehealth" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I - NAME

The name of this organization is the Medical Staff of RCHP Billings-Missoula LLC DBA Community Medical Center

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1PURPOSE

The purposes of the Medical Staff are:

a. To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation, and professional support) may be obtained and the obligations of staff membership may be fulfilled;

b. To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;[1]

c. To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Organization shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other QAPI (Quality Assessment Performance Improvement) activities in accordance with the Organization's QAPI program;[2]

d. To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and APPs authorized to practice in the Organization through delineation of clinical privileges, on-going review, and evaluation of each practitioner's performance in the Organization, and supervision, review, evaluation and delineation of duties and prerogatives of APPs;[3]

e. To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;[4]

f. To promulgate, maintain and enforce bylaws, rules and regulations, and other policies and procedures related to medical care for the proper functioning of the Medical Staff;[5]

g. To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds, or other equipment that are or can be made available;[6]

h. To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;[7]
2.1(i)To provide a means by which issues concerning the Medical Staff and the Organization may be discussed with the Board or the CEO; and[8]
2.1(j)To accomplish its goals through appropriate committees, departments, and services.

2.2RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a)Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and APPs authorized to practice in the Organization, by taking action to:

1. Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;[9]
2. Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;[10]
3. Participates in continuing medical education programs addressing issues of QAPI and including the types of care offered by the Organization;[11]
4. Implement a utilization management program, based on the requirements of the Organization's Utilization Management Plan;[12]
5. Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of APPs;[13]
6. Initiate and pursue corrective action with respect to practitioners and APPs, when warranted;[14]
7. Develop, administer, and enforce these Bylaws, the Rules and Regulations of the staff and other Organization policies related to medical care;[15]
8. Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment; and[16]
9. Implement a process to identify and manage matters of individual provider health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix "D" hereto.[17]

2.2(b)Maintaining confidentiality with respect to the records and affairs of the Organization, except as disclosure is authorized by the Board or required by law.[18]

2.3PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT[19]

Patient information will be collected, stored, and maintained so that privacy and confidentiality are preserved. The Organization and all health care providers will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Organization and the providers to share information for purposes of treatment, payment, and health care operations. Under the OHCA, at the time of admission, a patient will receive the Organization's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement.

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Organization and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment or reappointment to the Medical Staff will not confer any clinical privileges or right to practice at the Medical Center. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board. No person shall admit patients to, or provide services to patients in the Organization, unless he/she has been granted appropriate privileges to do so.[20]

3.2THRESHOLD CRITERIA/CONDITIONS OF STAFF MEMBERSHIP

3.2(a)THRESHOLD CRITERIA[21]

To be eligible to apply for initial appointment or reappointment to the Medical Staff, practitioners must have

1. a current, unrestricted license to practice in the state of Montana (or be actively applying for one) and have never had a license to practice revoked or suspended by any state licensing agency
2. a current, valid professional liability insurance coverage in a form and amounts satisfactory to the medical center
3. where applicable to their practice, a current, unrestricted DEA registration
4. never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse
5. never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program.
6. never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct
7. have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
8. Never been convicted of, or entered a plea of guilty or no contest, to any felony
9. Never been convicted of, or entered a plea of guilty or no contest, to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
10. Comply and have complied with federal, state and local requirements, if any, for their medical practice; are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the

Organization;[22]

(10)Are graduates of an approved educational institution holding appropriate degrees;[23]

(11)Have successfully completed an approved residency program or the equivalent where applicable;[24]

(12) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals[25] and have the physical and mental health to adequately practice his/her profession;[26]

(14) Meet one (1) of the following requirements, in addition to those listed above:

(i)Board certification, sufficiently related to the privileges sought/in their primary area of practice at Community Medical Center, demonstrated by proof of maintenance/recertification to the extent required by the applicable specialty/subspecialty board; or

(ii)Adequate progress toward Board certification sufficiently related to the privileges sought. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; or

(iii) Demonstration to the satisfaction of the Credentials Committee, MEC and the Board of Trustees, competency and training equal or equivalent to that required for Board certification sufficiently related to the privileges sought.

(This requirement is applicable only to those individuals who apply for initial staff appointment after March 1, 2022. All individuals appointed previously will be governed by the board certification requirements in effect at the time of their appointments);[27]

(15) Have skills and training to fulfill a patient care need existing within the Organization, and be able to adequately provide those services with the facilities and support services available at the Organization; and[28]

(16) Practice in such a manner as not to interfere with the orderly and efficient rendering of services by the Organization or by other practitioners within the Organization.[29]

(17)Agree to fulfill all responsibilities regarding emergency call for their specialty if required by staff category;

(18)Have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable

2.A.2 Waiver of Threshold Eligibility Criteria

(a)Any individual who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b)A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing

the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chair, and the best interests of the Medical Center and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis for such.

(c)The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

(d)No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(e)The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(f)An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

3.2(b)No Entitlement to Appointment:

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

a. Is licensed to practice a profession in this or any other state;
b. Is a member of any particular professional organization;
c. Has had in the past, or currently has, Medical Staff appointment or privileges at any Organization or health care facility;
d. Resides in the geographic service area of the Medical Center; or
e. Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

3.2(c)Non-Discrimination

No individual will be denied Medical Staff membership or particular clinical privileges on the basis of sex, race, age, creed, color, national origin, marital status, familial status, parental status, religion, sexual orientation, gender identity, political beliefs, or disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Organization, to professional ability and judgment, or to community need.[30]

3.2(d)Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.[31]

3.3BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP[32]

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

3.3(a)To provide continuous and timely care to all patients for whom the individual has responsibility at the generally recognized professional level of quality;[33]

3.3(b)Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, to comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance, and adhere to local medical review policies with regard to utilization;[34]

3.3(c)To abide by all Bylaws, policies, and Rules and Regulations of the Medical Center and Medical Staff;[35]

3.3(d)To participate in Medical Staff affairs through committee service and participation in quality improvement and peer review activities, and by performing such other reasonable duties and responsibilities as may be assigned (within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients). To Discharge the staff, department, committee and Organization functions for which he/she is responsible by staff category assignment, appointment, and election or otherwise;[36]

3.3(e)Cooperate with other members of the Medical Staff, Leadership, the Board of Trustees and employees of the Organization;[37]

3.3(f)Adequately prepare and complete in a timely fashion the medical and other required records containing all information required by the Medical Center, for all patients he/she admits or in any way provides care to, in the Organization;[38]

3.3(g)Adequately enter all orders for treatment within the timeframe required by the applicable Medical Staff Rules, Regulations and Policies using Computerized Physician Order Entry as required by the Rules & Regulations;

3.3(h)Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Organization drug testing program;[39]

3.3(i)Abide by the ethical principles of his/her profession and specialty;[40]

3.3(j)Refuse to engage in improper inducements for patient referral;[41]

3.3(k)Notify the CEO, Medical Staff President, and Medical Staff Services immediately if:[42]

1. His/Her professional licensure in any state is suspended or revoked;
2. His/Her professional liability insurance is modified or terminated;
3. He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
4. His/Her specialty board certification expires, is voluntarily surrendered, or is revoked;
5. He/She voluntarily or involuntarily relinquishes his/her licensure to practice any profession in any jurisdiction;
6. He/She voluntarily or involuntarily relinquishes his/her National Drug Enforcement Agency (DEA) number or state licensure certificate;

7. His/Her medical staff membership or clinical privileges are voluntarily or involuntarily revoked, reduced, relinquished, limited or restricted in any health care facility;
8. His/Her patient management is the subject of an investigation by a state medical board;
9. He/She is excluded from participation in federal or state health insurance; including Medicare or Medicaid;
10. He/She has any changes in ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI") including participation in a voluntary or mandatory drug and/or alcohol rehabilitation program;
11. He/She has any criminal charges, other than minor traffic violations, brought/ initiated against him/her; or
12. He/She is subject to current, pending investigation or challenge to licensure, DEA certification, medical staff membership or clinical privileges at any health care facility, or participation in federal or state insurance.

Failure to provide any such notice, as required above, shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

3.3(l) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Organization.[43]

3.3(m) to maintain a current e-mail address with Medical Staff Services, through which the Medical Staff leadership and Medical Center may provide notice to him or her;

3.3(n) to immediately submit to a blood, hair and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned about the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;

3.3(0)to appear for personal interviews in regard to an application for initial appointment or reappointment, if requested;

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

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

3.3(r)to seek consultation whenever necessary;

3.3(s) to perform all services and conduct himself/herself at all times in a cooperative and professional

manner;

3.3(t)to promptly pay any applicable dues, assessments, and/or fines;

3.3(u)to satisfy continuing medical education requirements; and

3.3(v)that any misstatement in, or omission from, the application is grounds for the Medical Center to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal. Rather, 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 whether the application should be processed further.

3.3(w)Acknowledge and comply with the following standards concerning conflicts of interest:

The best interests of the community, Medical Staff and the Organization are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Organization and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Organization to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Organization or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Organization or its staff, or the Organization's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Organization;
2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Organization;
3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Organization; or

4. Business practices that may adversely affect the Organization or community.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Organization. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

When performing a function outlined in the Bylaws or the Rules and Regulations, if any Medical Staff member has 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.

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 the Medical Staff President (or to the CEO/CMO if the Medical Staff President is the person with the potential conflict), or the applicable department or committee chair. The Medical Staff President or the applicable department or committee chair will make a final determination as to whether the provisions in this Article should be triggered.

The fact that a department chair 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.

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.

3.4HISTORY & PHYSICAL EXAMINATIONS and INITIAL ASSESSMENT[44]

A medical history and physical examination must be performed no more than 30 days prior to, or within 24 hours after, registration or admission (regardless of whether care is being provided on an inpatient or outpatient basis), but prior to surgery or a procedure requiring anesthesia services by a practitioner who has been granted privileges to do so by the organization or by a qualified licensed practitioner in accordance with state law and Organization policy.

If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the

history and physical shall specifically document the circumstances surrounding the need for additional acute care.

When a medical history and physical examination is completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition must be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. All updates to history and physical examinations must be performed by a practitioner who has been granted privileges to do so.

The update must accompany an examination for any changes in the patient's condition since the patient's history and physical examination was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical examination was completed, he/she may indicate in the patient's medical record that the history and physical examination was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical examination was completed.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient's own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and (k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

Each department or service, with MEC approval, will determine for its members which outpatient diagnostic procedures require a history and physical examination as a prerequisite and, if required, the scope of such history and physical. A history and physical examination shall be required for all surgical procedures performed in the outpatient setting. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/ critical care unit must be performed no later than 2 hours[45] after admission or sooner if warranted by the patient's condition.

3.5DURATION OF APPOINTMENT[46]

3.5(a)Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years, as recommended by the Credentials Committee and approved by the MEC and Board. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

Initial appointment to the Medical Staff (regardless of the staff category) and all initial

grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to Focused Provider Practice Evaluation (FPPE).

3.5(b)Reappointments

Reappointment to the Medical Staff will be for a period not more than two (2) years.

3.5(c)Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5(d)Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting of Medical Staff privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of this Organization and in the best interest of the health and patient care capable of being provided by the Organization and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Organization and the patient community.

3.6LEAVE OF ABSENCE

3.6(a)Leave Status

An individual appointed to the Medical Staff may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Medical Staff President. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

Members of the Medical Staff must report to the CEO any time they are away from medical staff and/or patient care responsibilities for longer than 30 days and the reason for such absence if related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the Medical Staff President, may trigger an automatic medical leave of absence. A request for a leave of absence is not required for maternity or paternity leave.

The Medical Staff President will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the Medical Staff President will consult with the CEO and the relevant department chair

During the leave of absence, the individual will not exercise any clinical privileges. In addition, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement, and the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency town call obligations) during this period.

If the staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment. If they fail to do so, the individual's appointment and clinical privileges will lapse at the end of the appointment period.

3.6(b)Termination of Leave

(1)At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. Requests for reinstatement will then be reviewed by the relevant department chair, and forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for approval.

If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal

Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2)If a member requests a leave of absence for any reason and for any length of time, including but not limited to obtaining further medical training or an armed services commitment the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both.

(3)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 mentally capable of resuming practice and safely exercising the clinical privileges requested.

(4) 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 Medical Executive Committee. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Staff and the Medical Center.

(5)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, the determination will be final, with no recourse to a hearing and appeal.

3.7 RESIGNATIONS

Medical Staff or APP Staff members should make a good faith effort to give at least thirty (30) days' notice of a resignation. Resignations must be submitted to the CEO and/or Medical Staff President and shall become effective immediately upon receipt by the CEO and/or Medical Staff President or, if indicated, upon the date indicated by the Medical Staff or APP member in his/her notice. Resignation notices must be signed by the Medical Staff or APP member. They must be accompanied by evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any patient who is under the individual's care at the time of resignation. After consulting with the Medical Staff President, the Medical Center President will act on the request following approval of the Credential Committee, MEC and BOD.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1CATEGORIES

The staff shall include Active, Courtesy, Consulting, Emeritus and Affiliate categories.

4.2ACTIVE STAFF

4.2(a)Qualifications

The Active Staff shall consist of practitioners who:

(1)Meet the basic qualifications set forth in these bylaws;

(2)Have an office and/or residence located within 30 miles of the Organization in order to be continuously available for provision of care to his/her patients, as determined by the Board; and

(3)Regularly admit to or are otherwise regularly involved in the care of at least 24 patients in the Organization in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Organization setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single Organization stay, the multiple tests for that patient shall count as one (1) patient contact.

4.2(b)Prerogatives

Active Staff members may:

1. Admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;
2. Exercise such clinical privileges as are granted pursuant to Article VII;
3. Vote on all matters presented at general and special meetings of the Medical Staff and

applicable department and committee meetings;

4. Hold office in the staff organization, departments and on committees to which he/she is appointed; and

4.2(c)Responsibilities

Each member of the Active Staff shall/must:

1. Meet the basic responsibilities set forth in Section 3.3;
2. Within each practitioner area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Organization for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision;
3. Accept consultations within the practitioner's scope of privileges when requested (4) Actively participate:
    i. in the peer review and performance improvement process, (QAPI) and other patient care evaluation and monitoring activities required of the staff, and possess the requisite skill and training for the oversight of care, treatment and services in the Organization;
    ii. in supervision of other appointees and where appropriate;
    iii. in the emergency department on-call rotation (Unassigned patient call), including care for unassigned patients and personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department provider;
    iv. in promoting effective utilization of resources consistent with delivery of quality patient care; and
    v. in discharging such other staff functions as may be required from time-to-time.

(5)Serve on at least one (1) Medical Staff committee, if appointed by the Medical Staff President; and

1. Attend meetings of the Medical Staff and of the departments and committees of which he/she is a member.
2. Pay application fees, dues and assessments.

4.3COURTESY STAFF

4.3(a)Qualifications

The Courtesy Staff shall consist of practitioners, who:

1. Meet the basic qualifications set forth in these bylaws;
2. Have an office and/or residence located within 30 miles of the Organization in order to provide continuous care for a hospitalized patient or arranged to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided;
3. Do not admit or participate in the care of more than 24 patients in a calendar year. Courtesy members who admit or are involved in the care of more than 24 patients in a calendar year must transfer to Active Staff. The requirement to transfer to active staff may be waived by the Board for practitioners who have their primary practice

outside the community and provide services not otherwise available in the community; and

4. Are members in good standing of the Active Staff of another Organization where they actively participate in the QAPI program.

4.3(b)Prerogatives

Courtesy Staff members may:

1. Admit patients to the Organization, if granted the privileges to do so, within the limitations provided in Section 4.3(a);
2. Exercise such clinical privileges as are granted to him/her pursuant to Article VII;
3. Attend meetings of the medical staff and any staff or Organization education programs; and
4. Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she ***shall not*** be entitled to serve as or vote for Chairperson of any department or chairperson of any committee and ***shall not*** vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c)Responsibilities

Each member of the Courtesy Staff shall:

1. Discharge the basic responsibilities specified in Article 3.3;
2. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Organization for who he/she is providing service;
3. Attend meetings of the Medical Staff and of the committees of which he/she is a member; and
4. Participate in the emergency department on-call rotation (Unassigned Patient call) if there are an inadequate number of Active Staff physicians to provide coverage within a specific specialty. The MEC shall make recommendations to the Board of Trustees regarding the determination of which specialties require coverage by Courtesy Staff members, and the Board shall have final authority for determining if such requirement of Courtesy Staff members is necessary in order to provide quality care and meet the Organization's obligations under all applicable state and federal laws. The requirement to participate in unassigned patient call may be waived by the Board for practitioners who have their primary practice outside the community

(5) Must pay applicable fees, dues, and assessments.

4.4CONSULTING STAFF

4.4(a)Qualifications

Consulting Staff shall consist of a special category of practitioners each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

4.4(b)Prerogatives

Consulting Staff member:

1. Will consult on an unlimited number of patients within his/her specialty;
2. Will provide consultation reports/recommendations without managing the direct patient care.
3. Will not admit patients to the Organization perform inpatient or outpatient procedures, transfer patients from the Organization, or act as the physician of primary care or responsibility for any patient within the Organization.
4. May attend all meetings of the staff and the applicable department that he/she may wish to attend as a non-voting visitor.
5. Will not hold office nor be eligible to vote in the Medical Staff organization.

4.4(c)Responsibilities

Each member of the Consulting Staff shall assume responsibility for consultation and appropriate documentation thereof with regard to his/her patients.

4.5EMERITUS STAFF

4.5(a)Qualifications

The Emeritus Staff shall consist of physicians who are not active in the Organization and who are honored by emeritus positions. These may be:

1. Physicians who have retired from active Organization services and have no further privileges, but continue to demonstrate a genuine concern for the Organization; or
2. Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Emeritus Staff members shall not be required to meet the qualifications set forth in Section 3.2(a) of these bylaws.

4.5(b)Prerogatives

Emeritus Staff member:

1. May attend by invitation any such meetings that he/she may wish to attend as a non-voting visitor.
2. May not in any circumstances admit patients to the Organization or be the physician of primary care or responsibility for any patient within the Organization;
3. May not hold office nor be eligible to vote in the Medical Staff organization.

4.5(c)Termination

Appointment and reappointment to the Emeritus Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee.

4.6AFFILIATE STAFF

4.6(a)Qualifications

Appointees of the affiliate staff shall consist of those physicians who desire to be associated with the Organization, but who do not intend to care for or treat patients at this Organization. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing education endeavors, and to permit these individuals access to Medical Center services for their patients by referral to members of the Active Staff for admission and care. Affiliate Staff shall not be granted clinical privileges and shall not be subject to the eligibility criteria set forth in these bylaws nor the requirements for ongoing professional practice evaluation or focused professional practice evaluation.

4.6(b)Prerogatives

Affiliate Staff Appointees:

1. May refer patients for outpatient diagnostic testing and specialty services provided by the Organization;
2. May refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment;
3. May visit their Hospitalized patients, review their medical records and provide advice and guidance to the attending physician, but shall **NOT** be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the Organization
4. Are encouraged to attend educational programs sponsored by the Organization or Medical Staff and attend meetings of the full Medical Staff and the Department to which they are assigned; and
5. May attend meetings of the Medical Staff, department, and division but shall not vote on staff matters, or hold office,
6. May serve and vote on Medical Staff Committees, if assigned.
7. Must pay application fees and dues, if applicable.

4.6(c)Responsibilities

Individuals requesting Affiliate Staff appointment shall be required to:

1. Submit an application for initial appointment, or for reappointment no less than every two (2) years as prescribed by Article VI of these Bylaws;
2. Submit documentation of a current license, malpractice insurance in the amounts required by these Bylaws, and shall not currently be ineligible as defined in these Bylaws. Affiliate Staff members are not granted clinical privileges therefore Board Certification is not required; and
3. Acknowledge that appointment and reappointment to the Affiliate Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee with sixty (60) days written notice, without right to a hearing or appeal as set forth

in these Bylaws.

4.6(d)Reappointment Requirements

Individuals requesting re-appointment to the Affiliate Staff:

1. Shall provide evidence of a current license and Drug Enforcement Agency (DEA) registration if applicable;
2. Shall provide evidence of current malpractice insurance in the amounts required by Section 14.2
3. Shall not currently be an ineligible person as defined by these Bylaws;
4. Shall provide peer references from Medical Staff members who are members of the Organization's Medical Staff and are familiar with the Affiliate Staff member's competence.

4.7RESIDENTS

4.7(a) Qualifications

1. Residents consist of physicians who are participants in an American Medical Association graduate medical education program approved by the Medical Executive Committee and Board of Trustees.
2. Residents shall be credentialed by the residency program in accordance with written affiliation agreements between the Organization and residency program and in accordance with Organization policy. In addition, the MEC and Board shall receive information and data from the residency program, consider said information and data, and individually approve each practitioner prior to any grant of clinical privileges as a Resident. Any decision to not approve a Resident pursuant to an affiliation agreement between the Organization and residency program shall entitle the affected practitioner to any grievance procedure rights in the written affiliation agreement between the Organization and residency program. However, such administrative actions shall not entitle the Resident to any procedural rights pursuant to the Bylaws or Fair Hearing Plan.

   4.7(b) Prerogatives

   1. The appropriate director of the residency program shall monitor the clinical and ethical performance of Residents.
   2. Residents shall at all times when performing duties and services at the Organization be under the supervision of a member of the residency program's faculty who shall be a member in good standing on the Active or Courtesy Medical Staff.
   3. Residents may evaluate patients, perform procedures and make entries in the medical record under the supervision and signature of the supervising physician in accordance with Organization policy.
   4. The supervising physician to whom the Resident has been assigned must be primarily responsible for the care of the patient. It is the responsibility of the supervising physician to document in the progress notes that he has seen the patient and participated in the care of the patient.
   5. Residents shall abide by all provisions of the Medical Staff Bylaws, Rules and

Regulations, and Organization policies and procedures.

6. Any decision to remove a Resident from service at the Organization pursuant to an affiliation agreement between the Organization and residency program shall entitle the affected practitioner to any grievance procedure rights in the written affiliation agreements between the Organization and residency program. However, such administrative actions shall not entitle the Resident to any procedural rights pursuant to the Bylaws or the Fair Hearing Plan.
7. Residents may not hold Medical Staff office. Residents may be allowed to participate in Organization committees but shall have no voting rights. Residents may attend meetings of the Medical Staff but shall have no voting rights.

4.7(c)Qualifications and Prerogatives of Medical Students

Medical Students shall engage in activity in the Organization only pursuant to a written affiliation agreement between the Organization and an approved medical college and only upon express consent of the Medical Executive Committee as reflected in its minutes. Medical students in training at the Organization shall be permitted to engage in those activities outlined in the medical college affiliation agreement, the Organization's student manuals, and policies of the Graduate Medical Education Committee. They are not members of the Medical Staff and shall be limited in scope to those activities expressly authorized by the affiliation agreement and any addenda thereto and shall comply with all applicable state and federal laws for their activities within the facility.

4.7(d)Graduate Medical Education Committee

1. The MEC shall serve as the Graduate Medical Education Committee (GMEC) and shall be responsible for overseeing Residents and Medical Students.
2. The MEC as the GMEC shall require semiannual updates by the program director regarding academic progress of each Resident and Medical Student that has had facility activity in the previous 6 months. Said report shall include information concerning the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, Residents and Medical Students.
3. The MEC shall report to the Board concerning Residents and Medical Students on at least a semiannual basis. Said report shall include information concerning the safety and quality of patient care, treatment, and services provided by, and the related education and supervisory needs of, Residents and Medical Students.

ARTICLE V-ADVANCED PRACTICE PROFESSIONALS

5.1 Categories

5.1 (a)Independent APPs are those who are permitted by state law and regulations, and CMC's Advanced Practice Professionals Policy to provide patient care without direct physician direction or supervision. The scope of services an independent APP may provide to patients shall be subject to constraints delineated for each practitioner as outlined in their privileging documentation, and by state license, state law, and/or CMC or Medical Staff policy

Physician supervision is not a requirement of the practice of Independent APPs but APPs in some

subspecialty areas will require a collaborating physician as outlined in their privileging documentation.

5.1(b)Dependent APPs are those who are not permitted to provide patient care without direct physician direction or supervision. As a condition for obtaining and maintaining privileges, dependent practitioners must have a sponsoring relationship with a current physician member of the medical staff in the active category. The sponsoring physician must hold privileges in the same specialty and scope of practice in which the APP is practicing, and agree to provide supervision to the dependent APP. The scope of services an APP may provide to patients is limited by state license, state law, and/or CMC or Medical Staff policy.

The level of supervision required by a Dependent MS-APP is to be determined based on their licensure, location, nature and setting of the practice, and experience of the individual. Supervision may be any of the following:

1. Direct supervision: sponsoring physician is physically present or available to respond immediately
2. Onsite supervision: sponsoring physician is on campus and available to respond within an established time frame
3. General supervision: sponsoring physician is available by phone for guidance, and for general direction on a regularly scheduled basis

If at any time a dependent APP ceases to maintain this relationship, for any reason, the APP shall immediately notify Medical Staff Services (MSS). In the event of the termination, restriction or suspension of the Medical Staff membership or clinical privileges of the supervising physician, the clinical privileges of the APP shall immediately and automatically lapse. In such a case, the MS-APP shall not exercise Organization based clinical privileges until he/she has a supervising relationship with another member of the Medical Staff. The MS-APP shall have sixty (60) days within which to arrange and provide an affiliation agreement with another member of the Medical Staff. If the MS-APP does not provide a new affiliation agreement within sixty (60) days, the MS-APP will be deemed to have voluntarily resigned from the Medical Staff - Allied Health Staff.

5.2 Qualifications

Applications from APPs to provide services within the Medical Center will be considered based on Medical Center need and applicable state laws. Medical Center needs will include: patient needs, the patient care objectives of the Medical Center, availability of supervising or collaborating physician (when applicable), effect on quality care, availability of supplies and equipment, availability of trained staff, and effect on use of Organization resources.

The duties, responsibilities, and minimum qualifications are listed on the delineation of privilege or scope of practice form, as applicable, for each APP.

APPs seeking privileges to practice in the Medical Center shall obtain an application from the Medical Staff Office. At the time of application, APPs shall submit an application fee. A list of requested clinical privileges or scope of practice, as applicable, will be included with the application. The completed forms with required attachments shall be returned to MSS. The attachments must include

5.2.1Proof of current licensure

5.2.2Certification (if applicable)

5.2.3Malpractice insurance coverage in the amount required by these bylaws.

5.2.4Documentation of their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Organization

5.2.5References demonstrating that they adhere strictly to the ethics of their respective professions, work cooperatively with others and are willing to participate in the discharge of APP Staff responsibilities

5.2.6 A statement from a supervising or collaborating physician (when applicable as above) and an AMA query (PA-C's only).

5.3 Credentialing and Privileging

When all information is received, the application for MS-APPs will be processed in the same manner as for Medical Staff members as described in the Medical Staff bylaws or related policy,

For those applications that are approved, the APP must provide continued proof of licensure, certification (if applicable), and malpractice insurance coverage. Reappointment reviews for APPs will be completed every two years in the same manner as for Medical Staff members.

MS-APPs are credentialed and privileged in the same manner as the Medical Staff and are subject to the same reappointment, collegial intervention, investigation and automatic relinquishment provisions.

The number of MS-APPs sponsored by one physician, as well as the acts they may undertake, will be consistent with applicable state statutes and regulations and any other policies adopted by the Medical Center. The Sponsoring Physician will make all appropriate filings with the State Board of Medical Examiners regarding the collaboration and responsibilities of the MS-APP, to the extent that such filings are required.

5.4 Prerogatives

MS-APPs are members of the Allied Health Staff. They are not members of the Medical Staff and are not eligible to vote or hold office; they are encouraged to participate in Medical Staff meetings. They may serve on committees.

1. To exercise judgment within the APP's area of competence
2. To participate directly, including writing orders to the extent permitted by law, in the management of patients
   (3) And to participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time
   5.5 Conditions of Appointment
   APPs shall be assigned to at least one (1) of the clinical departments and shall be granted

clinical privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each APP may undertake. Such determinations shall be furnished in writing to the APP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

5.6 Responsibilities

5.6 (a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.6(b)Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Organization, if applicable;

5.6(c)Discharge any committee functions for which he/she is responsible;

5.6(d)Cooperate with members of the Medical Staff, APP Staff, administration, the Board of Trustees and employees of the Organization;

5.6(e)Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.6(f)Participate in performance improvement activities and in continuing professional education;

5.6(g)Abide by the ethical principles of his/her profession and specialty;

5.6(h)Notify the CEO and the Medical Staff President immediately if:

1. His/Her professional license in any state is suspended or revoked;
2. His/Her professional liability insurance is modified or terminated;
3. He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
4. His/Her specialty board certification expires, is voluntarily surrendered, or is revoked;
5. He/She voluntarily or involuntarily relinquishes his/her licensure to practice any profession in any jurisdiction;
6. He/She voluntarily or involuntarily relinquishes his/her National Drug Enforcement Agency (DEA) number or state licensure certificate;
7. His/Her medical staff membership or clinical privileges are voluntarily or involuntarily revoked, reduced, relinquished, limited or restricted in any health care facility;
8. His/Her patient management is the subject of an investigation by a state medical board;
9. He/She is excluded from participation in federal or state health insurance; including Medicare or Medicaid;
10. He/She participates in a voluntary or mandatory drug and/or alcohol rehabilitation program;
11. He/She has any criminal charges, other than minor traffic violations, brought/ initiated against him/her;
12. He/She is subject to current, pending investigation or challenge to licensure, DEA certification, medical staff membership or clinical privileges at any health care facility, or participation in federal or state insurance; or

13. He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of APP appointment and/or clinical privilege.

Failure to provide any such notice, as required above, shall result in immediate loss of APP membership and clinical privileges, without right of fair hearing procedures.

5.6(i)Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Organization.

5.6(j)Refuse to engage in improper inducements for patient referral; and

5.6(k)Attest that he/she suffers from no health problems which could affect ability to perform the functions of APP Staff membership and exercise the privileges requested prior to initial exercise of privileges and participate in the Organization drug testing program.

5.7CONFLICTS OF INTEREST

Each APP granted clinical privileges at the Organization must acknowledge and comply with the following standards concerning conflicts of interest:

The best interests of the community, APP Staff and the Organization are served by APP Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the APP Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Organization and the APP Staff for relationships of any APP Staff member which may influence the decisions related to the Organization to be disclosed on a regular and contemporaneous basis.

No APP Staff member shall use his/her position to obtain or accrue any improper benefit. All APP Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Organization or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the APP Staff as a whole or as a member of any committee of the APP Staff.

Upon being granted appointment to the APP Staff and/or clinical privileges and upon any grant of reappointment and/or renewal of clinical privileges, each APP Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a APP Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Organization or its staff, or the Organization's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another APP or Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Organization;

2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Organization;
3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Organization; or
4. Business practices that may adversely affect the Organization or community.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and an APP Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Organization. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each APP Staff member's written disclosure at the next MEC meeting following filing by the APP Staff member for review and discussion by the MEC.

1. **Procedural Rights of Advanced Practice Practitioners**
   Appointment of APPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting APP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected APP shall have the right to request to be heard before the MEC with an opportunity to rebut the basis for termination. Upon receipt of a written request, the MEC shall afford the APP an opportunity to be heard by the MEC concerning the APP's grievance ("an interview"). Before the appearance, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto. A record of the appearance shall be made. The MEC shall, after conclusion of the investigation, submit a written decision simultaneously to the Board and to the APP.[83]
   The APP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the MEC decision. The written request shall be delivered to the Medical Staff President and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the APP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the APP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the APP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.[84]

ARTICLE VI - PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1GENERAL PROCEDURES

The Medical Staff shall consider each application for appointment or reappointment to the staff and each request for modification of staff membership status. The Medical Staff Office shall transmit complete applications to the applicable Department Chair who prepares a written report to the Credentials Committee. The Credentials Committee investigates and considers each application and forwards a recommendation to the Medical Executive Committee and thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

6.2CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the appropriate forms, approved by the Board, and signed by the applicant. Applicants shall supply the Organization with all information requested on the application.

A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists and telemedicine providers), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application.

The application fee or Medical Staff dues (if any) shall be _____$350____.

The application form shall include, at a minimum, the following:

6.2(a)**Acknowledgment & Agreement**: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

1. to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and
2. to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

6.2(b)**Administrative Remedies**: A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;

6.2(c)**Criminal Charges**: Any current criminal charges, except minor traffic violations, pending against the applicant and any past convictions or pleas. The practitioner shall acknowledge the Organization's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

6.2(d)**Fraud**: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid;

6.2(e)**Health Status**. Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of safely and competently performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board. Applicant agrees to be bound by the Organization drug testing

policy;

6.2(f)**Program Participation**: Information concerning the applicant's current participation and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

6.2(g)**Information on Malpractice Experience**: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of a professional liability action against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions;

6.2(h)**Education:** Detailed information concerning the applicant's education and training.

6.2(i)**Insurance**: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws. Each practitioner must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

6.2(j)**Notification of Release and Immunity Provisions**: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;

6.2(k)**Professional Sanctions**: Information as to **previously successful or currently pending challenges to, or the voluntary relinquishment** of, any of the following:

1. Membership/fellowship in local, state or national professional organizations;
2. Specialty board certifications;
3. License to practice any profession in any jurisdiction;
4. Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists and telehealth providers) suspension, modification, termination, restriction, or relinquishment;
5. Medical Staff membership or voluntary or involuntary limitation, reduction, *or* loss, or denial of clinical privileges;
6. The practitioner's management of patients which may have given rise to investigation by the state medical board; or
7. Participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC, in writing through the CEO or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or his/her designee shall be responsible for notifying the MEC of all such actions.

6.2(l)**Qualifications**: Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;

6.2(m)**References**: The names of at least three (3) practitioners (excluding, when feasible, partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

6.2(n)**Practice Affiliations**: The name and address of all other Organizations, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

6.2(o)**Request**: Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;

6.2(p)**Photograph:** A recent, wallet sized government issued photograph of the applicant;

6.2(q)**Citizenship Status**: Proof of United States citizenship or legal residency;

6.2(r)**Professional Practice Review Data**: For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner's professional practice review, volumes, or outcomes from organization(s) that current privilege the applicant; and

6.2(s)**Continuing Education:** Evidence of satisfactory completion of continuing education requirements.

6.2(t)A request for specific clinical privileges.

6.3PROCESSING THE APPLICATION

6.3(a)Request for Application

A practitioner wishing to be considered for appointment or reappointment and clinical privileges may obtain an application form by submitting his/her written request for an application form to the Medical Staff Office. A copy of the Bylaws will be provided with the application and applicants will be expected to familiarize themselves with the threshold eligibility criteria for appointment and applicable criteria for clinical privileges.

6.3(b)Applicant's Burden

By submitting the application, the applicant:

1. Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of his/her current competence, character, ethics, and other qualifications for staff membership and clinical privileges ;
2. Is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed. An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and information has been verified from primary sources as required. An application will become incomplete if the need arises for new, additional, or clarifying information at any time.

3. Authorizes Organization representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(4)Consents to the inspection by Organization representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

(5)Has the burden of providing evidence that all the statements made and information given on the application are accurate and complete and represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Organization of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights;

(6)Acknowledges that, if he/she is determined to have made a material misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall have his/her medical staff membership and clinical privileges automatically removed, without fair hearing rights. The determination of materiality shall be in the sole discretion of the MEC and Board;

(7)Pledges to provide continuous care for his/her patients treated in the Organization; and

(8)Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.

6.3(c)Statement of Release & Immunity from Liability and Authorization to Obtain/Release Information

By applying for appointment, reappointment, or clinical privileges, whether or not appointment or clinical privileges are granted, the individual expressly accepts the following conditions, throughout the term of any appointment period and thereafter:

1. **Immunity**:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Medical Center or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures performed without intentional fraud or malice involving the individual that are made, taken, or received by the Medical Center, its authorized representatives, or third parties in the course of credentialing and professional practice evaluation activities.

And may relate to any of, but not limited to, the following:

a. applications for appointment or clinical privileges, including temporary privileges;

b. periodic reappraisals;

c. proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

d. summary suspension;

e. hearings and appellate reviews;

f. medical care evaluations;

g. utilization reviews;

h. any other Organization, Medical Staff, department, service or committee activities;

i. inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

j. any other matter that might directly or indirectly impact or reflect on competence, on patient care or on the orderly operation of this or Organization.

(2)**Authorization to Obtain Information from Third Parties**:

The individual specifically authorizes the Medical Center, Medical Staff leaders, and their authorized representatives to consult with any third party who may have information including otherwise privileged or confidential information, bearing on professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on the individual's qualifications for appointment to the Medical Staff or APP Staff and/or for the granting of clinical privileges, and to obtain any and all information that may be relevant. The individual also specifically authorizes third parties to release this information to the Medical Center and its authorized representatives upon request. 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 Medical Center.

1. **Authorization to Release Information to Third Parties**:

The individual also authorizes Medical Center representatives to release information to other Organizations, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

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

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

6.3(d)Submission of Application & Verification of Information

Applicant shall submit a completed application and required documents to the Medical Staff Office. The application must be accompanied by the application fee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

1. **Incomplete application.** The applicant has failed to provide any information required by these

bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application

2. **Fails to meet threshold eligibility criteria as outlined in 3.2 a**

(3)**Not Licensed**. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or APP Staff; or

(4) **Privileges Denied or Terminated**. Within one (1) year immediately preceding the request, the applicant has had his/her application for Medical Staff or APP Staff appointment at this Organization denied, has resigned his/her Medical Staff or APP Staff appointment at this Organization during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Organization; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

1. **Exclusive Contract or Moratorium**. The applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Organization or a moratorium has been imposed by the Board upon acceptance of applications within the practitioners' specialty
2. **Inadequate Insurance**. The applicant does not meet the liability insurance coverage requirements of these bylaws; or
3. **Ineligible for Medicare Provider Status**. The applicant has been excluded, suspended or debarred from any government payer program, or is currently the subject of a pending investigation by any government payer program; or
4. **No DEA number.** The applicant's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists or telemedicine providers); or
5. **Continuous Care Requirement**. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within the geographical area required by these bylaws;

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the Medical Staff Office will oversee the process of collecting and verifying the references, licensure and other evidence submitted. The Medical Staff Office will promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within thirty (30) days of receipt of such notification. Failure to provide requested information within the specified time will result in automatic withdrawal of the application.

Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented.

Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including, but not limited to, the applicant's past or current Department chiefs at other health care entities, residency or fellowship training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others

When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e)Description of Initial Clinical Privileges and Appointment Considerations

Medical Staff or APP Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Organization. Each individual who is appointed to the Medical Staff or APP Staff of the Organization shall be entitled to exercise only those clinical privileges specifically granted by the Board.

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

Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

The clinical privileges recommended to the Board shall be based upon evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including consideration of the following:

1. the applicant's education, training, experience, past performance, demonstrated current competence and judgment, references and other relevant information including medical/ clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
2. appropriateness of utilization patterns;
3. ability to perform the privileges requested competently and safely;
4. information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
5. availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;
6. adequate professional liability insurance coverage for the clinical privileges requested;
7. the Medical Center's available resources and personnel;
8. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
9. any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Organization;

10. practitioner-specific data as compared to aggregate data, when available;
11. morbidity and mortality data, when available; and
12. professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

The applicant has the burden of establishing qualifications for, and **current** competence to exercise the clinical privileges requested.

6.3(f)Recommendation of Department Chairperson

The Chairperson of the appropriate department(s) shall review the completed application, the supporting documentation, reports and recommendations, and such other relevant information available. The chairperson shall make a recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. The recommendation of the Chair of the clinical Department(s) in which privileges are sought will be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

The department chair will be available to the Credentials Committee, Medical Executive Committee, and the Board to answer any questions that may be raised with respect to that chair's report and findings.

6.3(g)Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Department Chairperson and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee may defer action up to 60 days. If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the Medical Center President, explaining the reasons for the delay.

The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

The Credentials Committee will determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination will be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application will cease.

The Credentials Committee shall transmit to the MEC a written recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment.

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

6.3(h)Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation of the Credentials Committee, and other relevant information available to it. The Medical Executive Committee may:

1. adopt the recommendation of the Credentials Committee as its own and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment; or
2. refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation.; or
3. state its reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation; or
4. defer action on the application
   The MEC shall forward to the Board a written recommendation concerning each application. The reasons for each recommendation shall be stated and supported by reference to the completed application and any other information considered by the committee. Documentation shall be transmitted with the recommendation. Any minority views shall also be reduced to writing, supported by reasons, references, and documents, and transmitted with the majority recommendation.

   6.3(i)Effect of Medical Executive Committee Action

   1. Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same. In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.
      (2)**Favorable Recommendation**: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chairperson. The Board shall act upon the recommendation at its next scheduled meeting or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.
      (3) **Adverse Recommendation**: When the recommendation of the MEC is averse to

the applicant, the CEO or his/her designee shall immediately inform the applicant by special notice. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. The applicant then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for APPs, the procedure outlined in Sections 5.4(b) and 5.4(c). Medical Staff Services will then hold the application until after the applicant has completed or waived a hearing and appeal. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for APPs, the procedure outlined in Sections 5.4(b) and 5.4(c).

6.3(j)Board Action

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

1. appoint the applicant and grant clinical privileges as recommended; or
2. refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Medical Center for additional research or information; or
3. reject or modify the recommendation.

The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

(b) Decisions

(1) **Favorable Action**. In the event that the Board of Trustees' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been granted. The CEO or his/her designee shall also keep each patient care area/department adequately informed concerning the current clinical privileges granted to each newly approved applicant as well as existing members of the Medical Staff. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of QAPI that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

(2) **Adverse Action**. In the event that the MEC's recommendation was favorable to the applicant, but the Board of Trustees' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan, or for APPs, the procedure outlined in Sections 5.4(b) and 5.4(c). The Medical Staff President shall immediately deliver to the applicant by special notice, a letter enclosing the Board of Trustees' written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan, or for APPs, the procedure outlined in

Sections 5.4(b) and 5.4(c).
If the Board's action is materially more restrictive than the MEC's recommendation after the evidentiary hearing, the affected practitioner may request a reconsideration of the Board's decision pursuant to the appellate procedure outlined in these Bylaws and the Fair Hearing Plan. Such reconsideration shall be based on the record of the preceding evidentiary hearing.
(c) Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.
Expedited Process: The Board may appoint a committee consisting of at least two (2) Board members to review and act on the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.
The expedited process may not be used in the following circumstances:
(i) The applicant submits an incomplete application;
(ii) The MEC makes a recommendation that is adverse or with limitation;
(iii) There is a current challenge or a previously successful challenge to licensure or registration;
(iv) The applicant has received an involuntary termination of medical staff or APP staff membership at another organization;
(v) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
(vi) There has been a final judgment adverse to the applicant in a professional liability action.
Any of the above circumstances will require review and consideration by the full Board.
In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce the full Board's decision to writing and shall set forth therein the reasons for the decision. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o).

6.3(k)Interview

An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the Department Chair(s), the Credentials Committee or representative, the Medical Executive Committee or representative, the Medical Staff President, CMO, and/or the CEO. An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) – 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(l)Reapplication After Adverse Appointment Decision
An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, the application materials.

6.3(m)Time Periods for Processing
Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the department chairperson upon completing his/her verification tasks, but in any event within one hundred and twenty (120) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process.

6.3(n)Denial for Organization's Inability to Accommodate Applicant
A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan, or for APPs, the procedure outlined in Sections 5.4(b) and 5.4(c):

1. On the basis of the Organization's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or
2. On the basis of inconsistency with the Organization's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or
3. On the basis of professional contracts the Organization has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Organization finds it possible to accept applications for staff positions for which the applicant is eligible, and the Organization has no obligation

to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

6.4REAPPOINTMENT PROCESS

6.4(a)Procedure for reappointment

At least ninety (90) days prior to the expiration date of a practitioner's present staff appointment and/or clinical privileges, the Medical Staff Office will provide the practitioner a reapplication form for use in considering reappointment. The practitioner who desires reappointment and/or renewal of clinical privileges will return a completed application to the Medical Staff Office at least sixty (60) days prior to such expiration date, Failure to return a completed application form at least two months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the current term.

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

Reappointment will be for a period of not more than two years.

In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

6.4 (b) Eligibility for Reappointment

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

a. completed all medical records;
b. completed all continuing medical education requirements;
c. satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
d. continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by the Department Chairperson and by one (1) other Medical Staff member who whenever possible is not a partner, employer, employee or relative of the practitioner or APP or two (2) Medical Staff members who whenever possible are not partners, employers or employees, or relatives, and results from the QAPI process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners and APPs who have not actively

practiced in this Organization during the prior appointment period will have the burden of providing evidence of their professional practice review, volumes and outcomes from organizations that currently privilege them and where they have actively practiced during the prior period of appointment.

At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Organization during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practitioners (excluding, when feasible, partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others.

Upon receiving an individual's application for reappointment, the factors and required disclosures listed in Section 6.2 will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

a. compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Medical Center;
b. participation in Medical Staff duties, including committee assignments and emergency call;
c. the results of the Medical Center's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that other practitioners will not be identified);
d. any focused professional practice evaluations;
e. verified complaints received from patients and/or staff; and

(f) other reasonable indicators of continuing qualifications.

6.4(c)Verification of Information

The application will be reviewed by Medical Staff Services to determine that all questions have been answered, all relevant information has been received, and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

Medical Staff Services will oversee the process of gathering and verifying relevant information including information regarding the applicant's professional activities, performance and conduct in the Organization and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process.

An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d)Processing Applications for Reappointment

The application for reappointment shall thereafter be processed as set forth as described in Sections 6.3(f)–6.3(m) for initial appointment.

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period. The applicant shall submit such additional information as the Medical Staff, or the Board may require. Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Medical Center President, or any other committee authorized to request such information, will result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

6.4(e)Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in this Article VI as they impact upon determinations regarding the applicant's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners, APPs and with patients, results of the Organization monitoring and evaluation process, including practitioner or APP-specific information compared to aggregate information from QAPI activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Organization.

If it becomes apparent to the Credentials Committee or the Medical Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and will be invited to discuss, explain, or refute it. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The committee will indicate as part of its report whether such a meeting occurred and will include a summary of the meeting with its minutes.

6.4 (f) Conditional Reappointments

(a)Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve a material restriction on clinical privileges as specified in the Fair Hearing Plan, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in the Fair Hearing Plan.

(b)In addition, reappointments 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 reappointment for a period of less than two years does not, in and of itself, entitle

an individual to the procedural rights set forth in the Fair Hearing Plan.

6.5MODIFICATION OF APPOINTMENT

A provider may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the Medical Staff Office. Such request will be processed in substantially the same manner as provided in Section 6.4 for reappointment. No provider may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Notwithstanding the foregoing, a staff member may not request modification of his/her staff category more than once in any two-year appointment term.

Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria. A request to relinquish/resign any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges.

6.6PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a)Qualifications & Processing

A practitioner who is providing contract services to the Organization must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

6.6(b)Requirements for Service

In approving any such practitioners for Medical Staff or APP Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements and CMS Conditions of Participation, are subject to appropriate quality controls, and are evaluated as part of the overall Organization quality assessment and improvement program.

6.6(c)Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 shall automatically result in concurrent termination of Medical Staff or APP Staff membership and clinical privileges. The Fair Hearing Plan does not apply in this case, nor do Sections 5.4(b) or 5.4(c) for APPs.

6.7CREDENTIALS VERIFICATION ORGANIZATION

Notwithstanding anything in these Bylaws to the contrary, the services of a credentials verification organization (that has been approved by the Board, after consultation with the MEC), may be utilized in order to meet the credentials verification requirements delineated herein and/or assist in the

credentialing process.

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1EXERCISE OF PRIVILEGES

Every practitioner or APP providing direct clinical services in this Organization will, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board, except in an emergency situation where delay in performing a procedure could result in serious harm to a patient. These privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and APP, and each practitioner or APP shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2DELINEATION OF PRIVILEGES IN GENERAL

7.2(a)Requests

Each application for appointment and reappointment to the Medical Staff or APP Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner or APP's qualifications to exercise the privileges requested.

In order for a request for privileges to be processed, the applicant must satisfy any applicable threshold eligibility criteria for Medical Staff or APP Staff membership.

In addition, each practitioner and APP must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a practitioner or APP for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria.

7.2(b)Waivers

Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.

Requests for waivers in accordance with this section will be processed in the same manner as requests for waivers of appointment criteria, as described in Article 3, and the factors outlined will be considered as part of that process.

7.2(c) Clinical Privileges for New Procedures

(a)Requests for clinical privileges to perform either a significant procedure not currently being performed at the Medical Center or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Medical Center (also see 3.5.d) and (2) criteria to be eligible to request those clinical privileges have been established.

(b)The applicable Medical Staff Department will conduct research and consult with experts, to develop recommendations regarding:

(1) the minimum education, training, and experience necessary to request the new procedure,

(2) the extent of monitoring and supervision that should occur if the privileges are granted.

(3) Factors to be considered include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar Organizations and the experiences of those institutions, and whether the Medical Center has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(c) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

7.2(d)Basis for Privileges Determination

Granting of clinical privileges shall be based upon the following:

(1)Applicant's education, relevant training, experience, and demonstrated current competence, including documented experience in treatment areas or procedures; the results of treatment; information resulting from ongoing and focused professional practice evaluation, performance improvement, appropriateness of utilization patterns; and other peer review activities; and the conclusions drawn from QAPI activities, when available,

(2)community and Organization need

(3)the Medical Center's available facilities, equipment, resources and personnel

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

For practitioners or APPs who have not actively practiced in the Organization within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in these Bylaws.

Those practitioners or APPs seeking new, additional or renewed clinical privileges (except those seeking emergency or disaster privileges) must meet all criteria for Medical Staff or APP Staff membership as described in these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information

pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for each provider.

7.2(e)Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.

7.2(f)Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(g)Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation ("FPPE"). The evaluation period may be renewed and extended for additional periods. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner's or APP's evaluation for reappointment.

7.3SPECIAL CONDITIONS FOR DENTAL & PODIATRIC PRIVILEGES

Requests for clinical privileges from dentists, oral surgeons, and podiatrists shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists, oral surgeons, and podiatrists shall be under the overall supervision of the Chief of Surgery; however, other dentists and/or oral surgeons or podiatrists, as applicable, shall participate in the review of the practitioner through the performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. To the extent required by state law, a physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during Hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4CLINICAL PRIVILEGES HELD BY NON-MEMBER PRACTITIONERS – TEMPORARY PRIVILEGES

Temporary Clinical privileges may be granted to individuals without membership on the Medical Staff or APP Staff in the following circumstances. Individuals granted clinical privileges in accordance with this Section do not have the rights or prerogatives of Medical Staff or APP Staff members.

Temporary privileges may be granted by the CEO or his/her designee, upon recommendation of the President of the Medical Staff, when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time.

In these cases only, the CEO may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Medical Center

7.4(a) Temporary Privileges—Important Patient Care Need—Pending Application

A new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Department Chair and pending MEC review and Board approval following a favorable recommendation of the Credentials Committee, may be granted temporary privileges. "New applicant" includes an individual applying for clinical privileges at the Organization for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.4(b) Temporary Privileges—Important Patient Care Need—No Pending Application or Application Incomplete

When no completed application for medical staff membership or clinical privilege is currently pending, upon receipt of a written request, an appropriately licensed person may be granted temporary privileges for an initial period not to exceed thirty (30) days.

Temporary privileges may be granted for situations such as the following:

1. A practitioner who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, (example: a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately) to prevent a lack or lapse of services in a needed specialty area
2. A practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient),

Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service within a calendar year.

All practitioners providing coverage for other practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The National Practitioner Data Bank query

must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary Organization. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute practitioner shall, where possible, advise the Organization at least thirty (30) days in advance of the identity of the practitioner and the dates during which the services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the practitioner's primary Organization. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases only, the CEO or his/her designee, upon recommendation of the President of the Medical Staff, Chairperson of the Credentials Committee and Chairperson of the applicable department, may grant such privileges upon receipt of the required information.

7.4(d)Conditions

Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner or APP's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation, supervision and reporting may be imposed on any individual granted temporary clinical privileges by the *Chief of* Medical Staff President, including a requirement that the patients of such practitioner or APP be admitted upon dual admission with a member of the Active Staff.

7.4(e)Termination

The granting of temporary privileges is a courtesy and may be terminated for any reason.

The CEO or Medical Staff President may, at any time after consulting with the chair of the Credentials Committee, and/or the department chair, when feasible, terminate temporary privileges.

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner or APP's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Medical Staff President terminate any or all of such practitioner or APP's temporary privileges.

Where the safety of a patient is endangered by continued treatment by the practitioner or APP, the CEO or the Medical Staff President may immediately terminate all temporary privileges. In the event of any such termination, the department chair or the Medical Staff President will assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged.

7.4(f)Rights of the Practitioner

A practitioner or APP shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary or proctoring privileges. or because of any termination or suspension of such privileges. Unless revoked due to professional competence or conduct.

7.4(g)Term

No term of temporary or proctoring privileges shall exceed a total of one hundred and twenty (120) days.

7.5 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS -

DISASTER PRIVILEGES

A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available providers is not adequate to provide all clinical services required by the citizens served by this facility. In the case of a disaster as defined herein, any licensed independent practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the Medical Staff President, be permitted to do, and be assisted by Organization personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed.

Prior to granting any disaster privileges:

a. A practitioner's identity will be verified through a valid government-issued photo identification issued by a state, federal or regulatory agency (i.e., driver's license or passport).
(b)A practitioner's license will be verified in any of the following ways:
    i. picture ID card from another Medical Center that clearly identifies the individual's professional designation;
    ii. current license to practice;
    iii. primary source verification of the license certification or registration;
    iv. identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance

Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or

v. identification by a current Medical Center employee or Medical Staff member who possesses personal knowledge regarding the practitioner's qualifications and the individual's ability to act as a volunteer during a disaster.

Disaster privileges are temporary. The CEO and/or Medical Staff President are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. After verification, pursuant to 7.4(a), the practitioner will be transitioned to temporary privileges.

In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible. In these situations, the Organization must document the following:

(a) the reason primary source verification could not be performed in the required time frame;

(b) evidence of the provider's demonstrated ability to continue to provide adequate care treatment and services; and

(c) an attempt to obtain primary source verification as soon as possible.

In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Medical Staff President, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

Each practitioner granted disaster privileges shall be issued an Organization ID (or if not practicable by time or other circumstances to issue official Organization ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster practitioner for purposes of overseeing the professional performance of the practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

Disaster privileges may be terminated immediately without prior notice by the CEO or the Medical Staff President or their respective designees at any time and the medical staff's hearing and appellate review procedures shall not apply.

Disaster privileges shall automatically terminate when:

(a) the disaster situation no longer exists;

(b) a decision is made by the Medical Staff President, the CEO or their designees that the immediate needs of the patients can be met by the Organization's Medical Staff or

(c) a decision is made by the Medical Staff President, the CEO or their designees that the professional practice of the licensed independent practitioner does not meet professional standards.

7.6 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS - TELEHEALTH PRIVILEGES

7.6(a)Scope of Privileges

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telehealth, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.6(b)Telehealth Physicians

Individuals applying for telemedicine privileges will meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to proof of immunizations and TB screening, coverage arrangements and emergency call responsibilities. Qualified applicants may be granted telemedicine privileges but will not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

Applications for telemedicine privileges will be processed in accordance with the provisions of this Policy in the same manner as for any other applicant. In circumstances in which the distant-site entity or Organization is accredited by a CMS deeming authority, the Medical Staff and Board may rely on the telehealth physician's credentialing information from the distant-site entity or distant-Organization to credential and privilege the telehealth physician ONLY if the Organization has ensured through a written agreement with the distant-site entity or distant-site Organization that all of the following provisions are met:

i. The distant-site entity or distant-site Organization meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity's or distant-site Organization's physicians and practitioners providing telehealth services;

ii. The distant-site entity, if not a distant-site hospital, is a contractor of services to the Organization and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Organization to comply with all applicable federal regulations for the contracted services;

iii. The distant-site organization is either a Medicare-participating Organization or a distant-site telehealth entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation;

iv. The telehealth physician is privileged at the distant-site entity or distant-site Organization providing the telehealth services, and the distant-site entity or distant-site Organization provides the Organization with a current list of the telehealth physician's privileges at the distant-site entity or distant-site Organization;

v. The telehealth physician holds a license issued or recognized by the State of Montana and

vi. The Organization has evidence, or will collect evidence, of an internal review of the telehealth physician's performance of telehealth privileges at

the Organization and shall send the distant-site entity or distant-site Organization such performance information (including, at a minimum, all adverse events that result from telehealth services provided by the telehealth physician and all complaints the Organization has received about the telehealth physician) for use in the periodic appraisal of the telehealth physician by the distant-site entity or distant-site Organization.

For the purposes of this Section, the term "distant-site entity" shall mean an entity that: (1) provides telehealth services; (2) is not a Medicare-participating Organization; (3) is accredited by a CMS deeming authority; and (4) provides contracted services in a manner that enables an Organization using its services to meet all applicable CMS Organization Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telehealth services. For the purposes of this Section 7.6, the term "distant-site Hospital" shall mean a Medicare-participating and CMS deeming authority accredited Organization that provides telehealth services.

If the telehealth physician's site is also accredited by a CMS deeming authority, and the telehealth physician is privileged to perform the services and procedures for which privileges are being sought in the Organization, then the telehealth physician's credentialing information from that site may be relied upon to credential the telehealth physician in the Organization. However, this Organization will remain responsible for primary source verification of licensure, current professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

ARTICLE VIII

CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Indications for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Organization operations including the inability of the member to work harmoniously with others, fail to comply with applicable ethical standards, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, a performance improvement plan or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the Chairperson of the Department of which the practitioner is a member, by the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Requests & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC and supported by reference to the specific activities or conduct which constitute the grounds for the request. The MEC may also initiate corrective action on its own initiative based on information received from other sources. The MEC shall reference the specific activities or conduct constituting the basis of the action. The Medical Staff President shall promptly notify the CEO or his/her designee in writing of all

requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the Code of Conduct Policy/Practitioner Wellness or the Behavior that Undermines a Culture of Safety (BUCS)), or to proceed in another manner. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation will begin only after a formal determination by the Medical Executive Committee to do so.

8.1(c) Investigation by the Medical Executive Committee

Once a determination has been made to begin an investigation, the MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Organization's Provider Wellness Policy. Within sixty (60) days after the investigation begins, a written report of the investigation shall be completed with its findings, conclusions, and recommendations.

1. The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical Staff.
2. Any ad hoc committee may include individuals not on the Medical Staff. The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Medical Center, as well as the authority to use outside consultants, if needed.
3. The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated will execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.
4. The individual may have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Neither the individual, nor the investigative committee and/or the MEC, will have the right to be represented by legal counsel at this meeting.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting the request for corrective action; (determine that no action is justified)

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a letter of guidance, counsel, warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(4) Imposing conditions for continued appointment

(5) require additional training or education;

(6) recommending terms of probation or required consultation;

(5) Recommending reduction, suspension or revocation of clinical privileges;

(6) Recommending reduction of staff category or limitation of any staff prerogatives;

(7) Recommending a period of focused professional practice evaluation (FPPE); or

(8) Recommending suspension or revocation of staff membership.

(9) make any other recommendation that it deems necessary or appropriate.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)***(4-8)** (where such action materially restricts a physician's or dentist's exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d) (where such action does not materially restrict a practitioner's exercise of privileges), it will take effect immediately and will remain in effect unless modified by the Board. Such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan or by modification of an MEC recommendation, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board and shall entitle the practitioner to the procedural rights

as specified in the Fair Hearing Plan.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these Bylaws or other Organization rules, regulations, or policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Medical Staff President, the CEO, the Board chair or the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. They may afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation (not to exceed thirty (30) days without report to applicable agencies). Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

Immediately upon the imposition of summary suspension, the Medical Staff President shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patients still in the Organization. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Medical Staff President and the CEO in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. However, if the MEC met as a full body to impose the summary suspension for investigational purposes (fourteen (14) days), the MEC is not required to meet again within seventy-two (72) hours. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the physician's or dentist's clinical privileges, the physician or dentist shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 AUTOMATIC SUSPENSION

8.3(a) License

A Medical Staff or APP Staff member whose license, certificate, or other legal credential authorizing him/her to practice in Montana is revoked, relinquished, suspended expired, or restricted shall immediately and automatically be suspended from the Medical Staff or APP Staff and practicing in the Organization. Suspensions based upon revocation, relinquishment, suspension or restriction of license shall require the practitioner or APP to request reinstatement, rather than automatic reinstatement upon reestablishment of his/her full licensure.

8.3(b) Drug Enforcement Administration (DEA) Registration Number

Any practitioner or APP (except a pathologist or telehealth provider) whose DEA registration number/ controlled substance certificate or equivalent state credential is revoked, suspended, relinquished or expired shall immediately and automatically be suspended from the staff and practicing in the Organization. Suspensions based on revocation, relinquishment, suspension or restriction of DEA registration number/controlled substance certificate shall require the practitioner to request reinstatement, rather than automatic reinstatement upon reinstatement of registration.

8.3(c) Medical Records

(1) Automatic suspension of a practitioner or APP's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner or APP satisfies the President of the Medical Staff that he/she has a justifiable excuse for such omissions.

(2) **Medical Records- Expulsion**: Any Medical Staff or APP Staff member who accumulates 90 or more CONSECUTIVE days of automatic suspension under said subsection 8.3(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension. (MSP-014 Medical Records)

8.3(d) Malpractice Insurance Coverage

Any practitioner or APP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

8.3(e) Failure to Appear/Cooperate

Failure of a practitioner or APP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner or APP's clinical privileges as the MEC may direct.

8.3(f) Exclusions/Suspension from Medicare

Any practitioner or APP who is excluded from the Medicare program or any state government payor program will be automatically suspended. Suspensions based on exclusion from the Medicare program or any state government payor program shall require the practitioner or APP to request reinstatement, rather than automatic reinstatement upon reenrollment in the applicable program.

8.3(g)

If the individual fails to satisfy any of the other threshold eligibility criteria set forth in this policy, the individual will be required to seek reinstatement instead of automatic reinstatement upon satisfaction of the eligibility criteria.

8.3(h) Contractual Prohibitions

Any practitioner or APP who is subject to any valid agreement (e.g., a non-compete agreement) that would prevent him/her from practicing at the Organization, upon discovery of such agreement, shall be immediately and automatically suspended from the staff and practicing at the Organization. The affected practitioner of APP shall not be permitted to reapply for membership/clinical privileges unless or until the agreement is terminated or expires.

8.3(i) Automatic Suspension - Fair Hearing Plan Not Applicable

No practitioner or APP whose privileges are automatically suspended under this Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these bylaws. The President of the Medical Staff shall designate a physician to provide continued medical care for any suspended practitioner or APP's patients.

8.3(j) President of the Medical Staff

It shall be the duty of the President of the Medical Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the President of the Medical Staff informed of the names of staff members who have been suspended or expelled under Section 8.3.

8.3 k If an individual engages in any patient contact at the Medical Center after the occurrence of an event that results in automatic relinquishment, without notifying the Medical Center of that event, then the relinquishment will be deemed permanent.

8.3 l Notice and Opportunity to correct:

I. The individual shall be provided a brief written description of the reason(s) for the automatic relinquishment, within three days of Medical Center notice of relinquishment.

II. Failure to resolve the underlying matter leading to an individual's clinical privileges being automatically relinquished in accordance with this Policy, within 90 days of the date of relinquishment, will result in automatic resignation from the Medical Staff.

III. Requests for reinstatement will be reviewed by the Medical Staff President, and CEO or designee. If these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Medical Center.

8.4 ADMINISTRATIVE REMOVAL FROM LEADERSHIP POSITIONS

The Board may, in its sole discretion, remove any Medical Staff leader, including Department Chairpersons, from his/her leadership position whenever his/her activities, omissions, or any professional conduct are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Organization operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures. The Board, in its sole discretion, may also remove any

Medical Staff leader, including Department Chairpersons, from his/her leadership position in the event that he/she is no longer in good standing with the Medical Staff. Any such administrative removal from a leadership position shall not affect the individual's Medical Staff membership or clinical privileges, nor shall it entitle the individual to any grievance or hearing rights.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

8.6 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff, the APP Staff and Organization personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Article VIII of these bylaws.

8.7 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the practitioner's privileges. Any of the following shall have the right to impose supervision: President of the Medical Staff, applicable department chairman, the Board and/or CEO.

8.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1 or 8.2 which does not include a specific timeframe shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

8.9 WITHDRAWAL AFTER SUBMITTING A COMPLETED APPLICATION

An applicant who withdraws his/her application after it has been deemed complete may not resubmit an application for Medical Staff or APP membership or clinical privileges for one (1) year after the date of withdrawal, unless good cause is shown. The determination of good cause shall be made by the MEC and Board, in their sole discretion.

8.10 FALSE INFORMATION ON APPLICATION

Any practitioner or APP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner or APP who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.10 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner or APP, permit the practitioner or APP to appear before it and present information solely as to the issue of whether the practitioner or APP made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner or APP and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX

INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a practitioner, it may in its discretion give the practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING APPS

Any adverse actions affecting APPs shall be accomplished in accordance with Section 5.4 of these bylaws.

ARTICLE X

OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

1. President of the Medical Staff
2. President Elect of the Medical Staff and
3. Immediate Past President

10.1(b) Qualifications

Officers must be members of the Active Staff in good standing and have served on the medical staff for at least 2 years at the time of nomination and election and must remain members in good standing during their term of office. Before taking office, the Board must approve the appointment, approval of which will not be unreasonably withheld. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

The Nominating Committee for all general and special elections shall consist of the President Elect, Medical Staff President and at least two Past Presidents. The Committee shall submit to the Medical Executive Committee the names of one or more qualified nominees for each office. Notice of the

nominees shall be provided to the Medical Staff at least 30 days prior to the election. Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least ten days prior to the election. Nominations from the floor shall not be accepted.

10.1(d) Election

Officers shall be elected at the annual meeting of the staff and when otherwise necessary to fill vacancies. Only members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board of Trustees, which approval may be withheld only for good cause.

If no candidate receives a simple majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or disruptive to the operations of the Organization, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff or by the Board. Reasons for removal may include but shall not be limited to violation or failure to comply with applicable Policies, Bylaws, or Rules and Regulations, breaches of confidentiality, unethical behavior, conduct detrimental to the interests of the Medical Center and/or its Medical Staff; failure to perform the duties of the position held. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

At least ten 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 is to be considered. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board prior to a vote on removal

10.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than President of the Medical Staff shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of President of the Medical Staff, the President Elect of the Medical Staff shall serve out the remaining term

10.1(h) Duties of Elected Officers

(1) **President of the Medical Staff** shall serve as the principal official of the staff. As such he/she will:

a. appoint multi-disciplinary Medical Staff committees;

b. be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Organization and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;

c. in concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

d. participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Organization management committees;

e. report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;

f. be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

g. call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

h. serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;

i. assist in coordinating the educational activities of the Medical Staff;

j. confer with the CEO, CFO, CNO and Department or Service Chief as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

k. assist the Department or Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

l. attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

(2) **President Elect of the Medical Staff** shall:

a. assume all duties of the Medical Staff President and act with full authority as Medical Staff President in his or her absence;

b. serve as a voting member on the Medical Executive Committee;

c. assume all such additional duties as are assigned to him or her by the Medical Staff President or the Medical Executive Committee;

d. attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of the office;

e. become Medical Staff President upon completion of his/her term

f. chair the Bylaws Committee; and

g. serve as a non-voting member of the Credentials Committee .

(3) The Immediate Past President shall be a member of the MEC, serve as Secretary of the MEC and an advisor to other Medical Staff leaders and perform such additional duties as may be assigned to him/her and his/her designee by the president, the MEC or the Board. Duties will include, but are not limited to, ensure:

a. proper notice of all staff meetings on order of the appropriate authority;
b. accurate and complete minutes for MEC and Medical Staff meetings;
c. that an answer is rendered to all official Medical Staff correspondence;

10.1(i) Conflict of Interest of Medical Staff Leaders

The best interest of the community, Medical Staff and the Organization are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Organization's Board of Trustees) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Organization and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Organization to be disclosed on a regular and contemporaneous basis.

No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Organization or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Annually, on or before February 28 , each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Organization or its staff, or the Organization's relationship to the community, including but not limited to each of the following:

1. Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Organization;
2. Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Organization;
3. Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Organization; or
4. Business practices that may adversely affect the Organization or community.
   A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed

broadly, and a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Organization. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Past President will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

Medical Staff leaders with a direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly with the Organization shall not be eligible for service on the Medical Executive Committee, Credentials Committee, Bylaws Committee, Quality Assurance Committee or the Board of Trustees. This prohibition may be waived by the Board of Trustees, in its sole discretion, for good cause shown.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal from office of a breaching member by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI

CLINICAL DEPARTMENTS & SECTIONS

11.1 DEPARTMENTS & SECTIONS

11.1(a) There shall be clinical departments of:

Ambulatory, Diagnostic Services, Emergency Medicine, Inpatient Medicine, Women's and Children's, and Surgical Services.

11.1(b) Further departmentalization of specialties may be made by unanimous vote of the MEC, subject to the bylaws amendment procedures as described in Article XV of these bylaws. Reduction in the number of departments shall require a two-thirds (2/3) vote of the MEC, subject to the bylaws amendment procedures as described in Article XV of these Bylaws.

11.2 DEPARTMENT FUNCTIONS

The primary function of each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall:

11.2(a) Require that patient care evaluations be performed and that appointees exercising privileges within the department be reviewed on an ongoing basis and upon application for reappointment;

11.2(b) Establish guidelines for the granting of clinical privileges within the department and submit the recommendations as required under these Bylaws regarding the specific clinical privileges for applicants and reapplicants for clinical privileges;

11.2(c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.2(d) Monitor on an ongoing basis the compliance of its department members with these Bylaws, and the Rules and Regulations, policies, procedures and other standards of the Organization;

11.2(e) Monitor on an ongoing basis the compliance of its department members with

applicable professional standards;
11.2(f) Coordinate the patient care provided by the department's members with nursing, administrative, and other non-Medical Staff services;
11.2(g) Foster an atmosphere of professional decorum within the department;
11.2(h) Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:

1. Findings of the department's review and evaluation activities, actions taken thereon, and the results thereof;
2. Recommendations for maintaining and improving the quality of care provided in the department and in the Organization; and
3. Such other matters as may be requested from time to time by the MEC.

11.2(i) Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from department subcommittees regarding all pertinent recommendations and actions by the subcommittees.

11.2 (j) Each department shall assure emergency call coverage, within the department, for all patients

11.3 SECTIONS

In addition to the departments of the Medical Staff, there shall be sections within the departments of the Medical Staff. The various sections within the Medical Staff shall not constitute departments as that term is used herein without the express designation by the MEC and the Board of Trustees. Each section shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these bylaws. The purpose of the sections shall be to provide specialized care within the Organization and to monitor and evaluate the quality of care rendered in the section and to be accountable to the department to which such section is assigned for the discharge of these functions:

(a) Sections may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs;

(4) development of recommendations to the department chair or the Medical Executive Committee;

(5) participation in the development of criteria for clinical privileges (when requested by the department chair); and

(6) discussion of a specific issue at the special request of a department chair or the Medical Executive Committee.

(b) No minutes or reports will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, department chair, Credentials Committee, or Medical Executive Committee.

(c) Sections shall not be required to hold any number of regularly scheduled meetings

11.4 DEPARTMENT CHAIRPERSONS

11.4(a) Each Department shall have a Chairperson, who shall be appointed by the Medical Staff President and approved by the Board and shall be a member of the Active Staff, qualified by training, certification by an appropriate specialty board or equivalent, (as described in Section 3.2(a)(9)), experience and administrative ability for the position. Department Chairpersons may be removed by affirmative vote of two-thirds (2/3) of the Department members or by a two-thirds vote of the Medical Executive Committee subject to Board confirmation; or by the Board, after reasonable notice and opportunity to be heard.

11.4(b) The responsibilities of the Department Chairperson include:

1. Accountability to the MEC for all professional and Medical Staff administrative activities within the department;
2. Continuing review of the professional performance qualifications and competence of the Medical Staff members and APPs who exercises privileges in the department;
3. Assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the departments is carried out;
4. Assuring the participation of department members in department orientation, continuing education programs and required meetings;
5. Assuring participation in risk management activities related to the clinical aspects of patient care and safety;
6. Assuring that required QAPI and quality control functions including surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection control and utilization review, are performed within the department, and that findings from such activities are properly integrated with the primary functions of the department level;
7. Recommending criteria for clinical privileges and specific clinical privileges for each member of the department;
8. evaluating requests for clinical privileges for each member or prospective member of the department
9. Implementing within the Department any actions or programs designated by the MEC;
10. Assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;
11. Developing, implementing and enforcing the Medical Staff Bylaws, Rules & Regulations, and policies and procedures that guide and support the provision of services;
12. Participating in every phase of administration with other departments or services, in cooperation with nursing, Organization administration and the Board;
13. Assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the department or organization;
14. Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the department;

15. Integration of the department into the primary functions of the organization and coordination and integration of inter- and intra-department services;
16. Determination of the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment and services; and
17. Recommending space and other resources needed by the department or service.
18. the development and implementation of policies and procedures that guide and support the provision of services;
19. the orientation and continuing education of persons in the department;

11.4(c) Department Chairpersons shall serve for a term of 2 years.

11.5 ORGANIZATION OF DEPARTMENT

11.5(a) All organized departments shall have written rules and regulations which govern the activity of the department. These rules and regulations shall be approved by the MEC and Governing Board. The exercise of clinical privileges within any department is subject to the department rules and regulations and to the authority of the Department Chairperson.

11.5(b) Each Department shall meet separately but such meetings shall not release the members from their obligations to attend the general meetings of the Medical Staff as provided in Article XIII of these Bylaws. Additionally, each department shall meet *monthly* as often as necessary at times set by the presiding officer. to present educational programs and conduct clinical review of practice within their department. Written minutes must be maintained and furnished to the MEC.

11.5(c) Each staff member will be assigned to his/her primary department at initial appointment. The practitioner's designation of department shall be approved by the MEC and shall be the department in which the practitioner's practice is concentrated. Assignment to a particular Department does not preclude an individual from seeking and being granted clinical privileges typically associated with another Department. Should the practitioner exercise privileges relevant to the care in more than one (1) department, each department chair, or designee, shall make a recommendation to the MEC regarding the granting of such privileges.

11.6 SECTION CHIEF

11.6(a) Section Chiefs shall be selected by the Department Chair in consultation with the President of the Medical Staff and must be approved by the Board. Section chief shall meet the same qualifications and shall be subject to the same appointment and removal provisions as department chairs.

The chief of each section shall have the following duties with respect to his/her service:

(1) Account to the appropriate department chairperson and to the MEC for all professional activities within the section;

1. Develop and implement service programs in cooperation with the department chairperson;
2. participation in the development of criteria for clinical privileges;
3. review and reporting on applications for initial appointment and clinical privileges, including interviewing applicants;

(2) Maintain continuing review of the professional performance of all Medical Staff and APP Staff appointees having clinical privileges in the service and report regularly thereon to the department chairperson;
(3) Implement within his/her service any actions or programs designated by the MEC;
(4) Participate in every phase of administration of his/her service in cooperation with the department chairperson, the nursing service, other departments, administration and the Board;
(5) Assist in the preparation of such annual reports regarding the service as may be required by the MEC, the CEO or the Board of Trustees;
(6) As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory; and
(7) Perform such other duties as may reasonably be requested by the Medical Staff President, the MEC, the Department Chairperson or the Board of Trustees

ARTICLE XII

COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The Medical Executive Committee may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish standing or ad hoc committees to perform one or more staff functions. In the same manner, the Medical Executive Committee may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.
12.1(c) All information pertaining to activities performed by the Medical Staff and its committees and departments shall be privileged and confidential to the full extent provided by law.
12.1(d) The Medical Staff President and the CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.
12.1 (e) Appointment of Committee Chairs and Members

1. All committee chairs shall be appointed by the Medical Staff President, in consultation with the Medical Executive Committee. Committee chairs shall meet the same qualifications, and shall be subject to the same appointment and removal provisions as department chairs
2. Committee chairs shall be appointed for initial terms of one year but may be reappointed for additional terms.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include, and have voting rights unless otherwise noted, the following:

(1) The President of the Medical Staff, who shall act as Chairperson;

(2) The Medical Staff President Elect;

(3) The Immediate Past President;

(4) The Chairs of Departments;

(5) Representative of the medical staff office (non-voting)

(6) Delegates-At-Large (3) as recommended by the Medical Staff President and approved by the Board

(7) Standing Committee Chairs, without vote

(8) CEO, without vote

(9) CMO, without vote

(10) Director of Quality, Risk Management, without vote

(11) Chief Nursing Officer, without vote

12.2(b) Functions

The Medical Executive Committee has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges.

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Organization administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include, at least the following:

(1) Receiving and acting upon department and committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to the Medical Staff's structure, appointments and reappointments, the delineation of clinical privileges, staff category, the mechanism by which Medical Staff appointment may be terminated, hearing procedures and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Organization;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Assuring regular reporting of QAPI and other staff issues to the MEC and to the Board of Trustees and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate staff members;

(7) Assuring an annual evaluation of the effectiveness of the Organization's QAPI program is conducted;

(8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Organization standards;

(9) Recommending action to the CEO on matters of a medico-administrative nature;

(10) Developing and implementing programs to inform the staff about provider health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;

(11) Requesting evaluation of practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a practitioner to the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;

(12) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated;

(13) Developing and implementing programs for continuing medical education for the Medical Staff;

(14) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(15) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Organization;

(16) Participating in identifying community health needs and in setting Organization goals and implementing programs to meet those needs;

(17) performing such other functions as are assigned to it by these Bylaws, or Rules and Regulations, the Board or other applicable policies.

12.2(c) Meetings

The MEC shall meet as often as needed to fulfill its responsibilities, but at least ten times annually and maintain a permanent record of its proceedings and actions.

12.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the President of the Medical Staff, when a majority of the MEC can be convened.

12.2(e) Removal of MEC Members

All members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership positions. Officers of the Medical Staff who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e). Department Chairpersons who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 11.4(a)

12.3 MEDICAL STAFF FUNCTIONS

12.3(a) Composition of Committees

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff

Specific provisions for the following committees:

- Bylaws Committee
- Credentials Committee
- Infection Control Committee
- The Assistance Committee
- Pharmacy and Therapeutics Committee
- Utilization Management Committee
- Trauma (Interdisciplinary Committee)
- Multidisciplinary Peer Review Committee
- Physician IT Oversight Committee
- Ethics Committee

12.3(b) Functions

The functions of the staff are to:
(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;
(2) Conduct or coordinate appropriate QAPI reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record, core measures and other appropriate reviews;
(3) Conduct or coordinate utilization review activities;
(4) Assist the Organization in providing continuing education opportunities responsive to QAPI activities, new state-of-the-art developments, services provided within the Organization and other perceived needs and supervise Organization's professional library services;
(5) Develop and maintain surveillance over drug utilization policies and practices;
(6) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Organization patient care and administrative services;
(7) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence;
(8) Investigate and control nosocomial infections and monitor the Organization's infection control program;
(9) Plan for response to fire and other disasters, for Organization growth and development, and for the provision of services required to meet the needs of the community;
(10) Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Organization administration, and review and maintenance of Organization accreditation;
(11) Provide as part of the Organization and Medical Staff's obligation to protect patients and others in the organization from harm, the Medical Staff has adopted a Provider Wellness

Policy;
(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

i. medical assessment and treatment of patients;
ii. use of medications, use of blood and blood components;
iii. use of operative and other procedure(s);
iv. efficiency of clinical practice patterns; and
v. significant departure from established patterns of clinical practice.

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

i. education of patients and families;
ii. coordination of care, treatment and services with other practitioners and Organization personnel, as relevant to the care of an individual patient;
iii. accurate, timely and legible completion of patients' medical records including history and physicals;
iv. patient satisfaction;
v. sentinel events; and
vi. patient safety.

(14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers;

(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

(18) Investigate any breach of ethics that is reported to it;

(19) Review APP appeals of adverse privilege determinations as provided in Section 5.4(b); and

(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

12.3(c) Execution of Functions

These functions shall be performed by committees of the Medical Staff as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

12.4 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two (2) members of the Organized Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two non-physician Board members who are selected by the Board Chair, and the CEO. The CNO shall serve as an non-voting, ex-officio member of the Committee whose presence or absence will not be considered in determining a quorum. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

ARTICLE XIII

MEETINGS

13.1 STAFF MEETINGS

13.1(a) Meeting Frequency &Time

The Medical Staff shall meet at least once a year at a date, time and place determined by the Medical Staff President.

If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.1(b) Order of Business & Agenda

The order of business at all medical staff meetings shall be determined by the President of the Medical Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or his/her designee, the President of the Medical Staff and appropriate Department Chairperson;

(3) The election of officers and other officials of the Medical Staff when required by these bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business

13.1 (c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the CEO, Medical Staff President, the Medical Executive Committee, the Board, or by a petition signed by not less than ten percent (10%) of the Active Staff. and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

The presiding officer for the meeting shall set the agenda for any regular or special meetings of the Medical Staff, department, section, or committee.

A special meeting of any department or committee may be called by or at the request of the presiding officer, the Medical Staff President, or by a petition signed by not less than ten percent (10%) of the Active Staff members of the department, section, or committee, but not by fewer than two members.

13.2 NOTICE OF MEETINGS

Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments, sections, and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings. The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required.

If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the President of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally, by mail, or electronic mail, to each person entitled to be present there at not less than 48 hours - before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of objection to the notice of such meeting.

13.3 QUORUM

13.3(a) General Staff Meeting

The members of the Active Staff who are present at any staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

13.3(b) Committee Meetings

The members of a committee who are present, but not less than two (2) voting members, shall constitute a quorum at any meeting of such committee; except that the MEC shall require fifty (50%) percent of voting members to constitute a quorum.

13.4 MANNER OF ACTION

Except as otherwise specified, recommendations and actions of the Medical Staff, MEC, departments, sections, and committees shall be by unanimous consent. In the event unanimous consent is not obtained, the issue will be determined by a majority vote of those individuals present and voting at a meeting at which a quorum is present shall be the action of the group.

At the sole discretion of the presiding officer, action may be taken without a meeting of the Medical Staff, a department, or a committee, if a unanimous consent in writing setting forth the action to be taken is returned to the Chair by each member entitled to vote, by the method designated.

13.5 MINUTES

Minutes of all meetings of the Medical Staff, departments, and committees (and applicable section meetings) shall be prepared by a member of the MSO and shall include a record of the attendance of

members and the recommendations made and the votes taken on each matter. The minutes shall be approved by the presiding officer, approved at the next scheduled meeting by the voting members in attendance, and forwarded to the MEC. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees, at the discretion of the Medical Staff President.

A permanent file of the minutes of each meeting shall be maintained by the Medical Center.

Complete and detailed minutes must be recorded and maintained.

13.6 ATTENDANCE

13.6(a) Regular Attendance

Members of the Medical Staff are encouraged and expected to attend the regular and special meetings of the Medical Staff as well as the meetings of those departments and committees of which they are members.

13.6(b) Special Appearance; Cooperation with Medical Executive Committee

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the practitioner's clinical course of treatment or professional conduct. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved three (3) days advance notice of the time and place of the meeting shall be given to the practitioner and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV

GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS AND POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the Organization. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any Medical Staff meeting by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Organization policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff at least 14 days prior to the vote. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff. Any Active member may submit written comments on the amendments to the Medical Executive Committee.

14.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

14.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. A special meeting of the Medical Staff will be called. The agenda for the meeting will be limited to the amendment(s) or policy at issue. The purpose of the meeting is to discuss and strive to resolve the differences that exist with respect to Medical Staff policies. If the differences cannot be resolved at the meeting, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff policies offered by the Active members of the Medical Staff, to the Board. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet, as needed, with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

14.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner or APP granted clinical privileges in the Organization shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 in indemnity limits per occurrence and $3,000,000.00 in indemnity in the aggregate. Policies of insurance in which defense costs reduce the available indemnity limits ("wasting policies") do not meet the requirements of this provision.

The insurance coverage contemplated by this paragraph shall be with a carrier reasonably acceptable to the Organization, and shall be on an occurrence basis or, if on a claims made basis, the practitioner shall agree to obtain tail coverage covering his/her practice at the Organization. Each practitioner shall also provide annually to the MEC and CEO the details of such coverage, including evidence of compliance with all provisions of this paragraph. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

14.3 CONSTRUCTION OF TERMS & HEADINGS

Words used in these bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these bylaws.

14.4 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.4(a) Report Confidentiality

Information with respect to any practitioner, including applicants, staff members or APPs, submitted, collected or prepared by any representative of the Organization including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

Members of the Medical Staff who have access to credentialing and/or Quality Assurance/Performance Improvement (QAPI), agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or QAPI processes, except as authorized by the Medical Staff Bylaws, Rules and Regulations, or other applicable Medical Staff or Medical Center policy. A breach of confidentiality may result in the imposition of disciplinary action.

14.4(b) Release from Liability

No representative of the Organization, including its Board, CEO, administrative employees, Medical Staff

or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Organization including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the Organization, provided such disclosure or representation is in good faith and without malice

The Medical Center shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Medical Center's Bylaws.

14.4(c) Action in Good Faith

The representatives of the Organization, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XV

ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Organization, the Board, and the community.

Amendments may be proposed by a petition signed by10%of the Active staff, by the Medical Executive Committee or the Bylaws Committee. All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. Notice of all proposed amendments shall be provided to each Active member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any Active member may submit written comments on the amendments to the Medical Executive Committee. The Medical Executive Committee shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. To be adopted, the amendment must receive a majority of the votes cast by the Active staff at the meeting.

15.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed periodically and as needed. When necessary, the Bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, corporate and Organization policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Executive Committee may present proposed amendments to the Active staff by mail or e-mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably.

The Medical Staff Bylaws may be adopted, amended or repealed by a majority vote of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least fourteen (14) days written or electronic notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

The Medical Executive Committee shall have the power to adopt such clarifications to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

15.2(b) Board

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these Bylaws), and shall advise the staff of the basis for its action in this regard.

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Medical Staff President, the CEO, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form; or

15.3(b) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Medical Staff President, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these Bylaws in a timely manner.

A. ^ MS 01.01.01; LD 01.05.01
B. ^ MS 05.01.01; MS 05.01.03; LD 04.03.07; LD 01.05.01 EP 5
C. ^ 42 CFR 482.22; LD 01.05.01 EP 5
D. ^ TJC MS.12.01.01, EP 1 requires that Organization-sponsored educational activities are

prioritized by the organized medical staff. TJC MS.12.01.01 requires that all licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

E. ^ MS 01.01.01 EP 1-6

F. ^ MS 01.01.01

G. ^ LD 01.05.01; LD 04.03.01;. LD 02.01.03

H. ^ LD 01.05.01; MS 01.01.01

I. ^ 42 CFR 482.24; 42 CFR 482.11; LD 01.05.01; MS 01.01.01

J. ^ MS 01.01.01 EP 14 and 26; MS 03.01; .01 EP 2 MS 06.01.01 - MS 06.01.09

K. ^ MS 12.01.01

L. ^ MS 05.01.01; MS 05.01.03; 42 CFR 482.30(f).

M. ^ MS 07.01.01; MS 03.01.01

N. ^ MS 01.01.01 EP 28-34; MS 10.01.01; MS 09.01.01

O. ^ MS 01.01.01 EP 1-2 and 5-6

P. ^ MS 09.01.01; MS 07.01.01; MS 03.01.01;MS.05.01.03 EP 4.

Q. ^ MS 11.01.01

R. ^ 45 CFR Parts 164 (HIPAA Security and Privacy Regulations)

S. ^ 45 CFR 164.506(b)(5)

T. ^ MS 03.01.03

U. ^ 42 CFR 482.22; MS 01.01.01 EP 13

V. ^ MS 06.01.05 EP 9

W. ^ MS 06.01.03

X. ^ MS.06.01.03

Y. ^ MS.06.01.03 (describes the Organization's requirements with respect to credentialing and emphasizes the six areas of "General Competencies" adapted from the joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). Among these areas are professionalism and interpersonal and communication skills.

Z. ^ MS.06.01.05 EP 6 (requires the medical staff to evaluate applicants' health status and ability to practice.)

AA. ^ 42 CFR 482.12(a)(7)

AB. ^ MS.06.01.01 requires the Organization to determine that it has sufficient resources to support the clinical privileges sought to be exercised.

AC. ^ LD.03.01.01 rationale indicates that behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to the patient. Thus, willingness to practice in such a way as not to interfere with Organization operations is important.

AD. ^ 42 USC 1981; LD 04.01.01; MS 07.01.01 EP 3, require that gender, race, creed and national origin are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

AE. ^ 42 CFR 482.12(a)(6)

AF. ^ 42 CFR 482.22

AG. ^ 42 CFR 482.12(a)(5) (Interpretive Guidelines)

AH. ^ 42 CFR 482.30(f)

AI. ^ MS 01.01.01 EP 5-6

AJ. ^ MS 01.01.01 EP 5-6

AK. ^ MS 01.01.01

AL. ^ 42 CFR 482.24

AM. ^ MS 06.01.05 EP 2 and 6

AN. ^ 42 CFR 482.12(a)(6)

AO. ^ 42 USC 1320a-7b; 42 USC 1395nn

AP. ^ 42 CFR 482.12(a)(6); MS 06.01.05 EP 9

AQ. ^ 45 CFR Parts 164 (HIPAA Security and Privacy Regulations)

AR. ^ Pursuant to recent revisions, the Interpretive Guidelines for 42 C.F.R. §482.22(c)(5)(i) now mandate that the requirements of history and physical examinations be delineated in the medical staff bylaws rather than the rules & regulations. Further, Lifepoint Organizations, Inc. has queried CMS as to whether such requirements may remain in the rules & regulations if incorporated by reference in the medical staff bylaws. CMS responded that such a practice would violate the provisions of the Organization Conditions of Participation, and therefore requirements of history and physical examinations must be delineated in the medical staff bylaws. MS.01.01.01 EP 16 also requires that the requirement for completing and documenting medical histories and physical examination be located in the Bylaws.

AS. ^ Please note that Organizations should review what timeframe is workable for their facility and Medical Staff so that the set standard can be met on a consistent basis. Contact your Operations Counsel if a change in this standard is recommended for your facility.

AT. ^ 48 CFR 482.22(a)(1) (Interpretive Guidelines); MS 06.01.07 EP 9; MS 07.01.01 EP 3 requires the organized medical staff to use criteria in appointing members to the medical staff and that appointment does not exceed a period of two years.

Approval Signatures

Step Description	Approver	Date
Board	Bonnie Stephens: CMO	09/2022

MEC	Bonnie Stephens: CMO	09/2022
Bylaws Committee	Bonnie Stephens: CMO	09/2022
Department Committee Approval	Bonnie Stephens: CMO	09/2022