

The Medical Center of Aurora/Centennial Medical Plaza

BYLAWS OF THE MEDICAL STAFF

2016

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ARTICLE ONE: NAME, PURPOSES & RESPONSIBILITIES

1.1. NAME

The name of the Medical Staff shall be the “Medical Staff of The Medical Center of Aurora.”

1.2. ESTABLISHMENT OF MEDICAL STAFF

There shall be established within The Medical Center of Aurora a Medical Staff, which shall consist of all physicians, dentists, podiatrists and other categories of Licensed Independent Practitioners who have been deemed eligible to apply for Medical Staff membership or clinical privileges within The Medical Center of Aurora. No Practitioner shall admit or provide medical or health-related services to any patient in The Medical Center of Aurora unless he or she has been granted clinical privileges, including temporary privileges. The Board of Trustees shall, in the exercise of its discretion, delegate to the Medical Staff the responsibility for providing appropriate professional care to The Medical Center of Aurora patients. The Medical shall conduct a continuing review and appraisal of the quality of professional care rendered in the Hospital and shall report such activities and their results to the Board of Trustees.¹

1.3. PURPOSES AND RESPONSIBILITIES

The purpose and responsibilities of the Medical Staff are:

- 1.3.1. To provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board of Trustees. These Bylaws shall reflect the current organization and functions of the Medical Staff.²
- 1.3.2. To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;
- 1.3.3. To collaborate with the Hospital in providing for the uniform performance of patient care processes throughout the Hospital.³
- 1.3.4. To serve as a primary means for accountability to the Board of Trustees concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the Hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance.⁴
- 1.3.5. To provide mechanisms for recommending to the Board of Trustees the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals.
- 1.3.6. To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- 1.3.7. To adopt Rules and Regulations for the proper functioning of the Medical Staff, and the integration and coordination of the Medical Staff with the functions of the Hospital;
- 1.3.8. To provide a means for communication with regard to issues of mutual concern to the Medical Staff, Administration, and Board of Trustees;⁵
- 1.3.9. To participate in identifying community health needs and establishing appropriate institutional goals;⁶

¹ Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

² MS.01.01.01; LD.01.05.01, , 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3), 42 C.F.R. §482.12(a)(3)

³ LD.04.03.07

⁴ MS.01.01.01; LD.01.05.01, , 42 C.F.R. §482.22(b)(1), 42 C.F.R. §482.22(c)(3)

⁵ MS.01.01.01, MS.03.01.03, MS.04.01.01; LD.03.04.01

- 1.3.10. To assist the Board of Trustees by serving as a professional review body in conducting professional review activities, which include, without limitation, focused professional practice evaluations, ongoing professional practice evaluations, quality assessment, performance improvement, and peer review.⁷
 - 1.3.11. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted.
 - 1.3.12. To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies.
 - 1.3.13. To maintain compliance of the Medical Staff with regard to applicable accreditation requirements and applicable Federal, State, and local laws and regulations.⁸
- 1.4. POWERS AND RESPONSIBILITIES OF THE BOARD OF TRUSTEES

- 1.4.1. The Hospital is owned by the Corporation HCA-HealthONE LLC. The Corporation retains all authority and control over the business, policies, operations, and assets of the Hospital. The Board of Trustees retains ultimate responsibility for the Hospital's compliance with all applicable Federal, State, and local laws and regulations.⁹ The Board of Trustees has delegated certain duties to the Corporation's officers. The rights and duties delegated to the Board of Trustees, acting in its capacity as the authorized agent of the Corporation and the governing body of the Hospital are described in these Bylaws.¹⁰
- 1.4.2. The Board of Trustees assists and advises the CEO and the Medical Staff.¹¹ The primary function of the Board of Trustees shall be to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For this purpose, the Board of Trustees has the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions in compliance with the Corporation's policies regarding Medical Staff appointments, reappointments, and the granting of clinical privileges, to oversee performance improvement, utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish policies regarding such matters.¹² All officers, Medical Staff members, advanced practice professionals, employees, non-employees who provide patient care under an approved scope of practice, and other agents of the Hospital are subject to the control, direction and removal by the Board of Trustees. All Practitioners are subject to appointment, termination or modification of their Medical Staff Membership and/or clinical privileges by the Board of Trustees, based on factors deemed relevant by the Board of Trustees. Actions taken by the Board of Trustees may, but need not, follow the procedures outlined in the Medical Staff Bylaws and related documents.¹³
- 1.4.3. In a manner mutually agreeable to the Corporation and the Board of Trustees, the Board of Trustees shall report any matters of concern to the Corporation. Any such matters that are within the scope of duties of the Board of Trustees, but exceed the scope of their authority, such as issues related to financial management, can be referred back to the Corporation and the Board of Directors.¹⁴
- 1.4.4. The Board of Trustees, through its officers and the CEO, retains authority for the Hospital's business decisions, adherence to HCA Ethics & Compliance Policies, and financial management, including long-range and short-range planning and budgeting.

1.5. NATURE OF APPOINTMENT

No Practitioner shall admit or provide medical or health-related services to patients in the Hospital unless he or she has been appointed to the Medical Staff or has been granted clinical privileges, or temporary privileges

⁶ LD.02.01.01LD.04.03.01; LD.04.03.01

⁷ 42 C.F.R. §482.12(a)(5), MS.05.01.01, MS.08.01.01; MS.08.01.03; MS.09.01.01

⁸ LD.04.01.01; 42 C.F.R. §482.11(a)

⁹ 42 C.F.R. §482.11; 42 C.F.R. §482.12; The Joint Commission Standard, LD.04.01.01

¹⁰ The Joint Commission Standard, LD.01.01.01

¹¹ The Joint Commission Standard, LD.01.03.01

¹² The Joint Commission Standard, LD.01.03.01; 42 C.F.R. §482.12(a)

¹³ Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

¹⁴ The Joint Commission Standard, LD.01.03.01

pursuant to these Bylaws. Appointment to the Medical Staff shall confer upon the Medical Staff member a privilege in the nature of a license to exercise only such clinical privileges within the Hospital as are specifically granted by the Board of Trustees in accordance with these Medical Staff Bylaws. The requirements and procedures for appointment and reappointment to the Medical Staff and granting of clinical privileges are set forth in these Bylaws. A Medical Staff appointee or Practitioner with clinical privileges is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and such Medical Staff member or Practitioner with clinical privileges. In the event of any conflict between the language of these Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies and a specific contract between the Hospital and a Medical Staff member or Practitioner with clinical privileges, the language of the contract shall control.¹⁵

1.6. ORGANIZED HEALTH CARE ARRANGEMENT; HIPAA COMPLIANCE.

The Hospital and all members of the Medical Staff shall be considered members of, and shall participate in, the Hospital's Organized Health Care Arrangement ("OHCA") formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA. An OHCA is a clinically integrated care setting in which individuals typically receive health care from more than one healthcare provider. An OHCA allows the Hospital to share information with the Physicians and the Physicians' offices for purposes of payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Physicians, Advanced Practice Professionals with clinical privileges or practice prerogatives, and non-employees who provide patient care under an approved scope of practice. Each Medical Staff member, each Physician with temporary privileges, Advanced Practice Professional with clinical privileges or practice prerogatives, and non-employee with an approved scope of practice agrees to comply with the Hospital's policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").¹⁶

¹⁵ Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

¹⁶ 45 C.F.R. §164.501

2. ARTICLE TWO: APPOINTMENT/REAPPOINTMENT

2.1. REQUIREMENTS FOR MEMBERSHIP AND GENERAL QUALIFICATIONS

The Medical Staff includes fully licensed Physicians and other Practitioners permitted by law and by the Hospital to provide patient care within the Hospital, and whom the Board of Trustees appoints.¹⁷ Medical Staff membership is a privilege extended by the Hospital, and not a right of any Physician, Practitioner or other person. Membership and/or the permission to exercise clinical privileges shall be extended to and exercised only by those individuals who continuously meet the requirements of these Bylaws.

2.1.1. Patients may be admitted to the Hospital only on the orders of a Physician (MD/DO), or other categories of licensed Practitioners eligible for admitting privileges under State laws and as approved by the Board of Trustees. All Hospital patients must be under the care of a Member of the Medical Staff or under the care of a Practitioner who shall be directly under the supervision of a Member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a Practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges.¹⁸

2.1.1.1. Patients admitted by Licensed Independent Practitioners who are not physicians, including DDS, DMD, DPM, shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner.¹⁹

Appointment to the Medical Staff or granting of clinical privileges shall confer on the individual only such prerogatives of membership that are granted by the Board of Trustees or as are afforded to APPs when clinical privileges are granted to an individual in this category. For purposes of these Bylaws, "membership in" is used synonymously with "appointment to" or "reappointment to" the Medical Staff. The granting of membership or approval of appointment does not automatically confer clinical privileges. The Board of Trustees has determined the categories of healthcare professionals eligible for Medical Staff membership and/or clinical privileges, as defined in these Bylaws.²⁰ All Medical Staff members and individuals with clinical privileges are subject to these Bylaws and Rules and Regulations.²¹ Only those individuals meeting all Threshold Eligibility Criteria shall be eligible to apply for appointment to the Medical Staff or clinical privileges, and these professional criteria shall apply uniformly to all applicants:²²

2.2. THRESHOLD ELIGIBILITY CRITERIA

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or to apply for clinical privileges, a Practitioner must be a physician, dentist or oromaxillofacial surgeon, podiatrist, advanced practice registered nurse, physician assistant, certified nurse midwife, certified nurse anesthetist and:

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

2.2.2. Have a current, unlimited, unrestricted, active (as defined in these Bylaws) legal license to practice in his or her respective profession in Colorado, which license permits him or her to practice in the Hospital setting and authorizes him or her to receive and examine patients, diagnose conditions and prescribe and implement a treatment plan and to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, independent of review, supervision or prescription by another Practitioner, and have never had a license to practice

¹⁷ MS.01.01.01; LD.01.05.01, 42 C.F.R. §482.22(a)

¹⁸ 42 C.F.R. §482.12(a)(5), Interpretive Guidelines

¹⁹ 42 C.F.R. §482.12(c)(4); MS.03.01.03

²⁰ 42 C.F.R. §482.12(a)(1)

²¹ MS.01.01.01, MS.01.01.03, MS.06.01.07, MS.08.01.03

²² MS.06.01.03, MS.06.01.07, MS.08.01.03

revoked or suspended by any state licensing agency, or in the case of an APP, to practice within the full scope of licensure with any supervision as may be required by law;²³ and,

- 2.2.2.1. If the applicant is an active duty military Practitioner, and will be practicing exclusively within the scope of military duties for patients who are members of the armed forces or their dependents, then current, unlimited, unrestricted, active licensure from any State shall be accepted.
- 2.2.2.2. If the applicant is a telemedicine Practitioner located in a different State, the applicant must also possess current, unlimited, unrestricted, active licensure in that State.²⁴
- 2.2.2.3. If the applicant is an out-of-state Practitioner who will be providing patient care in this state under an exception to state licensure requirements, the exception must be verified with the State licensure board and documented. Any conditions associated with the exception (i.e., that the exception requires that the Practitioner must be licensed in his/her home State) must also be verified and documented.²⁵
- 2.2.3. Where applicable to his or her practice, have a current, unrestricted Federal DEA registration valid for prescribing within Colorado and which permits him or her to prescribe all medications necessary for the treatment of conditions and diagnoses within the Practitioner's area of practice, independent of review, supervision or prescription by another Practitioner;²⁶ and,
- 2.2.4. Can document his or her (i) background, experience, training and demonstrated competence; (ii) adherence to the ethics of their profession; (iii) good reputation and character, including the applicant's mental and emotional stability and physical health status, and (iv) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by him or her in the Hospital will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner; and
- 2.2.5. Be located (office and residence) within the geographic service area of the Hospital, as defined by the Board of Trustees, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital; and
- 2.2.6. Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the Practitioner for whom he or she is providing coverage.)²⁷ Compliance with this eligibility requirement means that the Practitioner must document that he or she is willing and able to:
 - 2.2.6.1. Respond within 15 minutes, via phone, to STAT pages from the Hospital and respond within 30 minutes, via phone, to all other pages; and,²⁸
 - 2.2.6.2. Appear in person to attend a patient within 30 minutes, when requested to do so by the Practitioner caring for the patient at the Hospital;²⁹
- 2.2.7. For APPs, have the necessary coverage by a sponsoring or supervising physician as required by State laws and regulations, or the supervision required in association with the clinical privileges granted to the APP; and,

²³ MS.06.01.07, 42 C.F.R. §482.11(c), 42 C.F.R. §482.22(c)(4)

²⁴ §482.26(c)(1)

²⁵ HCA Ethics Policy, CSG.QS.002

²⁶ 21 U.S.C. §§ 823(f) and 824(a)(3)

²⁷ EMTALA

²⁸ EMTALA

²⁹ EMTALA

- 2.2.8. Have current, valid professional liability insurance coverage in a form acceptable to the Hospital, including insurance through a carrier authorized to do business in the State of Colorado as a licensed provider of professional malpractice insurance, insurance for the clinical privileges requested, and with limits of at least \$1 million for each claim and \$3 million in aggregate; and,
- 2.2.9. Have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state government or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same; and,
- 2.2.10. Have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program, as verified by screening ineligible persons against the OIG, GSA; and,
- 2.2.11. Have never had Medical Staff appointment, employment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct; and,
- 2.2.12. Have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation; and,
- 2.2.13. Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence; and,
- 2.2.14. Agree to fulfill all responsibilities regarding emergency service call coverage for his or her specialty as may be required by the Hospital and the Medical Staff; and,
- 2.2.15. Have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable; and,
- 2.2.16. Demonstrate recent clinical activity in his or her primary area of practice during the last two years; and,
- 2.2.17. Meet any current or future eligibility requirements that are applicable to the clinical privileges being sought; and,
- 2.2.18. If applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract; and,
- 2.2.19. Have successfully completed:³⁰
 - 2.2.19.1. Graduation from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine, or a school of dentistry accredited by the Commission on Accreditation of the American Dental Association, or a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or other accredited school appropriate to his or her profession. If the applicant is a physician who is a foreign medical graduate, he/she must have successfully completed the Education Commission for Foreign Medical Graduate (ECFMG) verification of graduation from a foreign medical school; and,
 - 2.2.19.2. For purposes of this Section and these Bylaws, an “approved” postgraduate training program for physicians is a residency program fully accredited throughout the time of the Practitioner’s training by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or an equivalent organization in a country eligible for licensure by endorsement of current license by the licensure board.

³⁰ MS.06.01.03, 42 C.F.R. 5482.12(a)(6), 42 C.F.R. 5482.22(c)(4)

An approved post-graduate training program for podiatrists and dentists or oromaxillofacial surgeons is one fully accredited throughout the time of the Practitioners training by the Commission on Dental Accreditation, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by a successor agency to any of the foregoing or by an equivalent professionally recognized national accrediting body in the United States or in a country eligible for licensure by endorsement of current license by the licensure board; and,

- 2.2.19.3. Participation in continuing education as related to the clinical privileges requested;³¹ and,
- 2.2.19.4. For a physician, a dentist, an oromaxillofacial surgeon, or a podiatrist, to be Board Certified or Board Eligible, as follows:
 - 2.2.19.4.1. All initial physician applicants must be either Board Certified, Board Eligible or demonstrate that he or she has obtained the training requisite to board certification in the areas of proposed practice. For physicians, they must be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), or the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA). For podiatrists, the board certification program accepted by the Hospital is the American Board of Podiatric Surgery (ABPS) and for dentists and oromaxillofacial surgeons the board certification program accepted by the Hospital is the American Board of Oral/Maxillofacial Surgeons (ABOMS) or the American Dental Association (ADA) and for optometrists the American Board of Optometry (ABO). If the applicable board eligibility requirements include the successful completion of a residency program, this residency program must be completed through an approved postgraduate training program. In the event that the board eligibility requirements include a post-residency practice requirement, this requirement may be met at the Hospital provided that all other requirements for Medical Staff membership are met. All initial other applicants must have successfully completed an approved postgraduate training program in their respective profession.
 - 2.2.19.4.2. Continued Medical Staff membership will require a physician who is Board Eligible to obtain board certification in the proposed area of practice within seven (7) years of initially becoming Board Eligible or, in the absence of board certification, demonstrating training requisite to board certification. Notwithstanding the foregoing, the Board shall have the power to waive the board certification requirement under extraordinary circumstances. There shall be documentation of the need for the talents of the applicant prepared by the Credentials Committee for review and recommendation by the Medical Executive Committee and for review and action by the Board. Extraordinary circumstances should be considered only if (i) the applicant has a current, unrestricted license as required by the State in which the Hospital is located, (ii) the applicant is not an Ineligible Person, and (iii) the applicant has achieved extraordinary recognition in the field of medicine as related to the needed talents documented by the Credentials Committee.
- 2.2.19.5. The requirement outlined in these Medical Staff Bylaws for satisfactory completion of approved postgraduate training, and the board certification requirements outlined in

³¹ MS.12.01.01

these Medical Staff Bylaws, shall be waived for any Practitioner who was a member of the Medical Staff prior to the effective date of January 1, 2009.

2.3. WAIVER OF THRESHOLD ELIGIBILITY CRITERIA

- 2.3.1. When an individual does not satisfy one or more of the Threshold Eligibility Criteria outlined above, the individual shall be notified by the CPC that the Request for Consideration (RFC) or the Reappointment Request for Consideration (RRFC) that does not satisfy a Threshold Eligibility Criterion will not be processed.
- 2.3.2. 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.
- 2.3.3. A request for a waiver shall 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 applicant in question, input from the relevant Service Line chair, and the best interests of the Hospital 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 specific basis for the recommendation.
- 2.3.4. The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board of Trustees regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- 2.3.5. No applicant is entitled to a waiver or to a hearing if the Board of Trustees 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. Rather, it is a final determination that the individual is ineligible to request appointment or clinical privileges based on current information.
- 2.3.6. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- 2.3.7. A Request for Consideration (RFC) or Reappointment Request for Consideration (RRFC) that does not satisfy a Threshold Eligibility Criterion will not be processed until the Board of Trustees has determined that a waiver should be granted.

2.4. FACTORS FOR EVALUATION OF APPLICATION

When a Request for Consideration (RFC) or the Reappointment Request for Consideration (RRFC) is received that is complete and meets all Threshold Eligibility Criteria, it will be processed by the CPC and submitted to the Hospital as an application. Six general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated by the Medical Staff as part of the appointment and reappointment processes, as reflected in the following factors:

2.4.1. CURRENT COMPETENCE, EXPERIENCE AND JUDGMENT

The applicant must document his/her relevant training and experience, and current clinical competence, skills and judgment including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided, with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board of Trustees, to demonstrate that patients receiving healthcare services from him/her will receive care of the generally recognized professional level of quality and efficiency established by the

Hospital.³² Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Service Line Chairperson(s).³³

2.4.2. CONDUCT/BEHAVIOR

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

2.4.3. PROFESSIONAL ETHICS AND CHARACTER

The applicant must demonstrate adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession. By virtue of applying for Medical Staff membership or clinical privileges, and agreeing to abide by the Medical Staff Bylaws, the applicant shall agree to abide by applicable provisions of the Code of Conduct of HCA, and the code of ethical business and professional behavior of this Hospital.³⁴

2.4.4. HEALTH STATUS/ABILITY TO PERFORM

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

2.4.5. INTERPERSONAL AND COMMUNICATION SKILLS

The applicant shall possess an ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and to communicate in English in an understandable manner sufficient for the safe delivery of patient care (as determined in the sole discretion of the Hospital), both verbally and in writing. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English.

2.4.6. COMMITMENT TO QUALITY CARE

The applicant shall demonstrate recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

³² MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.12(a)(6), 42 C.F.R. §482.22(c)(4)

³³ MS.06.01.03, MS.06.01.07, 42 C.F.R. §482.12(a)(6)

³⁴ 42 C.F.R. §482.12(a)(6), LD.02.02.01; LD.04.02.01; LD.04.02.03; LD.04.02.05; HCA, Ethics and Compliance Policies

2.5. NO ENTITLEMENT TO APPOINTMENT

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

- 2.5.1. Is licensed to practice a profession in this or any other state;
- 2.5.2. Is a member of any particular professional organization;
- 2.5.3. Is certified by any specialty certification board;
- 2.5.4. Resides in the geographic service area of the Hospital;
- 2.5.5. Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity; or,
- 2.5.6. Has/had Medical Staff membership or clinical privileges in another hospital or health care organization.³⁵

2.6. HOSPITAL NEED AND ABILITY TO ACCOMMODATE

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

2.6.1. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

Clinical privileges shall be granted only for the provision of care that is within the scope of services, capacity, and capabilities of the Hospital. Prior to granting of a clinical privilege, the resources necessary to support the requested privilege shall be determined to be currently available, or available within a specified time frame. Resource considerations shall include whether there is sufficient space, equipment, staffing, financial resources or other necessary resources to support each requested privilege.³⁶

2.6.2. EXCLUSIVE CONTRACTS

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

2.6.3. MEDICAL STAFF DEVELOPMENT PLAN

The Board of Trustees may decline to accept applications based on the requirements or limitations in the Hospital's Medical Staff development plan which shall be based on identification by the Hospital of the patient care needs within the population served.³⁷

2.6.4. EFFECTS OF DECLINATION

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

³⁵ 42 C.F.R. §482.12(a)(7)

³⁶ MS.06.01.01

³⁷ MS.06.01.03, MS.06.01.07, MS.08.01.03

2.7. BASIC OBLIGATIONS OF MEMBERSHIP AND CLINICAL PRIVILEGES

By submitting Request for Consideration, Recredentialing Request for Consideration or application for Medical Staff membership and/or a request for clinical privileges, the Practitioner signifies agreement to fulfill on a continuing basis the following obligations of holding Medical Staff membership and/or clinical privileges. The Practitioner shall agree to:

- 2.7.1. Appear by phone or in person for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding the applicant's performance;
- 2.7.2. Provide continuous care to his/her patients³⁸ at the generally recognized professional level of quality and efficiency established by the Hospital; delegate in his/her absence the responsibility for diagnosis and/or care of his/her patients only to a Practitioner who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges; and seek consultation whenever necessary, and in accordance with the consultation policies of the Medical Staff;
- 2.7.3. Abide by these Bylaws, the Rules and Regulations, Medical Staff Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital in force during the entire term of appointment or clinical privileges;
- 2.7.4. Abide by all local, State and Federal laws and regulations, Joint Commission and other accreditation standards as they apply within the Hospital, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 2.7.5. Participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;
- 2.7.6. Within the scope of clinical privileges granted, to provide on-call coverage for emergency care services within his/her clinical specialty, as required by the Hospital or the Medical Staff;
- 2.7.7. Comply with clinical practice protocols and evidence-based medicine 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, or clearly document the clinical reasons for variance;
- 2.7.8. Participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare a patient record for each patient;
- 2.7.9. Complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;
- 2.7.10. Utilize the Electronic Health Record (EHR) system of the Hospital;
- 2.7.11. Cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;
- 2.7.12. Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities as requested;
- 2.7.13. Cooperate with all oversight activities related to utilization and medical appropriateness;
- 2.7.14. Participate in continuing education to maintain clinical skills and current competence;³⁹
- 2.7.15. Refrain from illegal fee splitting or other illegal inducements relating to patient referral;

³⁸ MS.03.01.01

³⁹ MS.12.01.01

- 2.7.16. Refrain from delegating responsibility for hospital patients to any individual who is not appropriately licensed, qualified or adequately supervised;
- 2.7.17. Refrain from deceiving patients as to the identity of any individual providing treatment or services;
- 2.7.18. Seek consultation whenever required or necessary;
- 2.7.19. Perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- 2.7.20. Promptly pay any applicable dues, assessments, and/or fines;
- 2.7.21. Complete the Hospital's new physician/practitioner orientation within a timeframe defined by the hospital;
- 2.7.22. Agree that the Hospital may obtain an evaluation of the applicant's performance by a consultant selected by the Hospital if the Hospital considers it appropriate;
- 2.7.23. Comply with the Medical Staff Policy for Practitioner Health & Wellness by immediately submitting to an evaluation as required when there are identified, credible concerns with the individual's ability to safely and competently care for patients; and,
- 2.7.24. Agree that, if there is any misstatement in, or omission from, the Request for Consideration, Recredentialing Request for Consideration or application, the Hospital may stop processing (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board of Trustees whether the application should be processed further. In either situation, there shall be no entitlement to a hearing or appeal.

2.8. TERMS OF APPOINTMENT

Terms of membership and/or the granting of clinical privileges shall be for a period that may be less than, but shall not exceed two years (24 months).⁴⁰

2.9. CREDENTIALS VERIFICATION

Upon the receipt of a completed Request for Consideration (RFC) or Recredentialing Request for Consideration (RRFC) form, the Credentials Processing Center shall arrange to verify the qualifications and obtain supporting information relative to the RFC or RRFC. The Credentials Processing Center shall consult primary sources of information about the individual's credentials, where feasible.⁴¹ Completion of a background check, verifications of licensure, controlled substance registration, specialty board certification, and professional liability claims history, a query of the NPDB, queries of the OIG Sanction Report, GSA List, and State exclusion list, if applicable, and collection of any other information necessary to verify that the individual satisfies all Threshold Eligibility Criteria shall be done within 150 days prior to the Board of Trustees receiving the application. If there are delays in completing the RFC or RRFC, any of these verifications or queries that were done more than 150 days before the Board of Trustees is scheduled to receive the application shall be repeated. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Credentials Processing Center and the verification is documented. If the primary source has designated another organization as its officially-designated agent in providing information to verify credentials, the Credentials Processing Center (CPC) may use this other organization as the designated equivalent source.⁴² The Credentials Processing Center shall

⁴⁰ MS.06.01.07

⁴¹ MS.06.01.03

⁴² MS.06.01.03

promptly notify the individual of any problems in obtaining required information. Any action on an application shall be withheld until it is completed; meaning that all information has been provided and verified, as defined in these Bylaws.⁴³

2.9.1. BURDEN ON APPLICANT TO PROVIDE COMPLETE INFORMATION

- 2.9.1.1. Any individual requesting initial appointment, reappointment, or clinical privileges shall be sent (1) a letter that outlines the Threshold Eligibility Criteria for appointment and clinical privileges, and (2) a Request for Consideration (RFC) or a Recredentialing Request for Consideration (RRFC) form which requests proof that the individual meets the Threshold Eligibility Criteria for appointment, reappointment and clinical privileges. A completed RFC or RRFC form with copies of all required documents must be returned to the Credentialing Processing Center. The Credentialing Processing Center (CPC) shall not have any obligation to process any RFC or R-RFC unless it is complete. Only after a completed RFC or RRFC has been received and all information verified, and the individual has been deemed eligible to apply, shall the CPC submit the information to the Hospital as an application. There is no right to a hearing because of failure to submit a complete RFC or RRFC or because of a determination of ineligibility.
- 2.9.1.2. RFCs may be provided to residents or fellows who are in the final six months of their training. Such RFCs may be processed, but final action shall not be taken until all applicable Threshold Eligibility Criteria are satisfied.
- 2.9.1.3. Individuals seeking appointment, reappointment and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.
- 2.9.1.4. Individuals seeking appointment, reappointment and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the RFC or RRFC are accurate and complete.
- 2.9.1.5. The individual seeking appointment, reappointment, or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.
- 2.9.1.6. An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- 2.9.1.7. Medical Staff Services shall oversee the process of analyzing the information gathered by the CPC, and confirming that all references and other information or materials deemed pertinent have been received.

⁴³ MS.06.01.03, MS.06.01.07, MS.08.01.03

2.9.1.8. The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

2.9.2. REQUEST FOR CONSIDERATION (RFC) / RECREDENTIALING REQUEST FOR CONSIDERATION (RRFC)

An RFC or RRFC shall contain a request for specific clinical privileges if privileges are being sought, and shall require detailed information concerning the individual's professional qualifications. In addition to other information, the RFC/RRFC shall seek the following:

2.9.2.1. Identifying information, including full name, social security number, date of birth, any aliases, and addresses of office & residence, and any other information required to verify identification or background. Verification of identity may be performed by a current/licensed notary public and documented with a notarized statement, or verification may be performed by the staff of Medical Staff Services provided that the individual physically presents himself/herself for the verification process before the application may be considered complete.

2.9.2.2. For new applicants, an attestation of US citizenship, or evidence that the individual is in the US legally and has the required permission(s) to work in this country. For individuals who are not US citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required. The requirements of this Section do not apply to an individual who is residing and working from a foreign country (i.e., a foreign-based telemedicine Practitioner) because the immigration laws of the US do not apply.

2.9.2.3. For a new applicant, written permission from the individual for a background check, and completion of the background check.

2.9.2.4. Evidence of current, unlimited, unrestricted licensure in the State of Colorado and information from the individual regarding any current or past licensure in any healthcare profession or in any other state or other jurisdiction;⁴⁴

2.9.2.5. For individuals requesting medication prescribing privileges, evidence of a current, unlimited, unrestricted Federal DEA listing an in-state address;

2.9.2.6. For a new applicant, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education, including professional degrees earned, and in the case of a foreign graduate, ECFMG certificate;⁴⁵

2.9.2.7. For individuals for appointment who are not newly graduated from residency or fellowship program within the last year, and for individuals for reappointments or renewal of clinical privileges, documentation of the individual's participation in continuing education, specifically as related to the clinical privileges requested;⁴⁶

2.9.2.8. The names and contact information for two peers practicing in the same or like professional discipline as the individual, shall be requested from the individual, who shall provide a written evaluation of the individual's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and ability to perform the clinical privileges requested before an application will be considered complete. The peers shall be persons with current knowledge of the individual who can provide an unbiased appraisal;⁴⁷

⁴⁴ MS.06.01.03, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(2), Guidance to Surveyors, HCA Requirement

⁴⁵ MS.06.01.03, MS.06.01.07, MS.08.01.03, Intent, 42 C.F.R. §482.22(a)(2)

⁴⁶ MS.12.01.01

⁴⁷ MS.06.01.03, MS.06.01.07, MS.08.01.03, MS.07.01.03, 42 C.F.R. §482.22(a)(2)

- 2.9.2.9. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of all qualifying and certifying examinations taken, the results of each qualifying and/or certifying examination, and dates of board certification;
- 2.9.2.10. Information regarding all current healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation and reasons for termination of Medical Staff membership and limitation, reduction or termination of clinical privileges;⁴⁸
- 2.9.2.11. Evidence of current professional liability insurance, including the name of the carrier, amount and dates of coverage, and professional practice covered;
- 2.9.2.12. Medicare Provider NPI for the individual provider (e.g., not a NPI for a group practice);
- 2.9.2.13. Information as to any current, or pending sanctions affecting participation in any Federal Health Care Program, or any actions which might cause the individual to become an Ineligible Person, as well as any sanctions from a professional review organization;⁴⁹
- 2.9.2.14. Accurate and complete disclosure with regard to the following queries:
 - 2.9.2.14.1. Whether the individual's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the individual has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;⁵⁰
 - 2.9.2.14.2. Whether the individual has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital or other healthcare facility;⁵¹
 - 2.9.2.14.3. Whether the individual has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the individual; and,⁵²
 - 2.9.2.14.4. Whether the individual has ever been subject to a criminal action, as defined in these Bylaws, or whether any such action is pending.
- 2.9.2.15. A statement from the individual that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Section 2.4.4;⁵³
- 2.9.2.16. Evidence that the individual has complied with the health screening and immunization requirements of the Hospital. Documentation of TB skin test within the last twelve (12) months. If no current test results are provided, or test is positive, applicant must provide written explanation. Administrative suspension will be enacted until documentation of TB testing or appropriate explanation is provided;
- 2.9.2.17. All Physicians and other Practitioners shall submit a signed Physician Acknowledgement Statement. The Physician or other Practitioner must complete the acknowledgment at the time he or she is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient to the hospital (i.e., when temporary privileges have been granted). Existing acknowledgments signed by physicians already on

⁴⁸ MS.06.01.03

⁴⁹ HCA, Ethics & Compliance Policy CSG.QS.002

⁵⁰ MS.06.01.07

⁵¹ MS.06.01.07

⁵² MS.06.01.07

⁵³ MS.06.01.03, 42 C.F.R. §482.22(c)(4)

staff remain in effect as long as the physician has admitting privileges at the hospital.⁵⁴ Physicians, other Practitioners, and Advanced Practice Professionals will also sign a Confidentiality and Security Agreement at the time of submitting a RFC for initial appointment and periodically as such Agreement may be revised, and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the privacy and confidentiality policies of the Hospital. Completed Agreements will be maintained in the individual's credentials file.⁵⁵

2.9.2.18. Unless the individual is applying for Medical Staff membership only, all RFCs and RRFCs must include a specific written request for clinical privileges using prescribed forms.⁵⁶ Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the individual meets the criteria for each of the privileges requested.

2.9.3. REQUIRED CONSENTS AND AGREEMENTS

Once completed and all information verified by the CPC, the RFC/RRFC shall be turned over to the Hospital for processing as an application. By requesting an RFC, RRFC, application, and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

2.9.3.1. ACCEPTANCE TO BE BOUND TO BYLAWS AND OTHER GOVERNING DOCUMENTS

The individual agrees that he/she has been given access to and read the current Medical Staff Bylaws, Rules and Regulations, and Policies and agrees to be bound by them, including any amendments to Bylaws, Rules and Regulations and Policies as may be adopted pursuant to Article Twelve;⁵⁷

2.9.3.2. AGREEMENT TO PROVIDE CONTINUOUS CARE

The individual agrees to provide continuous care to his/her patients, as defined in these Bylaws.

2.9.3.3. CONSENT TO RELEASE OF INFORMATION

The individual consents to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the individual's health status as required by these Bylaws and for a new applicant a permission to conduct a background check, and a statement providing absolute immunity and release from civil liability for all individuals requesting or providing information relative to the individual's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background.

2.9.3.4. IMMUNITY FROM LIABILITY

By applying for and/or accepting appointment to the Medical Staff and by applying for, accepting and/or exercising clinical privileges within the Hospital, each applicant, Medical Staff appointee, and individual who is granted clinical privileges extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

2.9.3.4.1. The Hospital and the Board of Trustees, any member of the Medical Staff and the Board of Trustees, their authorized representatives, and third parties who provide information for any matter relating to Requests for

⁵⁴ 42 C.F.R. §412.46(c)

⁵⁵ HCA Ethics & Compliance Policy IS.SEC.005

⁵⁶ 42 C.F.R. §482.22(a)(2)

⁵⁷ LD.03.04.01

Consideration, Recredentialing Requests for Consideration, appointment, reappointment, clinical privileges, or the individual's qualifications for the same;

2.9.3.4.2. Any third party for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital representative concerning the individual whether the individual is a former or current applicant or Medical Staff appointee unless such information is false and the third party providing it knew it was false.

2.9.3.4.3. The immunity provided by the Medical Staff Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

2.9.3.4.3.1. Applications for appointment and/or clinical privileges;

2.9.3.4.3.2. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges;

2.9.3.4.3.3. Corrective action;

2.9.3.4.3.4. Hearings and appellate reviews;

2.9.3.4.3.5. Patient care audits;

2.9.3.4.3.6. Medical care evaluations;

2.9.3.4.3.7. Utilization reviews;

2.9.3.4.3.8. Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

2.9.3.4.3.9. Matters or inquiries concerning the credentials of any applicant, Medical Staff appointee, or Practitioner with clinical privileges;

2.9.3.4.3.10. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital; and

2.9.3.4.3.11. Reports to the National Practitioners Data Bank established pursuant to the Act.

2.9.3.5. AUTHORIZATION TO OBTAIN INFORMATION FROM THIRD PARTIES

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to solicit and act upon information, including otherwise privileged or confidential information, provided by third parties bearing on his or her credentials and agrees that any information so provided shall not be required to be disclosed to him or her if the third party providing such information does so on the condition that it be kept confidential (2) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (3) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release information, including otherwise privileged or confidential information, as well as reports, records, statements, recommendations

and other documents in their possession, bearing on his or her credentials to any Hospital Representative, and consents to the inspection and procurement by any Hospital Representative of such information, records and other documents.. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

2.9.3.6. BACKGROUND INVESTIGATION

The individual requesting initial appointment or initial clinical privileges shall provide written permission to conduct a background investigation as part of the initial credentials verification process and on an ad hoc basis upon request by the Chief Executive Officer.

Circumstances that may trigger a request for an ad hoc background investigation include, but are not limited to:

- 2.9.3.6.1. Disciplinary action against the individual's license;
- 2.9.3.6.2. Sanctions or revocation of the individual's Federal DEA or State narcotic registration;
- 2.9.3.6.3. Identification of felony or misdemeanor arrests or convictions; or
- 2.9.3.6.4. Reports of disruptive behavior, harassment, professional misconduct, or alcohol/substance abuse.

2.9.3.7. AUTHORIZATION TO MAINTAIN INFORMATION

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

2.9.3.8. AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTIES

The individual authorizes Hospital representatives to release information to the Hospital's affiliated management entities (e.g., Division office), other hospitals, 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. The individual also authorizes the Hospital to release confidential information, including peer review and/or quality assurance information, obtained from or about the Practitioner to peer review committees of the Hospital and affiliates of the Hospital for purposes of reducing morbidity and mortality and for the improvement of patient care.

2.9.3.9. HEARING AND APPEAL PROCEDURES

The individual agrees that the hearing and appeal procedures set forth in these Bylaws are the sole and exclusive remedy with respect to any professional review action taken by the Hospital and agrees that, if any adverse decision is made with respect to him or her, (1) he or she will follow and exhaust the administrative remedies afforded by the Medical Staff Bylaws and the Hearing Procedure as a prerequisite to any other action, and (2) he or she will have the burden of demonstrating that he or she meets the standards for appointment or continued appointment to the Medical Staff or for the clinical privileges requested.

2.9.3.10. REPORTING

The individual consents to the reporting by any Hospital Representative of information to the National Data Bank established pursuant to the Health Care Quality Improvement Act

of 1986, and to other Federal agencies or to State agencies as required by laws, statutes or regulation, which such Hospital Representative believes in good faith is required by law to be reported.

2.9.3.11. AGREEMENT TO IMMEDIATELY NOTIFY HOSPITAL OF CHANGES IN INFORMATION

The individual shall specifically agree to immediately provide in writing within one business day of being officially notified of a change in status, a notice to the Medical Staff and the Hospital, with or without request, of any new or updated information that is pertinent to the individual's professional qualifications or any question on the RFC/RRFC form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status or status with a State controlled substance regulatory agency, or any exclusion or other sanctions imposed or recommended by the U.S. Department of Health and Human Services or any state, the receipt of a Quality Improvement Organization (QIO) citation, any change in legal status to reside and/or work in the USA, any investigation by a specialty certification board, any payer contract termination, any change in health status, any change in location of office or residence, loss of on-call coverage, any criminal investigation, termination of or notice of non-renewal of professional liability insurance coverage, initiation of any corrective action by any health care facility or professional organization, and/or a quality denial letter concerning alleged quality problems in patient care.

2.9.3.12. LEGAL ACTIONS

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges and does not prevail on all claims or counts made in the complaint(s) or petition(s), he or she shall reimburse the Hospital and any member of the Medical Staff or Board of Trustees involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

2.9.3.13. SCOPE OF SECTION

The individual agrees that the foregoing provisions are in addition to any agreements, understandings, covenants, waivers, authorizations or releases provided by law or contained in any application or request forms.

2.9.3.13.1. All of the provisions in this Section 2.10.3 are applicable in the following situations:

2.9.3.13.1.1. Whether or not appointment or clinical privileges are granted;

2.9.3.13.1.2. Throughout the term of any appointment or reappointment period and thereafter;

2.9.3.13.1.3. Should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

2.9.3.13.1.4. As applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

2.9.4. APPLICATION PROCESSING

After verification is accomplished and the RFC or RRFC is deemed fully complete and it has been verified that all Threshold Eligibility Criteria have been met, the information shall be submitted as an application and it shall be reviewed and processed as follows:⁵⁸

- 2.9.4.1. Time Period for Processing: Once an application is deemed complete, it is expected to be processed within 150 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. If the action of the Board of Trustees has not been taken within 150 days after an application is turned over by the CPC for MSO File Review, the verifications must first be repeated to assure that the information is current before the Board of Trustees takes action.
- 2.9.4.2. Determination of Clinical Privileges: Determination of initial clinical privileges shall be based upon the professional criteria used in evaluating applicant's credentials for Medical Staff appointment, and the professional criteria established by the Hospital for specific clinical privileges. In the course of development of its recommendation concerning an applicant's request for clinical privileges, the Credentials Committee shall forward to the Chairperson of the applicable Service Line the applicant's qualifications and request for clinical privileges. This request shall be communicated through a summary of the pertinent information, such as the electronic Cactus profile and supporting documents. Following receipt of the Service Line Chairperson's recommendation regarding the applicant's clinical privileges, the Credentials Committee shall consider such recommendation and, if the committee concurs, report to the Medical Executive Committee its recommendations for privileges to be granted applicant. The written comments of the Medical Executive Committee, if any, will be forwarded to the Board of Trustees simultaneously with the recommendation of the Credentials Committee. Should the Credentials Committee not concur with the Service Line Chairperson's recommendation for clinical privileges, the request may be returned to the Service Line Chairperson for further consideration. The time frame for completion of the Service Line report(s) shall be within 30 days of receipt of a complete application.⁵⁹ For Advanced Practice Registered Nurses (APRNs), since they provide nursing care, treatment and services, their practice shall be under the supervision and direction of the Chief Nursing Officer (CNO)⁶⁰ in addition to Medical Staff oversight. Therefore, the CNO shall make an evaluation and provide recommendations regarding the clinical privileges to be granted to an APRN, and any concerns regarding the clinical privileges requested or level of supervision needed.
- 2.9.4.3. Credentials Committee Report: The Credentials Committee shall receive from the Service Line Chairperson and review the application, supporting materials, the report of the Service Line Chairperson, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee shall prepare a written report and recommendation for the Medical Executive Committee as to Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Service Line/Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for completion of the Credentials Committee action shall be at the next

⁵⁸ MS.01.01.01, MS.06.01.07, MS.08.01.03

⁵⁹ MS.01.01.01, MS.06.01.07, MS.08.01.03, LD.04.01.05

⁶⁰ NR.01.01.01, 42 C.F.R. §482.23

regular meeting of the committee following receipt of the Service Line report, to be within 30 days.

2.9.4.4. Criteria for Additional Inquiry: Additional inquiry shall be conducted by the Service Line Chairperson, Credentials Committee, or Medical Executive Committee for any of, but not limited to, the reasons listed below. Additional inquiry may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, or any other means appropriate to resolving questions about the application. The application shall be deemed incomplete until additional inquiry is completed, and questions about the following matters are explained to the satisfaction of the Service Line Chairperson, Credentials Committee, Medical Executive Committee or Board of Trustees. Criteria for additional inquiry are:

2.9.4.4.1. Inability to verify through original source documentation any of the information or credentials represented in the application;

2.9.4.4.2. Any unexplained gaps in Medical Staff membership, clinical privileges and/or work history;

2.9.4.4.3. Any other inconsistent or less than favorable information about the applicant's professional qualifications, competence or character, as judged by the Service Line Chairperson Credentials Committee, Medical Executive Committee or Board of Trustees.

2.9.4.5. Medical Executive Committee Recommendation: The Medical Executive Committee shall receive from the Credentials Committee and review the application, supporting materials, the reports of the Service Line Chairperson and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. The Medical Executive Committee shall prepare a written report and recommendation for the Board of Trustees as to Medical Staff appointment and Medical Staff category in the case of applicants for Medical Staff membership, the Service Line to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted.⁶¹ The Board of Trustees shall not take action upon any Credentials Committee recommendations until having received the written comments from the Medical Executive Committee. In the event there are any adverse recommendations, the reasons shall be stated. The time frame for the Medical Executive Committee to decide on a recommendation to the Board of Trustees shall be at the next regular meeting of the committee following receipt of the Credentials Committee report.

2.9.4.6. EFFECT OF MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

2.9.4.6.1. Deferral: The Medical Executive Committee may defer making a recommendation where the deferral is not solely for the purpose of causing delay. A decision by the Medical Executive Committee to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Medical Executive Committee may delegate the responsibility for further consideration to the Credentials Committee or Service Line Chairperson as deemed appropriate.

⁶¹ 42 C.F.R. §482.22(a)(2), MS.02.01.01

- 2.9.4.6.2. Favorable Recommendation: When the recommendation is favorable, the application shall be forwarded promptly to the Board of Trustees for action at the Board of Trustees' next regular meeting.
- 2.9.4.6.3. Adverse Recommendation: If the recommendation of the Medical Executive Committee is adverse as defined by Article Six of these Bylaws, the President of the Medical Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in Article Six of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in Article Six of these Bylaws, and the recommendation need not be transmitted to the Board of Trustees until after the applicant has exercised or waived such rights.

2.9.4.7. BOARD OF TRUSTEES ACTION

Unless subject to the provisions of the fair hearing and appeal provisions in these Bylaws, the Board of Trustees shall act on the application at its next regular meeting following receipt of the recommendation from the Medical Executive Committee.⁶²

- 2.9.4.7.1. If the Board of Trustees adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.
- 2.9.4.7.2. If the Board of Trustees does not adopt the recommendation of the Medical Executive Committee, the Board of Trustees may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board of Trustees, or the Board of Trustees may take unilateral action. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall review the matter and shall forward its recommendation to the Board of Trustees. If the Board of Trustees adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital.
- 2.9.4.7.3. If the action of the Board of Trustees is adverse to the applicant, the Secretary of the Board of Trustees shall promptly send written notice to the applicant. Such notice shall contain the information prescribed in the Article Six of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article Six of these Bylaws, and the adverse decision of the Board of Trustees shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board of Trustees shall take final action.
- 2.9.4.7.4. All decisions to appoint shall include a delineation of clinical privileges when clinical privileges are being requested, the assignment of a Medical Staff category and Service Line affiliation, and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.
- 2.9.4.7.5. Subject to any applicable provisions of Article Six, notice of the Board of Trustees' final decision shall be given in writing through the Secretary of the Board of Trustees to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal was held, Article Six shall govern notice of the Board of Trustee' final decision.

⁶² 42 C.F.R. §482.12(a)(2), 42 C.F.R. §482.22(a)(2), MS.01.01.01, MS.06.01.03, MS.06.01.07

2.10. CREDENTIALS SUBJECT TO ONGOING VERIFICATION

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

- 2.10.1. Current licensure;⁶³
- 2.10.2. Drug Enforcement Administration registration;
- 2.10.3. Professional liability insurance;
- 2.10.4. Specialty board certification;
- 2.10.5. Privilege-specific requirements for current certifications as applicable to the clinical privileges granted; and, **[NOTE: This pertains to specific requirements such as ACLS certification for sedation privileges. Remove this Section if not applicable in your hospital.]**
- 2.10.6. Eligibility to participate in the Federal Health Care Programs. The OIG Sanction Report, the GSA List and the State Exclusion List as applicable shall be checked according to the frequencies defined by Hospital policy.⁶⁴

2.11. ELIGIBILITY FOR COMPLETING A RECREDENTIALING REQUEST FOR CONSIDERATION (RRFC)

To be eligible to complete a Recredentialing Request for Consideration (RRFC) or apply for reappointment and renewal of clinical privileges, an individual must satisfy the Threshold Eligibility Criteria defined in these Bylaws, and during the previous appointment term shall have:

- 2.11.1. Completed all medical records;
- 2.11.2. Completed all continuing medical education requirements;
- 2.11.3. Satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- 2.11.4. Continued to meet all qualifications and eligibility criteria for appointment and the clinical privileges requested; and,
- 2.11.5. For individuals requesting clinical privileges, the individual had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital, defined as less than one (1) patient encounter must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization) before the RRFC shall be considered complete and processed further.

2.12. EXPIRATION OF CURRENT APPOINTMENT

- 2.12.1. If a complete RRFC is not submitted timely, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Only after a complete application is received by the Hospital from the CPC shall an individual be considered for reappointment or renewal of clinical privileges.
- 2.12.2. If a complete application for reappointment is submitted timely, but the Board of Trustees has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the current term of appointment while the application for reappointment

⁶³ MS.06.01.03, MS.06.01.07, MS.08.01.03

⁶⁴ HCA Ethics & Compliance Policy CSG.QS.002

and/or renewal of clinical privileges continues to be processed and reviewed. The Board of Trustees may subsequently grant reappointment and renewal of clinical privileges on a go forward basis.⁶⁵

2.13. ASSISTANCE WITH EVALUATION

The Board of Trustees, the Medical Executive Committee, the Chief Executive Officer, or any committee authorized to review or evaluate applications for Medical Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Medical Staff membership or clinical privileges, may as part of these duties:

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

2.14. CONDITIONAL APPOINTMENT, REAPPOINTMENT OR PRIVILEGES

2.14.1. Recommendations for appointment, reappointment, initial granting of privileges and / or renewal of privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., demonstration of compliance to code of conduct) or to clinical issues (e.g., general consultation requirements, requirements for proctoring, completion of CME requirements). Unless the conditions being imposed constitute an adverse recommendation or action as set forth in these Bylaws or are reportable as defined by the Health Care Quality Improvement Act, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article Six of these Bylaws.

- 2.14.1.1. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, and successfully adheres to the conditions and completes the requirements, the individual shall be eligible to apply for full appointment, reappointment, or privileges.
- 2.14.1.2. If the individual accepts conditional appointment, reappointment, or privileges and agrees to the conditions imposed, but does not adhere to the conditions or does not complete the requirements specified in the conditional appointment, reappointment, or privileges then corrective actions as set forth in Article Five of these Bylaws shall commence.
- 2.14.1.3. If the individual refuses to accept conditional appointment, reappointment, or privileges or any of the conditions or requirements imposed as part of a conditional appointment, reappointment, or privileges, then corrective actions as set forth in Article Five of these Bylaws shall commence.

2.14.2. Conditional appointment, reappointments, or privileges may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that

⁶⁵ MS.06.01.09, EP 9; §482.22(a)(1)

may be imposed. A recommendation for appointment, reappointment, or privileges for a period of less than two years does not entitle an individual to the procedural rights set forth in Article Six of these Bylaws.

2.14.3. In the event an applicant for reappointment or renewal of privileges is the subject of an investigation or hearing at the time reappointment or renewal of privileges is due or is being considered, a conditional reappointment or conditional privileges may be granted for the limited amount of time needed to complete the investigation or hearing.

2.14.4. At the end a term of conditional appointment, reappointment, or privileges the individual shall be required to undergo all usual reappointment credentials verifications and privileging procedures.

2.15. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

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

2.16. MEDICO-ADMINISTRATIVE OFFICERS

2.16.1. DEFINED

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

2.16.2. MEDICAL STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws.⁶⁶ Additional requirements for employment or a contractual agreement may be imposed. The Medical Staff, as in the case of other Practitioners, shall delineate the clinical privileges of medico-administrative officers who request to admit and/or treat patients.

2.16.3. EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

In the event a Practitioner is employed by or under contract with the Hospital, or otherwise serving in a medico-administrative position pursuant to a contract which includes a provision removing the Practitioner from office through the termination or expiration of employment or of the contract, and the contract includes a provision terminating Medical Staff membership or clinical privileges upon expiration or termination of the contract, full effect shall be given to the specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. Termination of Medical Staff membership or clinical privileges upon expiration of or termination of the contract shall not entitle the Practitioner

⁶⁶ MS.03.01.01, MS.03.01.03

to the hearing and appeal procedures of Article Six of these Bylaws. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

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

2.17. INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

2.17.1. QUALIFICATIONS AND SELECTION

Practitioners providing clinical services pursuant to a contract, agreement or other arrangement or through Hospital employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws.⁶⁷ Additional requirements for employment or an agreement may be imposed. The Medical Staff, as in the case of other Practitioners, shall recommend the clinical privileges to admit and/or treat patients for Practitioners who are Hospital employed, or providing services through a contract, agreement or other arrangement.

2.17.2. EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

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

2.18. RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation becomes effective. Resignations shall be submitted to Medical Staff Services. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or APP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's or APP's Service Line Chairperson, the Medical Executive Committee, and the Board of Trustees shall review letters of resignation. Once submitted, a resignation may not be withdrawn until it has been considered by the Board of Trustees. If a Practitioner or APP requests to withdraw a resignation before the resignation is accepted by the Board of Trustees, the request for withdrawal shall also be forwarded to the Board of Trustees for consideration. The Board of Trustees may, but is not required to, honor the request for withdrawal of the resignation. Upon acceptance of the resignation by the Board of Trustees, the Practitioner or APP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding concerns about behavior, conduct, competence, or professional performance, a report shall be submitted to the state professional licensing board for reporting to the National Practitioner Data Bank (NPDB), as required by federal law and state law.⁶⁸

⁶⁷ MS.03.01.01, MS.03.01.03

⁶⁸ Health Care Quality Improvement Act, 42 U.S.C. §11135, 45 C.F.R. 60.9(a)(ii)(A)

3. ARTICLE THREE: CATEGORIES OF THE MEDICAL STAFF

3.1. CATEGORIES

The Medical Staff shall include the membership categories of Active Staff, Affiliate Staff, and Ambulatory Staff. At the time of appointment and at the time of each reappointment, the Medical Staff Member's membership category shall be recommended by the Medical Executive Committee and approved by the Board of Trustees.⁶⁹

3.2. LIMITATIONS ON PREROGATIVES

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

3.3. ACTIVE STAFF

3.3.1. REQUIREMENTS FOR ACTIVE STAFF

The Active Staff membership category shall consist of Practitioners who actively support the Medical Staff and the Hospital by contributing to efforts to fulfill Medical Staff functions. The Active Staff category of Practitioners shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.⁷⁰ To qualify for the Active Staff category, the Medical Staff Member shall have contributed to fulfilling Medical Staff functions by completing at least two of the following types of activities during the last term of appointment, as determined by the Service Line Chairperson and approved by the Board of Trustees, including following initial appointment:

- Term of office as a Medical Staff Officer or Service Line Chairperson;
- Membership on the Board of Trustees;
- Medical Staff committee Chairperson;
- Medical Staff committee Member;
- Timely response to on-call duties when on-call;
- Serving as a proctor to a Practitioner under focused professional practice evaluation;
- Serving as a physician advisor or peer reviewer;
- Timely completion of medical records (e.g., Member had patient admissions and had no delinquencies in completion of their records during term of appointment);
- Serving on a Hospital committee or team/task group;
- Supervisory duties, e.g., serving as the medical director of a Hospital department, or supervision of a Limited Licensure Practitioner;
- Providing education to fellow Medical Staff members, e.g., grand rounds, formal educational presentation, author of a Medical Staff newsletter article; or,
- Supervising participants in a Hospital-sponsored professional graduate education program.

3.3.2. PREROGATIVES OF ACTIVE STAFF

Members of the Active Staff shall be eligible to vote and hold office within the Medical Staff organization. Any Active Staff Member may attend Medical Staff and Service Line meetings and serve

⁶⁹ 42 C.F.R. §482.22(c)(3)

⁷⁰ MS.06.01.03, Introduction

on committees of the Board of Trustees, Medical Staff or Hospital. Members in the Active Staff category shall compose the group defined as the Organized Medical Staff.

3.3.3. OBLIGATIONS OF ACTIVE STAFF

Each Member of the Active Staff shall discharge the basic obligations of Medical Staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her Medical Staff Service Line as specified by the requirements of the assigned Medical Staff Service Line⁷¹; provide continuous care and supervision of his/her patients in the Hospital or arrange a suitable alternative; actively participate in the quality assessment and performance improvement activities of the Hospital; attend Medical Staff and Service Line meetings; and perform such further duties as may be required of him/her under these Bylaws, or Rules and Regulations, or Policies including any future changes to these Bylaws, or Rules and Regulations, or Policies, and comply with directives issued by the Medical Executive Committee.

3.4 AFFILIATE STAFF

3.4.1.1 REQUIREMENTS FOR AFFILIATE STAFF

The Affiliate Staff membership category shall consist of Practitioners who are not actively involved in Medical Staff affairs and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital and order diagnostic or therapeutic services.

3.4.1.2 PREROGATIVES OF AFFILIATE STAFF

Affiliate members may order outpatient tests and procedures and may receive reports and results pertaining to tests or procedures ordered by them. They may also receive reports/results on admitted or ambulatory patients ordered by an Active member of the Medical Staff as deemed appropriate. Members of the Affiliate Staff may visit patients, review medical records and discuss the care with the attending physician. Members of the Affiliate Staff shall not be eligible to vote or hold office within the Medical Staff organization. An Affiliate Staff Member may serve on committees of the Medical Staff or Hospital as approved by the MEC and may vote on Committee matters consistent with Committee membership. They may attend Medical Staff and Service Line meetings to which they are assigned and any Staff or Hospital education program. Affiliate Staff members completing at least two of the activities required for Active Staff during a current term of appointment may request advancement to the Active Staff category.

3.4.1.2 OBLIGATIONS OF AFFILIATE STAFF

Each Member of the Affiliate Staff shall discharge the basic obligations of Medical Staff members as required in these Bylaws and any future changes to these Bylaws and perform such further duties as may be required of him/her under these Bylaws, or Rules and Regulations, or Policies.

3.5 HONORARY RECOGNITION

3.5.1 REQUIREMENTS FOR HONORARY RECOGNITION

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

3.5.2 PREROGATIVES OF HONORARY RECOGNITION

⁷¹ 42 C.F.R. §482.55(b)(2)

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

3.6 CHANGE IN STAFF CATEGORY

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

3.7 ADVANCED PRACTICE PROFESSIONALS

The term, "Advanced Practice Professional" (APP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories/types of APPs eligible for clinical privileges shall be approved by the Board of Trustees and shall be credentialed through the same processes as a Medical Staff Member, as described in Article Two, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined State laws and in these Bylaws. Although APPs are credentialed as provided in these Bylaws, in Article Two, they are not eligible for Medical Staff membership. They may provide patient care services only as permitted by state laws and to the extent of the clinical privileges that have been granted. The Board of Trustees has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), anesthesiology assistants (AA), certified nurse midwives (CNM), clinical psychologists (Ph.D.), advanced registered nurse practitioners (ARNP), and clinical nurse specialists (CNS).⁷²

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

3.7.1 REQUIREMENTS FOR ADVANCED PRACTICE PROFESSIONALS

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

- 3.7.1.1 Name of the sponsoring Medical Staff Member and name of any alternative sponsoring Medical Staff members;
- 3.7.1.2 Completed sponsoring Medical Staff Member's evaluation;
- 3.7.1.3 Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical privilege, and shall be signed by the sponsoring Medical Staff Member(s);
- 3.7.1.4 Signed agreement by the sponsoring Medical Staff Member(s) to provide required supervision and accept responsibility for the patient care services provided by the APP.

3.7.2 PREROGATIVES OF ADVANCED PRACTICE PROFESSIONALS

APPs shall not be eligible to vote, or hold office within the Medical Staff organization. An APP may attend Medical Staff or Service Line/Division meetings if invited. An APP may admit patients to the Hospital only if eligible for admitting privileges if allowed by State laws, and only if granted admitting

⁷² 42 C.F.R. §482.12(a)(1)

privileges by the Board of Trustees. Patients admitted by an APP shall be under the care of a physician.⁷³

3.7.3 OBLIGATIONS OF ADVANCED PRACTICE PROFESSIONALS

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

⁷³ 42 C.F.R. §482.12(c)(2)

4 ARTICLE FOUR: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Every Practitioner or Advanced Practice Professional providing direct clinical services at this Hospital, by virtue of Medical Staff membership or otherwise, shall, in connection with such practice and except as provided in Sections 4.4 and 4.5 below, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board of Trustees.⁷⁴ The privileges must be Hospital-specific, within the scope of the license authorizing the individual to practice in this State or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and shall be subject to the Rules and Regulations of the Service Line. Clinical privileges may be granted, continued, modified, or terminated by the Board of Trustees upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient.⁷⁵ Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Service Line/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.⁷⁶

4.2 QUALIFICATIONS FOR PRIVILEGES

- 4.2.1 Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article Two of these Bylaws. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted.⁷⁷ The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.⁷⁸
- 4.2.2 There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested.⁷⁹ Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references and peer recommendations that include written information about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, and health status as related to ability to perform the privileges requested, information from the applicant's current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Service Line in which the privileges have been sought.⁸⁰ The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his/her patients.⁸¹ Clinical privileges that are granted, renewed, or revised shall be appropriate to the scope of services and service capabilities of the Hospital, meaning that in approving privileges, considerations shall include not only the applicant's qualifications but also the availability of equipment, the number, type and qualifications of staff, and/or the appropriateness

⁷⁴ MS.03.01.01, MS.03.01.03, MS.06.01.07

⁷⁵ MS.03.01.03

⁷⁶ MS.03.01.03

⁷⁷ MS.06.01.07, MS.08.01.03

⁷⁸ MS.06.01.07; MS.08.01.03

⁷⁹ MS.06.01.05

⁸⁰ MS.06.01.05

⁸¹ MS.01.01.01, MS.06.01.01

of the physical environment and resources in a particular Hospital setting, and clinical privileges may be restricted by the Board of Trustees to only certain settings within the Hospital, as appropriate to each setting.⁸²

4.2.3 The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation,⁸³ as provided for in the Medical Staff's Professional Practice Evaluation Policy. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges,⁸⁴ and the applicant's participation in continuing education shall be considered when renewing or revising such privileges.⁸⁵ Before clinical privileges are granted, renewed, or revised by the Board of Trustees, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:⁸⁶

4.2.3.1 For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of record, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about compliance with accepted performance standards and outcomes of the procedures;

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

4.2.3.3 The applicant's clinical judgment and technical skills;

4.2.3.4 Any evidence of unusual patterns of, or an excessive number of, professional liability claims or legal actions resulting in voluntary settlement(s) or final judgment(s) against the applicant;

4.2.3.5 Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization management/medical necessity review, risk management data, and patient safety data;

4.2.3.6 Relevant Practitioner-specific data that are compared to aggregate data available from specialty specific organizations such as the Society of Thoracic Surgeons (STS) or the American College of Cardiology (ACC);

4.2.3.7 Morbidity and mortality data, when available;

4.2.3.8 Practitioner's use of consultants;

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

4.2.4 The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistants at surgery, nursing and administrative personnel.⁸⁷ Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the Hospital, including any committee of the Medical Staff, or the Board of Trustees may, in its discretion, obtain assistance with their evaluation, as provided for in Article Two of these Bylaws.

⁸² MS.06.01.01, MS.06.01.07

⁸³ MS.05.01.03, MS.08.01.03

⁸⁴ MS.12.01.01

⁸⁵ MS.12.01.01

⁸⁶ MS.06.01.03, MS.06.01.07MS.08.01.03

⁸⁷ MS.08.01.03

4.2.5 REQUEST FOR PRIVILEGES

- 4.2.5.1 Clinical privileges may be granted only upon formal request on forms prepared and provided by the Hospital with subsequent processing and approval. Unless an individual is requesting Medical Staff membership only, every RFC or RRFC must contain a request for the specific clinical privileges desired by the individual if clinical privileges are being requested. A request for clinical privileges without a request for Medical Staff membership shall contain the same information as an application for Medical Staff membership. An individual requesting clinical privileges shall be subject to the same obligations as are imposed upon an applicant for Medical Staff appointment, as provided in these Bylaws. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to these Bylaws, the responsibility for producing a complete application and request for clinical privileges shall be the applicant's.
- 4.2.5.2 Admitting Privileges: Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.⁸⁸
- 4.2.5.3 Medical History and Physical Examination Requirements: Clinical privileges for performing a medical history and physical examination shall be delineated. The medical history and physical examination shall be completed and documented by a qualified Physician, a qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy⁸⁹ A medical history and physical examination shall be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia services.⁹⁰ An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oromaxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.⁹¹

4.2.6 ADDITIONS TO OR INCREASES IN CLINICAL PRIVILEGES

- 4.2.6.1 Determination of a change in clinical privileges shall be based on a Practitioner's subsequent training, experience, and demonstrated competence. A review of each Practitioner's documented professional training and focused professional practice evaluation will be included in the review of such Practitioner's request for a change in privileges. A Practitioner who desires a change in his or her clinical privileges in any department shall make a written request to the Chief Executive Officer. The CPC will process the request by performing verifications of training and/or experience and other queries as outlined in this Section 4.2.6. The Chief Executive Officer will then submit the Practitioner's written request and any related information to the Chairperson of the appropriate Service Line for recommendation. The request and the recommendation of the Chairperson of the appropriate Service Line will then be forwarded to the Credentials Committee. The Credentials Committee shall consider the request and will then report recommendations to the Medical Executive Committee. The written comments of the Medical Executive Committee, if any, will be forwarded to the Board

⁸⁸ MS.03.01.01; MS.06.01.07, MS.06.01.13

⁸⁹ MS.01.01.01, 42 C.F.R.§482.22(c)(5)(i)

⁹⁰ MS.01.01.01, 42 C.F.R.§482.22(c)(5)(i)

⁹¹ 42 C.F.R.§482.22(c)(5)(ii)

of Trustees. Should the Credentials Committee or the Medical Executive Committee make a proposed recommendation against the requested change, the proposed recommendation will be forwarded to the Chief Executive Officer who will notify the Practitioner of the proposed adverse recommendation and of the right to a hearing in accordance with the Fair Hearing Procedure. Such notification will be made prior to forwarding the proposed adverse recommendation to the Board of Trustees. No Practitioner may seek clinical privileges previously requested and denied unless supported by additional training and/or experience.⁹²

4.2.6.2 A request by an individual with clinical privileges for additional clinical privileges or an increase in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. The following documentation shall be included with any requests for an increase in clinical privileges and new clinical privileges:

4.2.6.2.1 Any additional license, certification or registration required for the new clinical privileges or increased clinical privileges requested shall be disclosed by the applicant and verified.⁹³

4.2.6.2.2 Training, continuing education, and experience related to the new clinical privileges or increased clinical privileges requested shall be disclosed by the applicant and verified.⁹⁴

4.2.6.2.3 Evidence of current competence related to the new clinical privileges or increased clinical privileges requested shall be verified. This shall include a review of relevant Practitioner-specific performance data when available.⁹⁵

4.2.6.2.4 An evaluation provided by peers of the applicant shall be included in the information considered after a request to add or increase clinical privileges. The peer evaluation shall be in writing and address medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.⁹⁶

4.2.6.2.5 Applicants are required to report and confirm malpractice insurance coverage information for the new privileges or increased clinical privileges requested. Claims history shall be evaluated to determine any evidence of an unusual pattern or excessive number of claims.⁹⁷

4.2.6.2.6 The Hospital shall query the National Practitioner Data Bank (NPDB) when new clinical privileges or increased clinical privileges are requested.⁹⁸

4.2.6.2.7 When adding or increasing clinical privileges the applicant shall be required to attest to his/her health status as related to ability to perform the new or increased clinical privileges being requested and health status shall be verified.⁹⁹

4.2.6.3 When adding or increasing clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:

4.2.6.3.1 Previously successful or currently pending challenges to licensure or registration, or voluntary or involuntary relinquishment of licensure or registration.¹⁰⁰

⁹² Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

⁹³ MS.06.01.05

⁹⁴ MS.12.01.01

⁹⁵ MS.06.01.05

⁹⁶ MS.06.01.05

⁹⁷ MS.06.01.05

⁹⁸ MS.06.01.05; 42 U.S.C. §11135, C.F.R. §60.10

⁹⁹ MS.06.01.05

¹⁰⁰ MS.06.01.05

4.2.6.3.2 Voluntary or involuntary reduction in privileges or termination of privileges or membership.¹⁰¹

4.2.6.3.3 Involvement in any liability actions, including any final judgments or settlements.¹⁰²

4.2.7 LOCUM TENENS PRIVILEGES

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

4.2.8 PRIVILEGES TO SUPPORT POST-RESIDENCY/FELLOWSHIP SURGICAL TRAINING

To support the introduction of a new procedure or new technology at the Hospital, the Board of Trustees shall determine the appropriateness of the Hospital as a training site, based on whether the Hospital has the resources necessary to support a request to conduct training, such as sufficient space, equipment, staffing, and financial resources, and whether the new procedure or new technology or the offer of training for the procedure/technology fits within the Hospital's operational planning and is appropriate for the Hospital's patient population.¹⁰³ Training shall not be conducted until first approved by the Board of Trustees based on a recommendation from the Medical Executive Committee. The preceptor/trainer and the preceptee/trainee shall be credentialed as described in Article Two of these Bylaws to verify the qualifications necessary for these roles. Clinical privileges shall be specifically delineated for the role in which the individual shall serve, and the new procedure or new technology to be taught. The preceptor/trainer and the preceptee/trainee shall be subject to the Medical Staff Bylaws, Rules & Regulations, and policies, specifically including any relevant requirements related to patient rights, informed consent, and if applicable, requirements related to the conduct of research. After completion of training, the preceptee/trainee may be eligible to request clinical privileges for the new procedure or new technology, provided that competency in the privilege has been validated. For purposes of this Section, the following definitions shall apply:

4.2.8.1 Preceptor/trainer: An expert surgeon/physician who undertakes to impart his or her clinical knowledge and skills in a defined setting to a preceptee. The preceptor must be appropriately privileged, skilled, and experienced in the procedure(s) and or technique(s) in question. To serve as a preceptor in a specific procedure or technique, the surgeon/physician (preceptor) must be a recognized authority (e.g., through publications, presentations, extensive clinical experience) in the particular field of expertise.

¹⁰¹ MS.06.01.05

¹⁰² MS.06.01.05

¹⁰³ MS.06.01.01

4.2.8.2 Preceptee/trainee: A surgeon/physician with appropriate basic knowledge and experience seeking individual training in skills and/or procedures not learned in prior formal training. The trainee must have appropriate background knowledge, basic skills, and clinical experience relevant to the proposed curriculum. The trainee should be board-eligible as defined in these Bylaws or certified in the appropriate specialty or possess equivalent board certification from outside the United States.

4.2.9 NEW OR TRANSPECIALTY PRIVILEGES

Prior to accepting a request for a specific privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame. Hospital leaders shall determine whether sufficient space, equipment, staffing, and financial resources are in place or will be available within a specified time frame to support each privilege. The clinical privileges available for request shall be approved by the Board of Trustees, based on this determination of hospital leaders.¹⁰⁴ Any request for clinical privileges that are either new to the Hospital or that overlaps more than one Service Line shall initially be reviewed by the Credentials Committee. The Credentials Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Service Lines, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege.¹⁰⁵ In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad-hoc committee with representation from all appropriate Service Lines or the committee members may undertake the process themselves. Information may be requested from one or more Practitioners or Service Lines, or from outside sources such as professional literature or specialty associations. The recommendation of the Credentials Committee shall be forwarded to the Medical Executive Committee for its review. The recommendation of the Medical Executive Committee and the approval of the Board of Trustees shall be based in part on whether the new procedure or service is appropriate to the Hospital.

4.2.10 DISCONTINUING A SERVICE

As part of the process for ongoing evaluation and planning of patient care services, the Board of Trustees may determine that a particular patient care service shall be discontinued. In the event that a patient care service is discontinued the Board of Trustees shall retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and APPs of the clinical privileges that have been retracted as of a specified effective date.¹⁰⁶ Clinical privileges shall be retracted due to changes in the services provided by the Hospital, and retraction of clinical privileges shall not be considered an adverse action, therefore, there shall be no right to hearing and appeal in association with decisions to change the services offered by the Hospital

4.2.11 EFFECT OF CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

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

4.2.12 TELEMEDICINE PRIVILEGES

¹⁰⁴ MS.06.01.01

¹⁰⁵ MS.01.01.01; LD.01.05.01

¹⁰⁶ MS.06.01.07

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff Member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws.¹⁰⁷ The Medical Staff shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards.¹⁰⁸ Consideration of appropriate utilization of telemedicine equipment by the telemedicine Practitioner shall be encompassed in clinical privileging decisions.¹⁰⁹ In addition to meeting all other qualification for clinical privileges, the following credentialing procedures shall be followed:

4.2.12.1 When a telemedicine provider is providing services from a different State, licensure and/or other requirements that may be imposed by a State will be verified for both the State where the Hospital is located and the State where the Practitioner is located.¹¹⁰

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

4.2.13 USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

4.2.13.1 Non-privileged Practitioners may only refer patients and order outpatient ancillary services. This may be done only if the Practitioner is:

4.2.13.1.1 Responsible for the care of the patient;

4.2.13.1.2 Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient;

4.2.13.1.3 Acts within his/her scope of practice under State law;

4.2.13.1.4 Is not an ineligible person; and,

4.2.13.1.5 Is authorized by the Medical Staff to order the applicable outpatient services under written facility policy that is approved by the Board of Trustees of the Hospital.

4.2.13.2 Out-of-state non-privileged Practitioners may be allowed to refer patients and order outpatient ancillary services without having a license to practice in the State in which the facility is located provided the State's professional licensure agency allows an exception.

4.2.13.3 A non-privileged Practitioner's ordering practices shall be subject to the supervision of the Medical Staff. If there is information that indicates the requirements for a non-privileged Practitioner to order patient care have not been satisfied, or if the order lacks evidence of medical appropriateness, the order shall not be performed and the non-privileged Practitioner shall be notified immediately to be given the opportunity to clarify the information or justify the order. The patient will be informed of the reasons why the test cannot be performed and instructed to call his/her Practitioner. The patient may be given a Patient Information Pamphlet.

4.2.13.4 All diagnostic tests that require an interpretation by a Practitioner granted clinical privileges to do so shall be subject to interpretation by a Member of the Medical Staff with such privileges and the interpretation shall be provided in writing to the non-privileged Practitioner.

4.3 UNAVAILABLE CLINICAL PRIVILEGES

¹⁰⁷ MS.13.01.01

¹⁰⁸ MS.13.01.01 – MS.13.01.03

¹⁰⁹ MS.13.01.01 – MS.13.01.03

¹¹⁰ 42 C.F.R. §482.26(c)(1), Interpretive Guidelines

Notwithstanding any other provisions of these Bylaws, to the extent that any requested clinical privilege is not available at the Hospital, the request shall be denied. Because such a denial of clinical privileges is unrelated to the applicant's qualifications or competence, an applicant whose request is so denied shall not be entitled to the fair hearing and appeal rights under these Bylaws and is not subject to reporting.

4.4 TEMPORARY CLINICAL PRIVILEGES

Temporary clinical privileges constitute temporary permission to attend patients at the Hospital. Temporary clinical privileges are distinguished from other privileges of the Hospital in that they are not based upon complete review of credentials and are granted or revoked by the Chief Executive Officer after consultation of the President of the Medical Staff or his or her designee. Temporary clinical privileges may be granted only for a specific period of time, not to exceed 120 days, and shall automatically expire at the end of the specified period, without recourse by the Practitioner under the Fair Hearing Procedure. Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws or to APPs as defined in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff or currently privileged APPs. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner or APP exercising such privileges. A Practitioner or APP shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any revocation of temporary privileges, unless the revocation is based on questions of clinical competency or professional conduct.

4.4.1 QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within this State, a current and unrestricted DEA registration reflecting an in-state address for the State of Colorado¹¹¹ (if the Practitioner will be prescribing or administering controlled substances), evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, documentation of professional liability insurance coverage as required by the Board of Trustees¹¹² except as specified in Section 4.4.2.3 in this Article, and for Practitioners a signed Physician Acknowledgement Statement must be submitted prior to performing any patient care.¹¹³ Qualifications for temporary privileges shall be verified from a primary source or designated agent of the primary source,¹¹⁴ and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person.¹¹⁵ For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the GSA List, and the State Exclusion List [delete if there is no State Exclusion List]. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges without any right to the hearing and appeal procedures in Article Six of these Bylaws. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies. Individuals who are granted temporary privileges will be subject to the Hospital's policy regarding focused professional practice evaluation (FPPE). Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.4.2 CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a favorable recommendation from the appropriate Service Line Chairperson or President of the Medical Staff

¹¹¹ Federal Register, Volume 71, No. 231, Friday, 12/1/2006, Page 69478 – 69480, Clarification of Registration

¹¹² MS.06.01.13

¹¹³ 42 C.F.R §412.46(c)

¹¹⁴ MS.06.01.03

¹¹⁵ HCA, Ethics & Compliance Policy CSG.QS.002

under the conditions noted below.¹¹⁶ Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Service Line to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below.¹¹⁷ During the time temporary privileges are in effect, the exclusion lists shall be rechecked according to the frequencies defined by Hospital policy.¹¹⁸ Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients.¹¹⁹ A request for temporary privileges shall be made in writing, on forms approved for that purpose by the Hospital.

4.4.2.1 Pendency of Application: After receipt of complete application for Medical Staff membership, as defined in these Bylaws, which includes a written request for temporary privileges, an applicant qualified as described in Section 4.4.1 may be granted temporary privileges while his/her application undergoes processing. Temporary privileges granted under this condition shall not exceed one hundred and twenty (120) consecutive days¹²⁰ and cannot exceed the regular privileges applied for by the applicant. An applicant awaiting processing of a complete application for Medical Staff membership shall be eligible for temporary privileges only after submitting a complete application and only under the following conditions:¹²¹

4.4.2.1.1 There are no current or previously successful challenges to licensure or registration;

4.4.2.1.2 There are no adverse membership actions at another hospital; and,

4.4.2.1.3 There are no adverse actions against the applicant's privileges at another hospital.

4.4.2.2 Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein. After receipt of a written request for temporary privileges, a Practitioner or APP qualified as described in Section 4.4.1 may be granted temporary privileges if the Practitioner or APP has a specific skill not possessed by a privileged Practitioner or APP, and the specific skill is needed by a specific patient or specific group of patients, authorization may be granted to provide care for that specific patient or group of patients. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient(s) or one hundred and twenty (120) consecutive days, whichever is less.¹²² A Practitioner or APP may be granted temporary privileges under this condition for no more than two instances in a twelve-month period. After a Practitioner or APP has been granted temporary privileges under this condition for the second instance within twelve months, he/she shall be required to apply for Medical Staff membership and/or clinical privileges before providing additional patient care, treatment or services at the Hospital.

4.4.2.3 Disaster Response and Recovery:¹²³ Potential disaster situations shall be described in the Hospital Emergency Operations Plan¹²⁴ and are defined as any occurrence that inflicts destruction or distress and that creates demands exceeding the capacities or capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural or a man-made disaster. Upon activation of the Hospital's Emergency Operations Plan and in a situation in which the Hospital is not able to meet immediate patient needs,¹²⁵ temporary

¹¹⁶ MS.06.01.13

¹¹⁷ MS.06.01.13

¹¹⁸ HCA, Ethics & Compliance Policy CSG.QS.002

¹¹⁹ MS.06.01.07, MS.08.01.03

¹²⁰ MS.06.01.13

¹²¹ MS.06.01.13

¹²² MS.06.01.13

¹²³ EM.02.02.13

¹²⁴ EM.02.01.01

¹²⁵ EM.02.02.13

disaster privileges may be granted to an appropriately qualified Practitioner as described in Section 4.4.1, based upon the needs of the Hospital to augment staffing due to the disaster situation. Privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the Hospital Emergency Operations Plan (EOP), upon recommendation by the President of the Medical Staff or the EOP designated Medical Staff Director.¹²⁶ All decisions to grant temporary disaster privileges are at the discretion of the Hospital Emergency Incident Commander or designees, and shall be evaluated on a case-by-case basis in accordance with Hospital and patient care needs.¹²⁷ Approvals shall be documented in writing. The President of the Medical Staff or the EOP designated Medical Staff Director shall also assign a Member of the Medical Staff to responsibilities for supervising Practitioners granted temporary disaster privileges, through direct observation, mentoring, or clinical record review.¹²⁸ Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or permanently in the service of the United States government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage.¹²⁹ Temporary privileges granted to Practitioners who are acting as agents of the Federal government shall be limited in their privileges at this Hospital to the scope of their Federal employment. Temporary privileges granted to anyone under a disaster situation shall not exceed the disaster response and recover period or one hundred and twenty (120) consecutive days, whichever is less.¹³⁰ In the event that the disaster creates extreme urgencies as defined in Section 4.5, a Practitioner could be permitted to provide patient care using emergency privileges.

4.4.2.3.1 Temporary disaster privileges may be granted upon presentation of a government-issued photo identification and to anyone meeting the qualifications required in Section 4.4.1 of this Article which shall be verified as soon as the immediate disaster situation permits the verifications to be performed, using a process identical to granting temporary privileges for an immediate patient care need, and verification shall be completed within 72 hours from the time the volunteer Practitioner presents to the organization, or as soon as possible in an extraordinary situation that prevents verifications within 72 hours.¹³¹

- 4.4.2.3.1.1 A current photo identification card from a healthcare organization with a legible photo and that clearly identifies professional designation¹³²;
- 4.4.2.3.1.2 A current license to practice in the State of Colorado;
- 4.4.2.3.1.3 Primary source verification of the license;
- 4.4.2.3.1.4 Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group;
- 4.4.2.3.1.5 Identification indicating that the individual has been granted authority to render patient care in emergency circumstances,

¹²⁶ EM.02.02.13

¹²⁷ EM.02.02.13

¹²⁸ EM.02.02.13

¹²⁹ 28 U.S.C. §2671; 42 U.S.C. §233(a),(g)

¹³⁰ MS.06.01.13

¹³¹ EM.02.02.13

¹³² EM.02.02.13

such authority having been granted by a federal, state or municipal entity; or,

- 4.4.2.3.1.6 Confirmation by a Licensed Independent Practitioner currently privileged by the hospital or by a Medical Staff member with personal knowledge of the volunteer Practitioner's ability to act as a Licensed Independent Practitioner during a disaster.
- 4.4.2.3.2 The following order of preference should be used in granting temporary disaster privileges:
 - 4.4.2.3.2.1 Expert Practitioners from government agencies and Medical Staff members from other HCA hospitals;
 - 4.4.2.3.2.2 Volunteer Practitioners sent from known agencies (e.g., American Red Cross); Presentation by a current hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner's identity.
 - 4.4.2.3.2.3 Volunteers from the community or surrounding areas.
- 4.4.2.3.3 If possible, photocopies of the above-listed credentials should be made and retained as part of a credentials file.
- 4.4.2.3.4 Upon approval, the Practitioner should be issued appropriate Hospital security identification as required by the Hospital,¹³³ and should be assigned to a Medical Staff Member if possible, with whom to collaborate in the care of disaster victims.
- 4.4.2.3.5 The Medical Staff shall oversee the professional practice of volunteer Practitioners either by the direct observation or mentoring provided by the Medical Staff Member assigned to the volunteer Practitioner ¹³⁴or when a Medical Staff Member is not available to be assigned, then by medical record review to be performed as designated by the President of the Medical Staff or MEC.¹³⁵
- 4.4.2.3.6 The Hospital shall make a decision, based on information obtained regarding the credentials and professional practice of the Practitioner, within 72 hours of the volunteer Practitioner presenting to the Hospital regarding whether to continue the disaster privileges initially granted. Continuing privileges shall be approved by the Hospital Emergency Incident Commander (Chief Executive Officer/designee) or the Operations Chief, if that position is activated as part of the EOP, upon recommendation by the President of the Medical Staff or the EOP designated Medical Staff Director.¹³⁶ In the event that verification of information results in an inability to confirm the qualifications of the Practitioner, privileges should be immediately terminated. When the emergency situation no longer exists, or when Medical Staff Members can adequately provide care, temporary disaster privileges terminate.

4.4.3 DENIAL, REDUCTION OR TERMINATION OF TEMPORARY CLINICAL PRIVILEGES

- 4.4.3.1 The CEO may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, or the Service Line chair, deny, reduce or terminate temporary clinical privileges.
- 4.4.3.2 Denial, termination or reduction of temporary privileges shall not constitute grounds for a hearing, and the termination shall take effect without hearing or appeal.

¹³³ EM.02.02.13

¹³⁴ EM.02.02.13

¹³⁵ EM.02.02.13

¹³⁶ EM.02.02.13

4.5 EMERGENCY PRIVILEGES

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

5 ARTICLE FIVE: INFORMAL INQUIRIES, COLLEGIAL INTERVENTIONS, INVESTIGATIONS AND CORRECTIVE ACTIONS

5.1 INFORMAL INQUIRES

Any person may provide information to the Medical Staff about the conduct, performance, or competence of a Practitioner or other individual with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical,¹³⁷ (3) unprofessional, inappropriate, disruptive or harassing, (as defined in Medical Staff and Hospital Policies, including sexual harassment),¹³⁸ (4) contrary to the Medical Staff Bylaws, Medical Staff Rules and Regulations, or Medical Staff Policies, or (5) below applicable professional standards, the President of the Medical Staff, appropriate Service Line Chairperson, Credentials Committee Chairperson, or Chief Executive Officer shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible.

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

5.2 COLLEGIAL INTERVENTIONS

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

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

- 5.2.1.1 Advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- 5.2.1.2 Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in the Medical Staff Policy regarding Professional Conduct, that may be taken to address unprofessional or inappropriate conduct;
- 5.2.1.3 Proctoring, monitoring, consultation, and letters of guidance;
- 5.2.1.4 Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms;
- 5.2.1.5 Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
- 5.2.1.6 Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 5.2.1.7 Suggestions or recommendations that the individual seek continuing education, consultations, or other assistance in improving performance;

¹³⁷ HCA Ethics & Compliance Policies

¹³⁸ HCA Ethics & Compliance Policies

5.2.1.8 Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,

5.2.1.9 Requirements to seek assistance for a health issue, as provided in these Bylaws.¹³⁹

5.2.2 The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.

5.2.3 The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

5.2.4 No action taken pursuant to this Section shall constitute an investigation or a corrective action.

5.3 SUMMARY SUSPENSION OR RESTRICTION

5.3.1 INITIATION OF SUSPENSION OR RESTRICTION

5.3.1.1 Whenever there are reasonable grounds to believe that the conduct or activities of a Practitioner or other individual with clinical privileges poses a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the President of the Medical Staff, the chairman of any Service Line with respect to physicians in that Service Line, the Executive Committee of the Medical Staff, the Chief Executive Officer and the Board of Trustees shall each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; and (3) restrict access to the Hospital by the suspended Practitioner or other suspended individual with clinical privileges.

5.3.1.2 A suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.

5.3.1.3 Suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

5.3.1.4 A suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer and the President of the Medical Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or the Medical Executive Committee. The Service Line Chairperson for the Service Line to which a suspended or restricted Practitioner is assigned shall be responsible for arranging appropriate medical coverage for any of the Practitioner's patients hospitalized at the time of the suspension or restriction. The wishes of each patient shall be considered, when feasible, in choosing a substitute Practitioner. A suspended or restricted Practitioner's elective admissions and procedures shall be rescheduled pending reinstatement or reassigned to another Practitioner as requested by each patient.

5.3.2 MEDICAL EXECUTIVE COMMITTEE RESPONSE TO A SUSPENSION OR RESTRICTION

5.3.2.1 As soon as possible after such suspension or restriction, the Medical Executive Committee shall be convened to review the matter resulting in a suspension or restriction and consider

¹³⁹ MS.11.01.01

the action taken. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

- 5.3.2.2 After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee must determine whether the suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
- 5.3.2.3 If the Medical Executive Committee's recommendation is not adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall not be entitled to a hearing and appeal.
- 5.3.2.4 If the Medical Executive Committee's recommendation is adverse to the Practitioner as defined in Article Six of these Bylaws, the Practitioner shall be afforded procedural rights to an appellate review as outlined in Article Six of these Bylaws. The terms of the suspension shall remain in effect pending a decision by the Board of Trustees.

5.4 FORMAL INVESTIGATION

The Chief Executive Officer shall consult with the President of the Medical Staff, or the Medical Executive Committee to determine whether a concern about professional competence or conduct should be formally investigated. Whenever it appears that corrective action against a Practitioner or other individual with clinical privileges may be necessary or advisable, the Chief Executive Officer may initiate an investigation by an ad hoc investigation committee. Requests for a formal investigation may be initiated by the Chief Executive Officer, the President of the Medical Staff, by any other officer of the Medical Staff, by the Chairman of any Service Line, by the Chairman of any committee of the Medical Staff, or by any member of the Board of Trustees. Any request for a formal investigation shall be in writing and shall be submitted to the Chief Executive Officer, together with detailed information concerning the specific activities or conduct which constitutes grounds for the request. The initiation of a formal investigation shall not preclude the imposition of suspension or restriction of clinical privileges under Section 5.3 of these Bylaws.¹⁴⁰ A formal investigation shall begin only after a determination by the Medical Executive Committee or the Board of Trustees to do so.

5.4.1 APPOINTMENT OF AD HOC INVESTIGATION COMMITTEE

If a determination is made to investigate formally the necessity or advisability of corrective action against a particular Practitioner, as the result of an informal investigation or otherwise, an Ad Hoc Investigation Committee shall be appointed. In addition, an Ad Hoc Investigation Committee shall be appointed to investigate a Practitioner any time the Licensure Board places a restriction or limitation of any sort on such Practitioner's license or places such Practitioner on probation, unless the action of the Licensure Board has resulted in automatic termination of the appointment of the Practitioner. It is the explicit intention of the Medical Staff that the Ad Hoc Investigation Committee shall consist of the President of the Medical Staff (or his or her designee), two (2) Practitioners appointed by the Chief Executive Officer and two (2) Practitioners appointed by the President of the Medical Staff. A designee of the Chairperson of the service to which the affected Practitioner is assigned shall serve as a consultant to the Ad Hoc Investigation Committee. The President of the Medical Staff (or his or her designee) shall serve as Chairperson of the Ad Hoc Investigation Committee. The Ad Hoc Investigation Committee shall have no voting members who are in direct economic competition with the Practitioner who is the subject of the investigation. In the event there are not a sufficient number of Practitioners who meet such criteria, the Chief Executive Officer may appoint physicians who are not

¹⁴⁰ MS.01.01.01

affiliated with the Hospital who meet such criteria. The Practitioner shall be advised of the names of the Ad Hoc Investigation Committee members within ten (10) days of the appointment of such Ad Hoc Investigation Committee. If the Practitioner who is the subject of the investigation advises the President of the Medical Staff that he or she believes a member of the Ad Hoc Investigation Committee does not meet this criterion, the President of the Medical Staff shall determine the merit of such contention and, if the contention is found to be correct, shall appoint a substitute to serve on the Ad Hoc Investigation Committee. An investigation by an Ad Hoc Investigation Committee shall be considered an administrative matter and not an adversarial proceeding. A Practitioner who is the subject of an investigation shall not be entitled to have legal counsel present during any meetings or discussions between such Practitioner and members of an Ad Hoc Investigation Committee. Testimony and documentary evidence taken informally at the ad hoc investigation stage must be verified under oath at any hearing, if considered.

5.4.2 PRELIMINARY REPORT OF AD HOC INVESTIGATION COMMITTEE

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

5.4.3 PROCEDURE AFTER REPORT OF AD HOC INVESTIGATION COMMITTEE

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

5.4.4 ACTION ON A FORMAL INVESTIGATION REPORT

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

- 5.4.4.1 Determine that corrective action is not warranted and dismiss the matter;
- 5.4.4.2 Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in Section 5.2 of these Bylaws; or,
- 5.4.4.3 Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article Six.

5.5 AUTOMATIC SUSPENSION OR TERMINATION OF PRIVILEGES

If an individual fails to maintain a legal credential authorizing him/her to practice, or other qualification necessary for Medical Staff membership or clinical privileges, upon confirmation of the circumstances by the Chief Executive Officer, the individual shall be immediately and automatically suspended from practicing in the Hospital by the Chief Executive Officer, and the individual's membership may be automatically terminated. The Chief Executive Officer shall notify the individual in writing of the automatic suspension, but the suspension is effective immediately and not subject to prior notice.¹⁴¹ The Chief Executive Officer shall also notify the President of the Medical Staff and Hospital staff members, and take necessary steps to enforce the suspension.

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

5.5.1 LICENSURE

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

5.5.2 CONTROLLED SUBSTANCE REGISTRATION

If an individual's DEA or State controlled substance registration is revoked, suspended, or restricted, (i.e., disciplinary action is taken by the DEA or State) he/she may be automatically suspended from practicing in the Hospital. If an individual fails to maintain a current unrestricted registration, (i.e., there is a lapse in renewal or failure to request all schedules needed for the prescribing privileges granted) the individual's prescribing privileges for the schedule(s) of drugs affected by the restrictions on the DEA or State controlled substance registration shall be immediately automatically suspended.

5.5.3 LIABILITY INSURANCE

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

5.5.4 ELIGIBILITY TO PARTICIPATE IN FEDERAL PROGRAMS

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

5.5.4.1 Becoming an Ineligible Person;¹⁴² or,

5.5.4.2 A criminal conviction.

5.5.5 COMPLETION OF MEDICAL RECORDS

A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge. When a Medical Staff Member or individual with clinical privileges has failed to complete a medical record and the record becomes delinquent, his/her clinical privileges shall be automatically suspended at thirty (30) days after the individual has been notified of the delinquency. The suspension shall continue until all of the individual's delinquent records are completed.

5.5.6 MISREPRESENTATION

Whenever it is discovered that an individual misrepresented the facts, omitted information or provided an erroneous or incomplete answer to the questions on an RFC or RRFC for Medical Staff membership or clinical privileges or in response to questions in an interview, and the misrepresentation or omission is a material or substantive misrepresentation, as determined in the

¹⁴¹ MS.01.01.01

¹⁴² HCA, Ethics & Compliance Policy CSG.QS.002

sole discretion of the Medical Executive Committee, the individual's membership and clinical privileges shall be automatically terminated. Substantial or material misrepresentation of the applicant's qualifications, competence or character may be grounds for the Board of Trustees to permanently disqualify an individual from applying for membership or clinical privileges or to set a specific time period after which the applicant may reapply.

If an individual fails to report to the Hospital any restriction or condition imposed on or probation with respect to his or her license by the licensure board within thirty (30) days of the imposition of such restriction, condition or probation he/she shall be immediately automatically suspended from practicing in the Hospital and his/her Medical Staff membership shall be automatically terminated.

5.5.7 FAILURE TO PROVIDE REQUESTED INFORMATION

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

5.6 CRIMINAL ARREST OR INDICTMENT

In the event that an individual is arrested or indicted for alleged criminal acts, an immediate inquiry into the circumstances of the arrest or indictment shall be made. The Medical Executive Committee shall review the circumstances leading to the arrest or indictment and may determine if a formal investigation, suspension or termination is warranted prior to the outcome of the legal action.

5.7 REPORTING REQUIREMENTS

In compliance with the Health Care Quality Improvement Act of 1986, the Hospital shall report to the Medical Board in the State of Colorado the following actions:

- 5.7.1 Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days;
- 5.7.2 Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist:
 - 5.7.2.1 While the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or
 - 5.7.2.2 In return for not conducting such an investigation or proceeding;
- 5.7.3 The Hospital may report to the Colorado Medical Board the actions as described in Sections 5.7.1 and 5.7.2 with respect to other health care practitioners.

5.8 COVERAGE DURING SUSPENSIONS

When a suspension has been imposed, the Hospital shall arrange for coverage for alternative coverage. When the individual being suspended or restricted is a Practitioner, the President of the Medical Staff or the Chairperson of the Practitioner's Service Line shall arrange for alternative medical coverage of a suspended Practitioner's patients in the Hospital and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Advanced Practice Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the individual.

5.9 REINSTATEMENT FOLLOWING A SUSPENSION

Requests for reinstatement will be reviewed by the relevant Service Line chief, the Chair of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member or other individual with clinical privileges who has been subject to suspension may immediately resume clinical practice at the Hospital. This

determination will then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board of Trustees for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board of Trustees for review and recommendation.

5.10 AUTOMATIC RESIGNATION

5.10.1 RELOCATION

Unless otherwise approved by the Board of Trustees upon recommendation of the Medical Executive Committee, any Member of the Medical Staff or other individual with clinical privileges who no longer meets the geographic proximity requirements of the Medical Staff because of relocation of residence or relocation of practice shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.

5.10.2 FAILURE TO APPLY FOR REAPPOINTMENT OR RENEWAL OF PRIVILEGES

In the event that reappointment or renewal of clinical privileges has not occurred due to lack of submission of a complete application prior to the expiration of the current term of appointment or privileges, the individual shall be deemed to have automatically resigned from the Medical Staff and automatically relinquished all clinical privileges. In such case the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to apply for reappointment and/or renewal of clinical privileges if desired. Automatic resignation of membership and/or automatic relinquishment of clinical privileges shall not entitle the individual to a fair hearing and appeal.

5.10.3 FAILURE TO BE REINSTATED FOLLOWING AUTOMATIC SUSPENSION

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

6 ARTICLE SIX: HEARING AND APPELLATE REVIEW PROCEDURES

6.1 OVERVIEW

The fair hearing and appeal process shall be the same for applicants for Medical Staff membership and existing Medical Staff members. Professional review actions are taken when there is a reasonable belief that the action shall be in the furtherance of quality healthcare, after a reasonable effort to obtain the facts of the matter, in reasonable belief that the action is warranted by the facts, and after adequate notice and hearing procedures or other procedures that are fair to the individual are afforded to the individual subject to professional review actions.¹⁴³ Individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a fair hearing and appeal process but that process shall be modified.¹⁴⁴ The hearing and appeal procedures for individuals with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members is described in Section 6.8.5 of these Bylaws.

6.2 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

6.2.1 COLLEIAL INTERVENTION

An individual does not have a right to a hearing or appeal under Article Six of the Bylaws because of the initiation of an informal inquiry as described in Section 5.1, or when a collegial intervention occurs as defined in Section 5.2, or when an adverse action is recommended but not taken.

6.2.2 AVAILABILITY OF FACILITIES, EXCLUSIVE CONTRACTS, MEDICAL STAFF DEVELOPMENT PLAN

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

6.2.3 MEDICO-ADMINISTRATIVE OFFICER OR OTHER CONTRACT PRACTITIONER

As specified in Section 2.17 of these Bylaws, the terms of any written contract between the Hospital, and a Contract Practitioner or Contractor, shall take precedence over these Bylaws as now written or hereafter amended. If the contract specifies that Medical Staff membership and clinical privileges terminate upon the expiration or termination of the contract, the contracting Practitioner shall not be entitled to the hearing and appeal procedures of Article Six of these Bylaws. The hearing and appeal rights of these Bylaws shall only apply to the extent that membership status or clinical privileges are independent of the individual's contract and are also removed or suspended. The contract may include a specific provision establishing alternative procedural rights applicable to reduction, removal, or suspension of Medical Staff membership and clinical privileges.

6.2.4 AUTOMATIC SUSPENSION, TERMINATION, OR RELINQUISHMENT OF PRIVILEGES

The hearing and appeal rights under these Bylaws do not apply if an individual's Medical Staff membership or clinical privileges are automatically suspended, terminated, or voluntarily relinquished in accordance with these Bylaws.

6.2.5 REMOVAL FROM EMERGENCY CALL PANEL

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

¹⁴³ 42 USCS §11112(a)(1) – (4)

¹⁴⁴ MS.10.01.01

6.2.6 HOSPITAL POLICY DECISION

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

6.2.7 ADMINISTRATIVE ACTIONS

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

- 6.2.7.1 Change to specific Medical Staff membership prerogatives (as examples: voting privileges, eligibility for committee membership, eligibility to hold office, etc.) if the reasons are unrelated to professional competence or conduct;
- 6.2.7.2 Actions taken due to failure to attend meetings as required;
- 6.2.7.3 Denial, termination or reduction of temporary privileges;
- 6.2.7.4 Denial of reinstatement from a leave of absence if the reasons are unrelated to professional competence or conduct;
- 6.2.7.5 Voluntary surrender of membership or clinical privileges because of failure to submit a complete application for reappointment or renewal of privileges prior to the expiration of the current term of membership or clinical privileges.
- 6.2.7.6 Any other actions except those listed in Section 6.3.

6.3 HEARING RIGHTS

6.3.1 ADVERSE RECOMMENDATIONS OR ACTIONS

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

- 6.3.1.1 Denial of initial Medical Staff appointment;
- 6.3.1.2 Denial of reappointment;
- 6.3.1.3 Suspension of Medical Staff membership;
- 6.3.1.4 Revocation of Medical Staff membership;
- 6.3.1.5 Limitation of the right to admit patients other than limitations applicable to all individuals in a Medical Staff category or a clinical specialty, or due to licensure limitations;
- 6.3.1.6 Denial of requested clinical privileges;
- 6.3.1.7 Involuntary reduction in clinical privileges;
- 6.3.1.8 Suspension or restriction of clinical privileges that lasts more than 14 days;
- 6.3.1.9 Revocation of clinical privileges; or,
- 6.3.1.10 Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to supervise, direct, or transfer care from the Practitioner under review (excluding monitoring incidental to focused professional practice evaluation or the granting of new privileges).

6.3.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 6.3 shall promptly be given written notice of such action by the Chief Executive Officer of the Hospital sent via certified mail, return receipt requested. Such notice shall:¹⁴⁵

- 6.3.2.1 State the reasons for an adverse recommendation or action, with enough specifics to allow response;
- 6.3.2.2 Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan.
- 6.3.2.3 Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing.
- 6.3.2.4 State that failure to deliver a written request for a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Trustees.
- 6.3.2.5 State a summary of the Practitioner's rights at the hearing.
- 6.3.2.6 State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time and place of the hearing.

6.3.3 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 6.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief Executive Officer either in person or by certified mail return receipt requested.¹⁴⁶

6.3.4 FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 6.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

- 6.3.4.1 An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall become effective pending the final approval of the Board of Trustees.
- 6.3.4.2 An adverse action by the Board of Trustees shall constitute acceptance of that action, which shall become immediately effective as the final decision by the Board of Trustees.

6.4 HEARING PREREQUISITES

6.4.1 WRITTEN NOTICE

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

- 6.4.1.1 The place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, unless both parties agree otherwise;¹⁴⁷

¹⁴⁵ 42 USCS §11112(b)(1)(A-C)

¹⁴⁶ 42 USCS §11112(b)(1)(B)(i – ii)

¹⁴⁷ 42 USCS §11112(b)(2)(A)

6.4.1.2 A list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;¹⁴⁸

6.4.1.3 The Practitioner involved has the right:¹⁴⁹

6.4.1.3.1 To be present at the hearing;

6.4.1.3.2 To representation by an attorney or other person of the Practitioner's choice;

6.4.1.3.3 To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;

6.4.1.3.4 To call, examine, and cross-examine witnesses;

6.4.1.3.5 To present evidence determined to be relevant by the Chairperson of the hearing panel, regardless of its admissibility in a court law; and,

6.4.1.3.6 To submit a written statement at the close of the hearing.

6.4.1.4 Upon completion of the hearing, the Practitioner involved has the right:¹⁵⁰

6.4.1.4.1 To receive a record of the proceedings upon payment of a reasonable charge;¹⁵¹

6.4.1.4.2 To receive the written recommendation of the hearing panel, including a statement of the basis for the recommendations;

6.4.1.4.3 To receive a written decision of the Board of Trustees, including a statement of the basis for the decision; and

6.4.1.5 The right to the hearing may be forfeited if the Practitioner fails, without good cause, to appear.

6.4.2 APPOINTMENT OF HEARING PANEL

6.4.2.1 By Medical Staff: A hearing occasioned by an adverse recommendation of the Medical Executive Committee shall be conducted by an ad hoc hearing committee appointed by the President of the Medical Staff.

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

6.4.2.3 Composition of Hearing Panel: The hearing panel shall be composed of three (3) members. One of the members so appointed will be designated as the Chairperson. The Chairperson will preside over the hearing. No Member may serve who has acted as accuser, investigator, fact finder, or initial decision maker in the matter. Knowledge of the matter shall not preclude a Member from serving. No Member shall be appointed who is in direct economic competition with the Practitioner, or is a Member of the Medical Executive Committee or Board of Trustees. At least one Member shall be of the same medical specialty as the Practitioner. A majority of the members shall be members of the Medical Staff. However, if there are not a sufficient number of Medical Staff members willing or able to serve on the hearing panel, the Medical Executive Committee or the Board of Trustees may appoint Practitioners who are not members of the Medical Staff.

6.4.2.4 Challenges for Cause: The Practitioner may question hearing panel members regarding potential bias, prejudice or conflict of interest and challenge any Member of the hearing

¹⁴⁸ 42 USCS §11112(b)(2)(B)

¹⁴⁹ 42 USCS §11112(b)(3)(i – v)

¹⁵⁰ 42 USCS §11112(b)(3)(D)(i – ii)

¹⁵¹ 42 USCS §11112(b)(3)(C)(ii)

committee for any cause, which would indicate bias or predisposition. The Chairperson, or if challenged, the President of the Medical Staff, shall decide the validity of such challenges. His/her decision shall be final.

6.5 HEARING PROCEDURE

6.5.1 PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 6.3.4.

6.5.2 PRESIDING OFFICER

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

6.5.3 APPOINTMENT OF A HEARING OFFICER OR LEGAL CONSULTANT

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

6.5.4 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice.¹⁵² The Medical Executive Committee or the Board of Trustees, depending on whose recommendation or action promoted the hearing, shall appoint an individual to present the facts and argument in support of its adverse recommendation or action, and to examine witnesses.

6.5.5 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:¹⁵³

- 6.5.5.1 Call and examine witnesses;
- 6.5.5.2 Introduce exhibits;
- 6.5.5.3 Cross-examine any witness on any matter relevant to the issues;
- 6.5.5.4 Impeach any witness;
- 6.5.5.5 Rebut any evidence;

¹⁵² 42 USCS §11112(b)(3)(C)(i)

¹⁵³ 42 USCS §11112(b)(3)(C)(iii – v)

6.5.5.6 Conduct discovery only in accordance with these Bylaws; and,

6.5.5.7 Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

6.5.6 PROCEDURE AND EVIDENCE

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

6.5.7 BURDEN OF PROOF

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

6.5.8 RECORD OF HEARING

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

6.5.9 POSTPONEMENT

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

6.5.10 PRESENCE OF HEARING PANEL MEMBERS AND VOTE

All members of the hearing panel must be present throughout the hearing and deliberations.

6.5.11 RECESSES AND ADJOURNMENT

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

6.6 HEARING PANEL REPORT AND FURTHER ACTION

6.6.1 HEARING COMMITTEE REPORT

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

Executive Committee, or the Board of Trustees in the event the adverse action originated with the Board of Trustees, and the Practitioner.

6.6.2 ACTION ON HEARING PANEL REPORT

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

6.6.3 NOTICE AND EFFECT OF RESULT

6.6.3.1 Notice: The Chief Executive Officer shall promptly send a copy of the result and report to the Practitioner by written notice, to the President of the Medical Staff, to the Medical Executive Committee and to the Board of Trustees.

6.6.3.2 Effect of Favorable Result:

6.6.3.2.1 Adopted by the Medical Executive Committee: If the Medical Executive Committee's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board of Trustees for its final action. The Board of Trustees shall take action thereupon by adopting, rejecting, or modifying the Medical Executive Committee's recommendation in whole or in part, or by referring the matter back to the Medical Executive Committee for further reconsideration. Any such referral back shall state the reasons for the referral, set a time limit within which a subsequent recommendation to the Board of Trustees must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Trustees shall within 30 days take final action. The Chief Executive Officer shall promptly send the Practitioner notice informing him/her of each action taken pursuant to this Section.

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

6.6.3.3 Effect of Adverse Result for Practitioner: If the result of the Medical Executive Committee or of the Board of Trustees continues to be adverse to the Practitioner in any of the respects listed in Section 6.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board of Trustees as provided in Section 6.7.1.

6.7 APPELLATE REVIEW

6.7.1 TIME FOR APPEAL

Within 10 days after receipt of notice of the Medical Executive Committee's or Board of Trustees' decision, under Section 6.6.2 of these Bylaws, upon the Hearing Panel's recommendation either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within the 10 day period, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board of Trustees for final action.

6.7.2 GROUNDS FOR APPEAL

The grounds for appeal shall be limited to the following:

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

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

6.7.3 TIME, PLACE AND NOTICE

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

6.7.4 NATURE OF APPELLATE REVIEW

6.7.4.1 The Board of Trustees may consider the appeal as a whole body, or the Chairperson of the Board of Trustees may appoint a Review Panel composed of three (3) persons, either members of the Board of Trustees or others, including, but not limited to, reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board of Trustees.

6.7.4.2 Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Board of Trustees (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

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

6.7.5 APPELLATE REVIEW IN THE EVENT OF BOARD OF TRUSTEES MODIFICATION OR REVERSAL OF HEARING PANEL RECOMMENDATION

If the Board of Trustees determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review, and such action would adversely affect the individual, the Board of Trustees shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board of Trustees shall take no final action until the individual has exercised or has waived that appeal provided in these Bylaws. The Board of Trustees has the final say in the matter.

6.7.6 FINAL DECISION OF THE BOARD OF TRUSTEES

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

6.7.6.2 The Board of Trustees may review any information that it deems relevant including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel. The Board of Trustees may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board of Trustees' ultimate legal authority for the operation of the Hospital and the quality of care provided.

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

6.7.7 FURTHER REVIEW

Except where the matter is referred by the Board of Trustees for further action and recommendation by any individual or committee, the final decision of the Board of Trustees shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board of Trustees in accordance with the instructions given by the Board of Trustees.

6.8 GENERAL PROVISIONS

6.8.1 BOARD OF TRUSTEES ACTION

The procedures specified herein shall not preclude the Board of Trustees from taking any direct action authorized under the Board of Trustees Bylaws, policies and/or procedures.¹⁵⁴

6.8.2 NUMBER OF HEARINGS AND REVIEW

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

6.8.3 RELEASE

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

6.8.4 CONFIDENTIALITY

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

6.8.5 HEARING AND APPEAL PROCEDURES FOR ADVANCED PRACTICE PROFESSIONALS

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

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

6.8.5.2 Hearing Panel: The Chief Executive Officer shall appoint a hearing panel, which will include three members. The panel members shall include the Chief Executive Officer, the President of the Medical Staff or another officer of the Medical Staff, and a peer of the APP who is not an economic competitor of the AAP in question. None of the panel members shall have had a role in the adverse recommendation or action.

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

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

¹⁵⁴ Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

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

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

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

6.8.6 EXTERNAL REPORTING REQUIREMENTS

The Hospital shall submit a report to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable Federal and/or State law(s) and in accordance with Hospital policy and procedures.¹⁵⁵

¹⁵⁵ 42 USCS §11133(a)

7 ARTICLE SEVEN: MEDICAL STAFF OFFICERS

7.1 ELECTED OFFICERS OF THE MEDICAL STAFF

7.1.1 IDENTIFICATION

The officers of the Medical Staff shall be the President, the President-Elect and the Immediate Past President.

7.1.2 QUALIFICATIONS

Officers must be members of the Active Staff in good standing at the time of nomination and election and must remain members in good standing thereof during their term of office. Failure to maintain such status or loss of license or Hospital privileges shall immediately create a vacancy in the office involved.^{156,157} To qualify for the position of President or President-Elect, a Member of the Medical Staff must be a doctor of medicine or osteopathy, a doctor of dental surgery, or dental medicine, or a doctor of podiatric medicine.¹⁵⁸ Except for these specific qualification requirements, no Medical Staff Member actively practicing in the Hospital is ineligible for election as an officer solely because of his/her professional discipline, specialty, or practice as a hospital-based physician. Only those members of the Active Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must continuously meet the following qualifications to be a nominee and to serve as an officer of the Medical Staff:

- 7.1.2.1 To have membership in good standing on the Active Medical Staff, and to have served on the Active Medical Staff for at least five years;
- 7.1.2.2 To not be under investigation by the Medical Staff or any local, state or Federal agency with regard to professional practice, and to have no adverse recommendations concerning Medical Staff appointment or clinical privileges;
- 7.1.2.3 To be willing to faithfully discharge the duties and responsibilities of the position;
- 7.1.2.4 To have experience in a leadership position for at least two years, or other involvement in performance improvement functions;
- 7.1.2.5 To attend continuing education relating to Medical Staff leadership and/or credentialing functions during the term of the office.

7.2 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

7.2.1 TERM OF OFFICE

Each officer shall serve a two (2) year term. The term of office shall commence on the first day of the Medical Staff year following the election. Each officer shall serve in office until the end his/her term or until a successor is duly elected and has qualified, unless he/she resigns, or is removed or recalled from office, or is otherwise unable to complete the term. At the end of the President's term, the President-Elect shall automatically assume that office and the President shall automatically serve as the Immediate Past President.¹⁵⁹

7.2.2 ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

¹⁵⁶ MS.01.01.01

¹⁵⁷Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

¹⁵⁸ LD.01.05.01, §482.22(b)(3)

¹⁵⁹ MS.01.01.01

7.3 ATTAINMENT OF OFFICE

7.3.1 NOMINATION

At least ninety (90) days before the end of the year of each odd-numbered year, the Medical Staff Leadership Development & Nominating Committee shall convene and submit to the President of the Medical Staff one or more qualified nominees for the offices of President-Elect and Secretary-Treasurer. The Medical Staff Leadership Development & Nominating Committee shall report the names of the nominees to the Medical Staff at least sixty (60) days before the end of the year. Nominations may also be made by petition signed by at least ten percent of the appointees of the Active Medical Staff, with receipt of a signed statement of willingness to serve by the nominee, filed with the President of the Medical Staff at least forty-five (45) days before the end of the year. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Medical Staff. If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the Medical Staff Leadership Development & Nominating Committee shall submit one or more additional nominees for the ballot.

7.3.2 ELECTION OF OFFICERS

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

7.3.3 BOARD OF TRUSTEES RATIFICATION/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Health Care Quality Improvement Act, the Board of Trustees reserves the right, in its discretion to ratify the appointments of Medical Staff officers and other leaders, such as Department and Division officers, who will perform professional review regarding competence or professional conduct of Practitioners and other individuals requesting clinical privileges, such as credentialing or quality assessment/performance improvement activities.¹⁶⁰ Ratification by the Board of Trustees is an indispensable prerequisite for the individual to assume the position as a Medical Staff officer, Department officer. The Board of Trustees' ratification shall serve as evidence that they are charged with performing important Hospital functions when engaging in professional review including credentialing or quality assessment/performance improvement activities.¹⁶¹ Such activities shall have the following characteristics:

7.3.2.1 The activities such leaders undertake shall be performed on behalf of the Hospital;

7.3.2.2 The activities shall be performed in good faith;

7.3.2.3 That any professional review action shall be taken:

7.3.2.3.1 In the reasonable belief that the action was in the furtherance of quality health care;

¹⁶⁰ 42 USCS §11111

¹⁶¹ **NOTE:** Legal Reasons for Board Ratification of Medical Staff Officers:

Board ratification is a critical step in making clear that, when performing credentialing and performance improvement activities, medical staff leaders are acting as agents of the hospital. As agents of the hospital, they are covered under the hospital's Directors' and Officers' insurance. Board ratification maximizes the legal protections offered under 42 USCS §11112(a)(1-4)

7.3.2.3.2 After a reasonable effort to obtain the facts of the matter;

7.3.2.3.3 After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,

7.3.2.3.4 In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section.

7.3.2.4 The activities shall substantially comply with these Bylaws, rules and regulations, or policies;

7.3.2.5 Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for indemnification for those activities through the Hospital.

7.4 VACANCIES

7.4.1 WHEN CREATED

Vacancies in office may occur from time to time, such as upon the death, disability, resignation, removal, or recall from office of an officer, or upon an officer's failure to maintain active Medical Staff membership, or failure to continue to meet any other qualification to be an officer.

7.4.2 OFFICE OF THE PRESIDENT OF THE MEDICAL STAFF

When a vacancy occurs in the office of the President of the Medical Staff, then the President-Elect shall serve the remaining term of the former President. The vacancy then created in the office of President-Elect shall be filled as described in Section 7.4.3 of these Bylaws.

7.4.3 VACANCIES IN OFFICE

Vacancies in office that occur between elections, except for the Presidency, shall be filled by a majority vote of the Medical Executive Committee of the Medical Staff to approve an individual who meets all of the qualifications to be an officer.

7.4.4 SIMULTANEOUS VACANCIES

In the temporary or permanent absence of both the President of the Medical Staff and President-Elect, the Secretary shall assume all duties and responsibilities and have the authority of the President of the Medical Staff until such time as such a new President and/or President-Elect are elected.

In the temporary or permanent absence of all officers, the Board of Trustees shall appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee of Active Medical Staff members of the Medical Staff shall be appointed by the Board of Trustees and shall convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

7.5 RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

7.5.1 RESIGNATION

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

7.5.2 REMOVAL

Any Medical Staff officer or a member of the Medical Executive Committee may be removed from office for cause. Removal shall occur upon the majority vote of the Medical Executive Committee that there is sufficient evidence of grounds for removal from office for cause, with approval by the Board of

Trustees, or upon a majority vote of the Board of Trustees. Grounds for removal include but are not limited to any one or more of the following circumstances:¹⁶²

- 7.5.2.1 Failure to perform the duties of office;
- 7.5.2.2 Failure to comply with or support the enforcement of the hospital and Medical Staff Bylaws, Rules and Regulations, or policies;
- 7.5.2.3 Failure to support compliance by the Hospital and the Medical Staff with applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 7.5.2.4 Failure to maintain qualifications for office, specifically, failure to maintain active Medical Staff membership or loss of license or Hospital privileges; and/or,
- 7.5.2.5 Failure to adhere to professional ethics, or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Hospital or the Medical Staff.
- 7.5.2.6 At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action shall be taken. The individual shall be afforded an opportunity to speak to the Medical Executive Committee or the Board of Trustees prior to a vote on removal.

7.5.3 RECALL FROM OFFICE

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

7.6 RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS¹⁶³

7.6.1 PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff shall serve as the chief administrative officer of the Medical Staff and shall have responsibility for the organization and conduct of the Medical Staff¹⁶⁴, and supervision of the general affairs of the Medical Staff. The specific responsibilities, duties, and authority of the President are to:

- 7.6.1.1 Act in coordination and cooperation with the Chief Executive Officer and the Board of Trustees in all matters of mutual concern within the Hospital;
- 7.6.1.2 Call, preside at, and be responsible for the agenda of all general and special meetings of the Medical Staff;
- 7.6.1.3 Serve as chairperson of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;
- 7.6.1.4 Serve as ex-officio Member of all other Medical Staff committees without vote, unless otherwise specified;

¹⁶² MS.01.01.01

¹⁶³ MS.01.01.01

¹⁶⁴ LD.01.05.01; 42 C.F.R. §482.22(b)(3)

- 7.6.1.5 Appoint committee members to all Medical Staff committees except the Medical Executive Committee;
- 7.6.1.6 Appoint ad hoc committees to: (1) assist in the development of Hospital policies and procedures, and (2) to provide a forum for consideration of plans for future growth or change in the Hospital organization, and for discussion of problems that arise in the operation of the Hospital. Prepare a written record of the proceedings and recommendations of the ad hoc committees and send it to the Board of Trustees and to the Medical Staff;
- 7.6.1.7 Be responsible for the enforcement of these Bylaws, the Rules and Regulations, and Hospital policies, implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;
- 7.6.1.8 Be accountable and responsible to the Board of Trustees for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;
- 7.6.1.9 Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board of Trustees;
- 7.6.1.10 Serve as an ex-officio Member of the Board of Trustees, with a vote;
- 7.6.1.11 Receive and interpret the policies of the Board of Trustees for the Medical Staff and report to the Board of Trustees on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
- 7.6.1.12 Act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations; and,
- 7.6.1.13 Perform all other functions as may be assigned to the President of the Medical Staff by these Bylaws, the Medical Staff, the Medical Executive Committee, or by the Board of Trustees.
- 7.6.1.14 Conduct surveillance of the professional performance of all individuals who have clinical privileges.¹⁶⁵

7.6.2 PRESIDENT-ELECT

The President-Elect shall serve as the Chair of the Facility Quality Management Committee. The President-Elect shall perform the duties and have the authority of the President of the Medical Staff in the absence or temporary inability of the President to perform. The President-Elect shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be assigned by the President of the Medical Staff or the Board of Trustees. The President-Elect shall automatically succeed the President when the latter fails to serve for any reason.

7.6.3 IMMEDIATE PAST PRESIDENT

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

7.7 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall be a physician who is employed or under contract with the Hospital to perform administrative duties related to the Medical Staff affairs of the Hospital. The Chief Medical Officer is not elected

¹⁶⁵ MS.06.01.07, MS.08.01.03

by the Medical Staff and therefore is not one of the officers of the Medical Staff organization. The Chief Medical Officer is a Medico-Administrative Officer, and as such, the provisions of Section 2.17 of these Bylaws apply.

7.7.1 QUALIFICATIONS

The Chief Medical Officer shall possess all of the qualifications for Medical Staff membership if the Chief Medical Officer desires Medical Staff membership or clinical privileges to provide patient care services.

7.7.2 RESPONSIBILITIES AND AUTHORITY

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

7.7.2.1 Administratively oversee the Medical Staff Services in performance of the credentialing function;

7.7.2.2 Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;

7.7.2.3 Serve as an ex-officio Member of all Medical Staff committees, without vote;

7.7.2.4 Advise and assist the officers of the Medical Staff in the performance of their duties, including providing orientation and education to Medical Staff leaders with regard to their leadership roles.

7.7.3 APPOINTMENT

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

7.7.4 VACANCY

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

8 ARTICLE EIGHT: CLINICAL SERVICE LINES AND SPECIALTY DIVISIONS

8.1 DESIGNATION

8.1.1 CURRENT CLINICAL SERVICE LINES

The Medical Staff shall be organized into clinical Service Lines. The Medical Staff Service Lines are:¹⁶⁶

- 8.1.1.1 Behavioral Health
- 8.1.1.2 Cardiovascular Services
- 8.1.1.3 Community Primary Care
- 8.1.1.4 Emergency Medicine
- 8.1.1.5 Inpatient Medicine
- 8.1.1.6 Neurosciences
- 8.1.1.7 Orthopedics
- 8.1.1.8 Pathology
- 8.1.1.9 Radiology
- 8.1.1.10 Perioperative Services
- 8.1.1.11 Trauma
- 8.1.1.12 Women's Services

8.1.2 SPECIALTY DIVISIONS WITHIN A SERVICE LINE

Each Service Line may be further subdivided into specialty Divisions. The Divisions are:¹⁶⁷

8.1.2.1 FOR THE INPATIENT MEDICINE SERVICE LINE

- 8.1.2.1.1 Allergy & Immunology
- 8.1.2.1.2 Cardiology
- 8.1.2.1.3 Dermatology
- 8.1.2.1.4 Emergency Medicine
- 8.1.2.1.5 Family Medicine
- 8.1.2.1.6 Gastroenterology
- 8.1.2.1.7 Internal Medicine
- 8.1.2.1.8 Physical Medicine & Rehabilitation
- 8.1.2.1.9 Preventive Medicine
- 8.1.2.1.10 Psychiatry & Neurology
- 8.1.2.1.11 Radiology & Nuclear Medicine

8.1.2.2 FOR THE PERIOPERATIVE SERVICE LINE

- 8.1.2.2.1 Anesthesiology
- 8.1.2.2.2 Colorectal Surgery

¹⁶⁶ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁶⁷ MS.01.01.01, MS.06.01.07, LD.04.01.05

- 8.1.2.2.3 General Surgery
- 8.1.2.2.4 Ophthalmology
- 8.1.2.2.5 Orthopedics/Podiatry
- 8.1.2.2.6 Otolaryngology
- 8.1.2.2.7 Neurological Surgery
- 8.1.2.2.8 Pathology
- 8.1.2.2.9 Plastic Surgery
- 8.1.2.2.10 Urology
- 8.1.2.2.11 Vascular Surgery

8.1.2.3 FOR THE WOMEN’S SERVICE LINE

- 8.1.2.3.1 Medical Genetics
- 8.1.2.3.2 Neonatology
- 8.1.2.3.3 Obstetrics/Gynecology
- 8.1.2.3.4 Pediatrics

8.2 CRITERIA TO QUALIFY AS A SERVICE LINE

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

8.2.1 CRITERIA TO QUALIFY AS A SERVICE LINE

To qualify as a Service Line, there shall be enough active Medical Staff members in a clinically distinct area of medical practice with sufficient patient volume to support meaningful ongoing quality assessment and performance improvement activities.

8.3 REQUIREMENTS FOR AFFILIATION WITH SERVICE LINES

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

8.4 FUNCTIONS OF SERVICE LINES

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

8.4.1 CLINICAL FUNCTIONS

- 8.4.1.1 Serve as a forum for the exchange of clinical information regarding services provided by Service Line members;

- 8.4.1.2 Provide recommendations to the Service Line Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Service Line members;
- 8.4.1.3 Provide recommendations to the Service Line Chairperson regarding professional criteria for clinical privileges designed to assure the Medical Staff and Board of Trustees that patients shall receive quality care.¹⁶⁸ The recommendations shall include:
 - 8.4.1.3.1 Criteria for granting, withdrawing and modifying clinical privileges;¹⁶⁹
 - 8.4.1.3.2 A procedure for applying these criteria to individuals requesting privileges.¹⁷⁰
- 8.4.1.4 Ensure that patients receive appropriate and medically necessary care from a Member of the Medical Staff during the entire length of stay with the Hospital;¹⁷¹
- 8.4.1.5 Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Service Line, across Service Lines, and between members and non-members of the Medical Staff with clinical privileges;¹⁷²
 - 8.4.1.5.1 By establishing uniform patient care processes;¹⁷³
 - 8.4.1.5.2 By establishing similar clinical privileging criteria for similar privileges;¹⁷⁴
 - 8.4.1.5.3 By using similar indicators in performance improvement activities.¹⁷⁵
- 8.4.1.6 Provide recommendations to the Service Line Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence;
- 8.4.1.7 Ensure effective mechanisms for the clinical supervision of Advanced Practice Professionals, and House Staff Practitioners, if any.

8.4.2 ADMINISTRATIVE FUNCTIONS

- 8.4.2.1 Provide information and/or recommendations to the Service Line Chairperson with regard to the criteria for granting clinical privileges within the Service Line;
- 8.4.2.2 Ensure that individuals within the Service Line who admit patients have privileges to do so,¹⁷⁶ and that all individuals within the Service Line with clinical privileges only provide services within the scope of privileges granted.¹⁷⁷
- 8.4.2.3 Provide information and/or recommendations to the Service Line Chairperson and/or the Medical Executive Committee with regard to Medical Staff Policies;
- 8.4.2.4 Provide recommendations to the Service Line Chairperson and/or the Medical Executive Committee with regard to ensuring appropriate call coverage by Service Line members.

8.4.3 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

- 8.4.3.1 Perform ongoing professional practice evaluation, initial focused professional practice evaluation, for-cause focused professional practice evaluation, peer review and other quality

¹⁶⁸ MS.02.01.01, MS.06.01.07

¹⁶⁹ 42 C.F.R. §482.22(c)(6), CMS Survey Procedures

¹⁷⁰ 42 C.F.R. §482.22(c)(6), CMS Survey Procedures

¹⁷¹ MS.03.01.01

¹⁷² MS.01.01.01; LD.01.05.01

¹⁷³ LD.04.03.07

¹⁷⁴ MS.01.01.01; LD.01.05.01

¹⁷⁵ MS.01.01.01; LD.01.05.01

¹⁷⁶ MS.03.01.01, MS.06.01.07

¹⁷⁷ MS.08.01.03

assessment activities relative to the performance of individuals with clinical privileges in the Service Line and report such activities to the Medical Executive Committee on a regular basis;

8.4.3.2 Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, and implementing procedures to comply with patient safety goals.¹⁷⁸

8.4.3.3 Ensure appropriate quality control is performed, if applicable to the Service Line;

8.4.3.4 Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Service Line and its members, and integrate the Service Line's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

8.4.4 COLLEIAL AND EDUCATIONAL FUNCTIONS

8.4.4.1 Recommend medical educational programs to meet the needs of Service Line members, based on the scope of services provided by the Service Line, changes in medical practice or technology, and the results of Service Line performance improvement activities.¹⁷⁹

8.5 OFFICERS OF SERVICE LINES

8.5.1 IDENTIFICATION

The officers of the Service Lines shall be the Service Line Chairperson and the Service Line Vice-Chairperson.

8.5.2 QUALIFICATIONS

The officers of the Service Lines shall be active Medical Staff members in good standing. Each Service Line Chairperson and Vice-Chairperson shall have demonstrated ability in at least one of the clinical areas of the Service Line. All officers of the Service Lines shall be certified by an appropriate specialty board, or affirmatively establishes comparable competence through the credentialing process.¹⁸⁰

Each Service Line Chairmen shall:

8.5.2.1 Be an Active Medical Staff member;

8.5.2.2 Be certified by an appropriate specialty board described in the definitions incorporated in these Bylaws, as confirmed through the credentialing and privileging process; and

8.5.2.3 Satisfy the eligibility criteria set forth for Medical Staff Officers.

8.5.3 ATTAINMENT OF OFFICE

Service Line officers shall be elected by a majority of the Service Line members eligible to vote. The officers selected during the election must be ratified by the Board of Trustees prior to taking office at the beginning of the subsequent Medical Staff year.

8.5.4 TERM OF OFFICE AND ELIGIBILITY FOR REAPPOINTMENT TO POSITION

Service Line shall serve a term of office of two years. No person may serve in the same position for more than two consecutive terms.¹⁸¹

¹⁷⁸ MS.03.01.01; 42 C.F.R. §482.22

¹⁷⁹ MS.12.01.01

¹⁸⁰ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁸¹ MS.01.01.01

8.5.5 RESIGNATION

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

8.5.6 REMOVAL

Any Service Line officer may be removed from office for cause. Removal shall occur with a majority vote of the Medical Executive Committee finding sufficient evidence exists of grounds for removal, followed by approval by the Board, or upon a majority vote of the Board, with or without a determination that cause exists for removal by the Medical Executive Committee. Grounds for removal include but are not limited to any of the following circumstances:¹⁸²

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

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

8.5.7 RECALL

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

8.5.8 VACANCY

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

8.5.9 RESPONSIBILITY AND AUTHORITY¹⁸³

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

¹⁸² MS.01.01.01

¹⁸³ MS.01.01.01, MS.06.01.07, LD.04.01.05

- 8.5.9.1 Presiding at all meetings of the Service Line;
- 8.5.9.2 Appointing Service Line members to membership positions on Service Line committees, if any;
- 8.5.9.3 Serving as an ex-officio Member of all departmental committees if any, without vote, unless specifically stated in the Bylaws or Rules and Regulations otherwise;
- 8.5.9.4 Serving as a Member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Service Line, specifically to regularly report the quality assessment and performance improvement activities of the Service Line to the Medical Executive Committee;
- 8.5.9.5 Conducting all clinically related activities of the Service Line;¹⁸⁴
- 8.5.9.6 Conducting all administratively related activities of the Service Line, unless otherwise provided by the Hospital;¹⁸⁵
- 8.5.9.7 Continuing surveillance of the professional performance of all individuals in the Service Line who have delineated clinical privileges;¹⁸⁶
- 8.5.9.8 Participating in the evaluation of Practitioners practicing within the Service Line;¹⁸⁷
- 8.5.9.9 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Service Line;¹⁸⁸
- 8.5.9.10 Recommending clinical privileges for each Member of the Service Line;¹⁸⁹
- 8.5.9.11 Assessing and/or recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Service Line or the Hospital;¹⁹⁰
- 8.5.9.12 Integrating the Service Line into the primary functions of the Hospital;¹⁹¹
- 8.5.9.13 Coordinating and integrating interdepartmental and intradepartmental services;¹⁹²
- 8.5.9.14 Developing and implementing policies and procedures that guide and support the provision of services;¹⁹³
- 8.5.9.15 Recommending a sufficient number of qualified and competent persons to provide care or services;¹⁹⁴
- 8.5.9.16 Determining the qualifications and competence of Service Line personnel who are not Licensed Independent Practitioners and who provide patient care services;¹⁹⁵
- 8.5.9.17 Ensuring the continuous assessment and improvement of the quality of care and services provided;¹⁹⁶
- 8.5.9.18 Maintaining quality control programs, as appropriate;¹⁹⁷
- 8.5.9.19 Ensuring the orientation and continuing education of all persons in the Service Line;¹⁹⁸

¹⁸⁴ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁸⁵ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁸⁶ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁸⁷ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁸⁸ MS.01.01.01, MS.02.01.01, MS.06.01.07, LD.04.01.05, 42 C.F.R. §482.22(c)(6)

¹⁸⁹ MS.01.01.01, MS.06.01.07, LD.04.01.05

¹⁹⁰ MS.01.01.01, LD.04.03.01, LD.04.03.09

¹⁹¹ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹² MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹³ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹⁴ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹⁵ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹⁶ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹⁷ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

8.5.9.20 Recommending appropriate space and other resources needed by the Service Line.¹⁹⁹

8.5.10 Service Line Vice-Chairperson: The Vice-Chairperson shall assist the Service Line Chairperson in the performance of the Chairperson's duties, and shall assume the duties of the Chairperson in his/her absence.

¹⁹⁸ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

¹⁹⁹ MS.01.01.01, LD.04.01.05, LD.03.06.01, LD.04.01.11, LD.04.01.07, LD.04.04.01

9 ARTICLE NINE: FUNCTIONS AND COMMITTEES

9.1 FUNCTIONS OF THE STAFF

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

9.1.1 GOVERNANCE

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

- 9.1.1.1 Establish a framework for self-governance of Medical Staff activities and accountability to the Board of Trustees.²⁰⁰
- 9.1.1.2 Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.²⁰¹

9.1.2 PLANNING

The leaders of the Hospital include members of the Board of Trustees, the Chief Executive Officer and other senior managers, Service Line leaders, the elected and the appointed leaders of the Medical Staff and the Medical Staff Service Lines and other Medical Staff members in medico-administrative positions, and the Chief Nursing Officer and other senior nursing leaders.²⁰² Medical Staff leaders, as defined above, shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

- 9.1.2.1 Planning patient care services;²⁰³
- 9.1.2.2 Planning and prioritizing performance improvement activities;²⁰⁴
- 9.1.2.3 Budgeting;²⁰⁵
- 9.1.2.4 Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Service Lines, across Service Lines, and between members and non-members of the Medical Staff who have delineated clinical privileges;²⁰⁶
- 9.1.2.5 Recruitment, retention, development, and continuing education of all staff;²⁰⁷
- 9.1.2.6 Consideration and implementation of clinical practice guidelines as appropriate to the patient population.²⁰⁸
- 9.1.2.7 Establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or Service Line.²⁰⁹

²⁰⁰ MS.01.01.01, MS.01.01.03

²⁰¹ MS.03.01.03, LD.1.10, LD.03.04.01

²⁰² Joint Commission Comprehensive Accreditation Manual for Hospitals, Glossary

²⁰³ LD.02.01.01

²⁰⁴ LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01

²⁰⁵ LD.04.01.03

²⁰⁶ LD.02.01.01; MS.01.01.01; LD.01.05.01

²⁰⁷ LD.02.01.01, LD.03.06.01

²⁰⁸ LD.04.04.07

²⁰⁹ MS.03.01.01

- 9.1.2.8 When emergency services are provided at the Hospital but not at one or more off-campus locations of the Hospital, the Medical Staff shall have policy and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.²¹⁰
- 9.1.2.9 If emergency services are not provided at the Hospital, the Medical Staff shall have written policy and procedures for appraisal of emergencies, initial treatment, and referral of patients when needed.²¹¹
- 9.1.2.10 The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical legal and educational interest.²¹²
- 9.1.2.11 The Medical Staff, specifically the attending physician, shall be informed of autopsies that the Hospital intends to perform.²¹³

9.1.3 CREDENTIALING AND PRIVILEGING

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

- 9.1.3.1 Establish specifically defined mechanisms for the process of appointment and reappointment to Medical Staff membership, and for granting delineated clinical privileges to qualified applicants.²¹⁴
- 9.1.3.2 Establish professional criteria for membership and for clinical privileges.²¹⁵
- 9.1.3.3 Conduct an evaluation of the qualifications and competence of individuals applying for Medical Staff membership or clinical privileges.²¹⁶
- 9.1.3.4 Submit recommendations to the Board of Trustees regarding the qualifications of an applicant for appointment, reappointment or clinical privileges.²¹⁷
- 9.1.3.5 Establish a mechanism for fair hearing and appellate review.²¹⁸
- 9.1.3.6 Establish a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted.²¹⁹

9.1.4 QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT/PATIENT SAFETY/OPPE/FPPE

The Board of Trustees requires that the Medical Staff be accountable to the Board of Trustees for the quality of care provided to patients.²²⁰ All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital's quality assessment and performance improvement activities.²²¹ All organized services related to patient care shall be evaluated.²²² The Hospital's quality assessment and performance improvement activities shall be described in detail in the Performance Improvement Plan. Through the activities of the Medical

²¹⁰ MS.03.01.01

²¹¹ MS.03.01.01

²¹² MS.05.01.01

²¹³ MS.05.01.01

²¹⁴ MS.01.01.01

²¹⁵ MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03

²¹⁶ MS.06.01.07

²¹⁷ MS.01.01.01, MS.06.01.03, MS.06.01.07

²¹⁸ MS.10.01.01

²¹⁹ MS.08.01.03

²²⁰ 42 C.F.R. §482.12(a)(5)

²²¹ MS.01.01.01, MS.05.01.01, MS.06.01.07, MS.08.01.03; 42 C.F.R. §482.22(a)(1)

²²² 42 C.F.R. §482.21(a)(1)

Staff Service Lines, the Medical Staff Quality/Peer Review Committee, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below.²²³ The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members and the Board of Trustees.²²⁴

The Medical Staff shall participate with the Board of Trustees and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program. The Board of Trustees, the Medical Staff, and Administration shall be responsible and accountable for ensuring the following:²²⁵

9.1.4.1.1 That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.

9.1.4.1.2 That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated.

9.1.4.1.3 That the results of Hospital-wide quality assessment and performance improvement are utilized for ongoing professional practice evaluation (OPPE), and focused professional practice evaluation (FPPE), and peer review activities.

9.1.4.1.4 That clear expectations for safety are established.

9.1.4.1.5 That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients.

9.1.4.1.6 That the determination of the number of distinct improvement projects is conducted annually.

9.1.4.2 Medical Staff Leadership Role in Performance Improvement: The Medical Staff shall perform a leadership role in the Hospital's quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges.²²⁶ Such activities shall include, but are not limited to a review of the following:

9.1.4.2.1 Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;²²⁷

9.1.4.2.2 Root cause analysis, investigation and response to any unanticipated adverse events;²²⁸

9.1.4.2.3 Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;²²⁹

9.1.4.2.4 Review and analysis of performance based on the results of core measures and other publicly reported performance information;²³⁰

9.1.4.2.5 Use of information about adverse privileging decisions for any Practitioner privileged through the Medical Staff process;²³¹

²²³ 42 C.F.R. §482.22(a)(1), 42 C.F.R. §482.22(c)(3), Survey Procedures

²²⁴ MS.05.01.03

²²⁵ 42 C.F.R. §482.21 (effective March 25, 2003)

²²⁶ MS.05.01.01

²²⁷ LD.04.04.05, MS.05.01.01

²²⁸ LD.04.04.05, MS.05.01.01

²²⁹ MS.05.01.01, MS.05.01.01; 42 C.F.R. §482.21(a)(3)

²³⁰ Hospital Quality Alliance and public reporting initiatives

- 9.1.4.2.6 Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;²³²
 - 9.1.4.2.7 Use of blood and blood components, including the review of any significant transfusions reactions;²³³
 - 9.1.4.2.8 Use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;²³⁴
 - 9.1.4.2.9 Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;²³⁵
 - 9.1.4.2.10 Significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and,²³⁶
 - 9.1.4.2.11 Use of developed criteria for autopsies.²³⁷
- 9.1.4.3 **Medical Staff Participant Role in Performance Improvement:** The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes.²³⁸ Such activities shall include, but are not limited to a review of the following:
- 9.1.4.3.1 Analyzing and improving patient satisfaction;²³⁹
 - 9.1.4.3.2 Education of patients and families;²⁴⁰
 - 9.1.4.3.3 Coordination of care with other Practitioners and hospital personnel, as relevant to the care of an individual patient; and,²⁴¹
 - 9.1.4.3.4 Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;²⁴²
 - 9.1.4.3.5 The quality of history and physical exams;²⁴³
 - 9.1.4.3.6 Surveillance of nosocomial infections.²⁴⁴
- 9.1.4.4 **Medical Staff OPPE, FPPE & Peer Review:** Findings relevant to an individual are used in ongoing professional practice evaluation (OPPE) to verify continued competence for the privileges granted, and focused professional practice evaluation (FPPE) for both the initial appraisal of the individual's competence and when indicated for-cause.²⁴⁵ When the findings of quality assessment or performance improvement activities are relevant to an individual's performance and the individual is a Medical Staff Member or holds clinical privileges, the Medical Staff is responsible for determining the use of the findings in FPPE, OPPE or peer review. In accordance

²³¹ MS.05.01.01

²³² MS.05.01.01, MS.05.01.01; 42 C.F.R. §482.21; 42 C.F.R. §482.23(c)(4); 42 C.F.R. §482.25(b)(6)

²³³ MS.05.01.01, MS.05.01.01; 42 C.F.R. §482.21

²³⁴ MS.05.01.01, MS.05.01.01; 42 C.F.R. §482.21

²³⁵ MS.05.01.01; 42 C.F.R. §482.21; 42 C.F.R. §482.30

²³⁶ MS.05.01.01; 42 C.F.R. §482.21

²³⁷ MS.05.01.01

²³⁸ MS.05.01.03

²³⁹ MS.03.01.01

²⁴⁰ MS.05.01.03

²⁴¹ MS.05.01.03

²⁴² MS.05.01.03;RC.01.03.01; 42 C.F.R. §482.21

²⁴³ MS.03.01.01

²⁴⁴ IC.01.03.01; 42 C.F.R. §482.21(a)(2); 42 C.F.R. §482.42(b)(1 – 2)

²⁴⁵ MS.05.01.03

with these Bylaws, clinical privileges are renewed or revised appropriately as determined by the Medical Staff or Board based on OPPE or FPPE findings.²⁴⁶

9.1.5 CONTINUING AND GRADUATE MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education.²⁴⁷ In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consonant with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable Federal laws and Hospital policy.²⁴⁸ The Medical Staff shall develop educational programs for Medical Staff members and others with clinical privileges related at least in part to:

9.1.5.1 The type and nature of care offered by the hospital; and,²⁴⁹

9.1.5.2 The findings of performance improvement activities.²⁵⁰

Additionally, the Medical Staff shall support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision of house staff members by members of the Medical Staff in carrying out their patient care responsibilities.²⁵¹

9.1.6 BYLAWS REVIEW AND REVISION

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

9.1.6.1 Remain consistent with the Bylaws of the Board of Trustees;²⁵²

9.1.6.2 Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;²⁵³

9.1.6.3 Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities,²⁵⁴ and,

9.1.6.4 Remain consistent with Hospital policies.²⁵⁵

9.1.7 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING

The Medical Staff shall provide a mechanism for developing future Medical Staff leaders by defining desired leadership characteristics, identifying and recruiting future potential Medical Staff leaders from among the Members of the Medical Staff, and determining the education and development needs of potential Medical Staff leaders so as to be successful in future roles. The Medical Staff shall provide a mechanism for selecting qualified officers to give leadership to the Medical Staff organization.²⁵⁶

²⁴⁶ MS.05.01.03; 42 C.F.R. §482.22(a)(1)

²⁴⁷ MS.12.01.01

²⁴⁸ MS.12.01.01, HCA, Ethics & Compliance Policy LL.010

²⁴⁹ MS.12.01.01

²⁵⁰ MS.12.01.01

²⁵¹ MS.04.01.01

²⁵² MS.01.01.01

²⁵³ LD.04.01.01

²⁵⁴ MS.01.01.01; LD.01.05.01

²⁵⁵ LD.01.03.01

²⁵⁶ MS.01.01.01

9.2 PRINCIPLES GOVERNING COMMITTEES

The key functions of the Medical Staff shall be performed on an ongoing basis through the activities of the Service Lines, Divisions, and committees of the Medical Staff. Specific key functions of the Medical Staff shall be performed through Medical Staff standing committees. The Medical Executive Committee may recommend to the Board of Trustees the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will not be enacted without approval by the Board of Trustees. In addition to the standing committees, the Medical Executive Committee or the President of the Medical Staff may designate a subcommittee of any standing committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which should be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished upon approval of the Medical Executive Committee.

9.3 DESIGNATION

The current standing committees of the Medical Staff are the Medical Executive Committee, the Credentials Committee, the Quality/Peer Review Committee, the Medical Education Committee, the Bylaws Committee, and the Nominating Committee.

9.3.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation.²⁵⁷ Medical Staff representatives for a Hospital committee shall be appointed by the President of the Medical Staff with input from the Chief Executive Officer or Chief Medical Officer. The purpose, functions, and scope of authority of each Hospital committee shall be described in a plan or charter, and shall be approved by the Board of Trustees.

9.3.2 EX-OFFICIO MEMBERS

The Chief Executive Officer and Chief Medical Officer shall be ex-officio members of all Medical Staff committees.²⁵⁸ The Chief Executive Officer may designate another senior administrative Member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board Member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

9.3.2 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Within three months prior to the end of each Medical Staff year, the Medical Executive Committee shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. The Medical Executive Committee may also appoint physicians and other LIPs who are not members of the Medical Staff to be members of a standing committee of the Medical Staff upon determination that the committee's function and operations necessitates the expertise of the non-medical staff member. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Quality/Peer Review Committee and any other committee performing a professional review activity shall be contingent upon ratification by the Board of Trustees per Section 7.3.3 of these Bylaws. The Chief Executive Officer, in consultation with

²⁵⁷ MS.01.01.01; LD.01.05.01, MS.01.01.03, MS.02.01.01,

²⁵⁸ MS.02.01.01

the President of the Medical Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

9.3.3 TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee Member shall be two (2) years. To promote continuity, an attempt will be made for approximately one half of the committee membership appointments to commence on the first day of odd-numbered Medical Staff years, and the other half to commence on even-numbered years.

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

9.3.4 NOTICE

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

9.3.5 MEETINGS

The frequency of meeting shall be specified in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Service Lines shall be held on the campus of the Hospital. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported secure voting system, fax, or email as approved by the Hospital.

9.3.6 QUORUM

A quorum is required for any committee to conduct a meeting. A quorum exists when a numerical majority of the appointed or elected voting members of a committee are present in person and/or by interactive telecommunications.

9.3.7 MANNER OF ACTING

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

9.3.8 ACTION THROUGH SUBCOMMITTEES

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

9.3.9 MINUTES

Each committee and subcommittee shall prepare minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years,²⁵⁹ after which they may be archived in any retrievable format indefinitely.

9.3.10 PROCEDURES

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

9.3.11 REPORTS

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

9.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

9.4.1 REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the provisions of this Article, the leaders of the Medical Staff may collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting the discharge of Medical Staff responsibilities, the Hospital committee shall include Medical Staff representation and participation.²⁶⁰ Medical Staff representatives for a Hospital committee shall be appointed by the President of the Medical Staff with input from the Chief Executive Officer or Chief Medical Officer. The purpose, functions, and scope of authority of each Hospital committee shall be described in a plan or charter, and shall be approved by the Board of Trustees. Examples of multidisciplinary Hospital committees are: Infection Control, Pharmacy & Therapeutics, Medical Records, and Surgical committees and subcommittees. Members typically include all stakeholders from multiple disciplines and all committee members have a vote. Peer review and other Medical Staff functions are not delegated to a Hospital committee.

9.4.2 EX-OFFICIO MEMBERS

The Chief Executive Officer and Chief Medical Officer shall be ex-officio members of all Medical Staff committees.²⁶¹ The Chief Executive Officer may designate another senior administrative Member to attend any meeting in his/her place. At the prerogative of the Board of Trustees, Board Member(s) may be appointed by the Board of Trustees to serve as representative(s) of the Board of Trustees on any Medical Staff committee or Hospital committee. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.

9.4.3 APPOINTMENT OF CHAIRPERSON AND MEMBERS

Within three months prior to the end of each Medical Staff year, the Medical Executive Committee shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. The Medical Executive Committee may also appoint physicians and other LIPs who are not members of the Medical Staff to be members of a standing

²⁵⁹ HCA, Ethics & Compliance Policy EC.014, Record Series Code ADM-90-09

²⁶⁰ MS.01.01.01; LD.01.05.01, MS.01.01.03, MS.02.01.01,

²⁶¹ MS.02.01.01

committee of the Medical Staff upon determination that the committee's function and operations necessitates the expertise of the non-medical staff member. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials Committee, Quality/Peer Review Committee and any other committee performing a professional review activity shall be contingent upon ratification by the Board of Trustees per Section 7.3.3 of these Bylaws. The Chief Executive Officer, in consultation with the President of the Medical Staff, shall make administrative staff appointments to a Medical Staff committee. Unless otherwise specified, administrative staff members serving on a Medical Staff committee shall not have the right to vote.

9.4.4 TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee Member shall be two (2) years. To promote continuity, an attempt will be made for approximately one half of the committee membership appointments to commence on the first day of odd-numbered Medical Staff years, and the other half to commence on even-numbered years.

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

9.4.5 NOTICE

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

9.4.6 MEETINGS

The frequency of meeting shall be specified in writing for each committee, and shall be appropriate to the duties and functions of the committee. All business meetings for all committees, subcommittees, Departments, and Divisions shall be held on the campus of the Hospital. Meetings may also be held through secure teleconference or secure web-based technology provided that off-site participants are able to view all of the documentation being presented, are able to interactively participate in the discussion, and are able to cast their vote either verbally, or through an approved alternative, i.e., web-supported secure voting system, fax, or email as approved by the Hospital.

9.4.7 QUORUM

A quorum is required for any committee to conduct a meeting. A quorum exists when a numerical majority of the appointed or elected voting members of a committee are present in person and/or by interactive telecommunications.

9.4.8 MANNER OF ACTING

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

9.4.9 ACTION THROUGH SUBCOMMITTEES

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

9.4.10 MINUTES

Each committee and subcommittee shall prepare minutes of each meeting in a format specified in Hospital policy and recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years,²⁶² after which they may be archived in any retrievable format indefinitely.

9.4.11 PROCEDURES

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

9.4.12 REPORTS

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

9.5 MEDICAL EXECUTIVE COMMITTEE

9.5.1 COMPOSITION

The Medical Executive Committee shall be a standing committee and shall be composed of fifteen (15) members, of which a majority of voting members shall be fully licensed physician members of the Medical Staff actively practicing in the Hospital.²⁶³ The membership shall include the President, the President-Elect, the Immediate Past President, the Treasurer, the Chairpersons of each Medical Staff Service Line, representation from hospital-based physician groups, the chairpersons of the remaining standing committees, the Chief Medical Officer and Chief Executive Officer. The Chief Medical Officer and Chief Executive Officer shall be ex-officio members without a vote.²⁶⁴ No Medical Staff Member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline, specialty, employment by an affiliate of the Hospital, or practice as a hospital-based physician.²⁶⁵ The President of the Medical Staff shall serve as the chairperson of the committee.

9.5.2 DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.²⁶⁶ The Medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies to address the details for describing, implementing, enforcing or otherwise carrying out the provisions contained within these Bylaws.²⁶⁷ The Medical Executive Committee shall perform or

²⁶² HCA, Ethics & Compliance Policy EC.014, Record Series Code ADM-90-09

²⁶³ MS.01.01.01; 42 C.F.R. §482.22(b)(2); MS.02.01.01

²⁶⁴ MS.02.01.01

²⁶⁵ MS.02.01.01

²⁶⁶ MS.02.01.01

²⁶⁷ MS.01.01.01

direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 9.1.1 and 9.1.2, and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

- 9.5.2.1 To provide for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board of Trustees;
- 9.5.2.2 To periodically review the Medical Staff Bylaws, Rules and Regulations and make recommended revisions thereto in order to reflect the Hospital's current policies with respect to Medical Staff organization and function;
- 9.5.2.3 Implement policies of the Medical Staff not otherwise the responsibility of the Service Lines;
- 9.5.2.4 To provide liaison and communication with all levels of Hospital governance and administration with regard to policy decisions affecting patient care services;
- 9.5.2.5 To collaborate with other leaders of the organization in Hospital planning;
- 9.5.2.6 To coordinate the activities and general policies of the various Service Lines;
- 9.5.2.7 To make recommendations to the Chief Executive Officer on matters of medico-administrative nature;
- 9.5.2.8 To make recommendations on Hospital management matters to the Medical Staff, Board of Trustees, and the Chief Executive Officer;
- 9.5.2.9 To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;
- 9.5.2.10 To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;
- 9.5.2.11 To report at each general Medical Staff meeting;
- 9.5.2.12 To review the recommendations from the Credentials Committee regarding establishment of written criteria, make recommendations from the Medical Executive Committee and forward to the Board of Trustees for final approval;
- 9.5.2.13 To review the recommendations of the Credentials Committee concerning all applications, and to make written comment to the Board of Trustees on the recommendations from the Credentials Committee regarding appointment, assignments to services, and delineation of clinical privileges;
- 9.5.2.14 To review periodically all information of Medical Staff appointees and other Practitioners with clinical privileges, including, but not limited to focused professional practice evaluation data, ongoing professional practice evaluation data, peer review information and credentialing data, and, as a result of such reviews, make recommendations for reappointments and renewal or changes to clinical privileges;
- 9.5.2.15 To take all reasonable steps to ensure professional ethical conduct and competent clinical performance on the part of all appointees of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;
- 9.5.2.16 To review the qualifications, evidence of current competence, and the recommendations of a Service Line Chairperson and the Credentials Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment, reappointment, Medical Staff category, assignment to Service Lines clinical privileges, and any disciplinary actions;
- 9.5.2.17 To organize the Medical Staff's quality assessment/performance improvement activities, including the review of the safety, effectiveness, patient-centeredness, equitability, efficiency,

and timeliness²⁶⁸ of medical and surgical care, and establishing mechanisms designed to conduct, evaluate, and revise such activities;²⁶⁹

9.5.2.18 To conduct and supervise Medical Staff professional review activities;

9.5.2.19 To receive and act on reports and recommendations from Medical Staff committees, Service Lines, and assigned activity groups, inclusive of, but not limited to reports of Medical Staff quality assessment and performance improvement activities;²⁷⁰

9.5.2.20 To fulfill the Medical Staff's accountability to the Board of Trustees for the medical care rendered to patients in the Hospital; and,

9.5.2.21 To make recommendations directly to the Board of Trustees with regard to all of the following:²⁷¹

9.5.2.21.1 The Medical Staff structure;²⁷²

9.5.2.21.2 The mechanism used to review credentials and to delineate individual clinical privileges;²⁷³

9.5.2.21.3 Recommendations of individuals for Medical Staff membership;²⁷⁴

9.5.2.21.4 Recommendations for delineated clinical privileges for each eligible individual;²⁷⁵

9.5.2.21.5 The participation of the Medical Staff in organization quality assessment, performance improvement, and patient safety activities;²⁷⁶

9.5.2.21.6 Reports regarding the Medical Staff's evaluation of the quality of patient care services provided by the Medical Staff and the Hospital;²⁷⁷

9.5.2.21.7 The mechanism by which Medical Staff membership may be terminated; and,²⁷⁸

9.5.2.21.8 The mechanism for fair hearing procedures.²⁷⁹

9.5.3 MEETINGS AND REPORTING

The Medical Executive Committee shall meet at least monthly, and shall report the activities of the Medical Staff and the Medical Executive Committee to the Board of Trustees.²⁸⁰

9.6 CREDENTIALS COMMITTEE

9.6.1 COMPOSITION

The Credentials Committee shall be composed of eleven (11) voting members who shall be active Medical Staff members in good standing. The voting membership shall include the President-Elect who shall chair the committee, Past Presidents and the current Medical Staff President. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Medical Staff Services Director.

9.6.2 DUTIES AND AUTHORITY

²⁶⁸ IOM, Crossing the Quality Chasm, six aims for improving healthcare

²⁶⁹ MS.01.01.01, MS.02.01.01, MS.05.01.01, MS.05.01.03, MS.10.01.01

²⁷⁰ MS.02.01.01

²⁷¹ MS.02.01.01

²⁷² MS.02.01.01

²⁷³ MS.02.01.01

²⁷⁴ MS.02.01.01

²⁷⁵ MS.02.01.01

²⁷⁶ MS.05.01.01, MS.05.01.03

²⁷⁷ 42 C.F.R. §482.12(a)(5); 42 C.F.R. §482.22.(b)

²⁷⁸ MS.02.01.01

²⁷⁹ MS.10.01.01

²⁸⁰ MS.02.01.01

The Credentials Committee shall perform the key function of Credentialing, as described in these Bylaws in Section 9.1.3, under the oversight and direction of the Medical Executive Committee, and with accountability to the Board of Trustees. The Credentials Committee shall review all applications for appointment, reappointment, and the granting, renewal or revision of clinical privileges and make recommendations as to whether the applicants meet the Medical Staff's criteria for membership and/or clinical privileges. In addition, the following specific functions shall be performed by the Credentials Committee:

- 9.6.2.1 Investigate the credentials of all applicants for Medical Staff appointment or clinical privileges;
- 9.6.2.2 Make recommendations to the Medical Executive Committee concerning applications for initial appointment, granting of clinical privileges, applications for reappointment, changes in clinical privileges, and changes in Medical Staff category;
- 9.6.2.3 Solicit recommendations from the clinical Service Lines concerning written criteria for the granting of clinical privileges within each Service Line. The Credentials Committee shall take such Service Line recommendations and prepare its own recommendation. Recommendations from the Credentials Committee regarding establishment of written criteria shall be forwarded to the Medical Executive Committee for their recommendations and to the Board of Trustees for final approval;
- 9.6.2.4 Determine whether a reduction in Medical Staff category for a Medical Staff member is warranted because of failure to meet the patient care requirements set forth in the Medical Staff Bylaws, or failure to meet the attendance requirements set forth in the Medical Staff Bylaws, or it is not warranted due to extraordinary circumstances;
- 9.6.2.5 Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;²⁸¹
- 9.6.2.6 Through making recommendations related to granting clinical privileges, ensure that the same quality of care is provided to patients by all individuals with delineated clinical privileges, within Medical Staff Service Lines, across Service Lines, and between members and non-members of the Medical Staff who have delineated clinical privileges;²⁸²
- 9.6.2.7 Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;²⁸³
- 9.6.2.8 Collaborate with the Advanced Practice Professionals (APP) Committee regarding questions about scope of licensure, scope of practice, sponsorship relationships, and level of supervision related to the clinical practices of physician assistants, advanced practice registered nurses and other professionals granted clinical privileges as an APP.
- 9.6.2.9 Make recommendations to the Medical Executive Committee with regard to any revisions in the process or procedures for appointment, reappointment or delineation of clinical privileges.

9.6.3 AVOIDING CONFLICT OF INTEREST

Whenever an applicant's or Medical Staff member's practice is in direct economic competition with the practice of a member of the Credentials Committee, such member of the Credentials Committee who is in direct economic competition with the Applicant or Medical Staff member shall abstain from voting during proceedings involving the applicant or Medical Staff member. Such abstention shall be recorded in the minutes of the meeting.²⁸⁴

9.6.4 MEETINGS AND REPORTING

²⁸¹ MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03

²⁸² LD.04.03.07; MS.01.01.01; LD.01.05.01

²⁸³ MS.08.01.03

²⁸⁴ Example from Healthcare Entity Bylaws and Related Documents, Second Edition, American Health Lawyers Association

The Credentials Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.²⁸⁵

9.7 PRACTITIONER HEALTH COMMITTEE

9.7.1 COMPOSITION

The Practitioner Health Committee shall be composed of at least three (3) voting members who shall be active Medical Staff members in good standing. Practitioner Health Committee members shall be selected based on their knowledge, skills and expertise in identification and management of Practitioner health issues. Practitioner Health Committee members shall be appointed by the President of the Medical Staff.

9.7.2 DUTIES

The Practitioner Health Committee shall perform the key functions of the Practitioner Health program as outlined in the Medical Staff's Practitioner Health and Wellness Policy.²⁸⁶ The Practitioner Health Committee shall:

- 9.7.2.1 Recommend education for all Medical Staff and Hospital staff regarding Practitioner health issues, including how to identify and report potential issues;
- 9.7.2.2 Develop and recommend policies for the Practitioner Health Program, such policies to include self-referral, referral by others, evaluating credibility of a reported concern, resources for evaluation, diagnosis and treatment, maintaining confidentiality, monitoring Practitioners under rehabilitation, intervening when patient safety is at risk, and taking appropriate actions;
- 9.7.2.3 Evaluate self-referrals and third party reports regarding potential Practitioner health issues;
- 9.7.2.4 Conduct investigations of potential Practitioner health issues;
- 9.7.2.5 Make recommendations for treatment and rehabilitation regarding Practitioner health issues;
- 9.7.2.6 Monitor individuals under treatment and rehabilitation for Practitioner health issues;
- 9.7.2.7 Make recommendations for reinstatement of clinical privileges following an individual's treatment and rehabilitation for Practitioner health issues.

9.7.3 MEETINGS AND REPORTING

The Practitioner Health Committee shall meet at least annually to review the Practitioner Health program and policies, and shall determine the frequency of other meetings based on frequency of activities related to reporting and monitoring Practitioner health issues.

9.8 ADVANCED PRACTICE PROFESSIONALS REVIEW COMMITTEE

9.8.1 COMPOSITION

The Advanced Practice Professionals (APP) Review Committee shall be appointed by the President of the Medical Staff and Chief Executive Officer. Permanent members of the committee shall include the Chief Medical Officer, the Chief Nursing Officer, the President of the Medical Staff or a designee, and the Medical Staff Services Director. Rotating members of the committee, depending on the type of APP being considered, shall be the relevant Medical Staff Service Line chief(s) or designee(s), hospital Service Line head(s) or nurse manager(s) of the Service Lines in which the APP would work.

9.8.2 DUTIES

²⁸⁵ MS.02.01.01

²⁸⁶ MS.11.01.01

The Advanced Practice Professionals Review Committee shall:

- 9.8.2.1 Evaluate and make recommendations to the Medical Executive Committee and the Board of Trustees regarding the need for the services that could be provided by types of APPs that are not currently permitted to practice in the Hospital;
- 9.8.2.2 Develop and recommend policies for each type of APPs permitted by the Board of Trustees to practice in the Hospital. Such policies shall specify training, education and experience requirements for applicants, the scope of practice or clinical privileges to be granted, any conditions that apply to the APP's functioning within the Hospital, any ongoing supervision requirements, and malpractice insurance requirements;
- 9.8.2.3 Review the qualifications of all APPs who apply for permission to practice in the Hospital, interview such applicants as may be necessary, and make a written report of its findings and recommendations;
- 9.8.2.4 Review on an ongoing basis the quality of care provided by APPs at the Hospital, including developing plans for focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) related to the professional practice of APPs and reviewing the data and making recommendations regarding continuation, limitation, or revocation of clinical privileges of each APP based on such data; and,
- 9.8.2.5 Review, as questions arise, all information available regarding the clinical competence and/or professional conduct of APPs currently permitted to practice in the Hospital and, as a result of such review, makes a written report of its findings and recommendations.

9.8.3 MEETINGS AND REPORTING

The Advanced Practice Professionals Review Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall make a report of its recommendations after each meeting to the Medical Executive Committee and the Board of Trustees. The chairperson of the committee shall be available to meet with the Medical Executive Committee, Board of Trustees, its committees or the Chief Executive Officer on all recommendations that the Advanced Practice Professionals Review Committee may make.

9.9 QUALITY/PEER REVIEW COMMITTEE

9.9.1 COMPOSITION

The Quality/Peer Review Committee shall be composed of voting members who shall be active Medical Staff members in good standing. The voting membership shall include three (3) active Medical Staff representatives of each of the Medical Staff Service Lines. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote may also include the Director of Quality Management and the Risk Manager. The Quality/Peer Review Committee shall also have the option of calling upon any Member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the President of the Medical Staff acting on behalf of the Medical Executive Committee and the Board of Trustees in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Section 7.3.3. Ad hoc members of the committee shall not have voting rights on the committee.

9.9.2 DUTIES AND AUTHORITY

The Quality/Peer Review Committee shall perform the key function of Quality Assessment/Performance Improvement, as described in these Bylaws in Section 9.1.4, under the oversight and direction of the Medical Executive Committee. The Quality/Peer Review Committee shall plan, implement, coordinate and promote ongoing Medical Staff leadership and participation in the Hospital's performance improvement program through the activities of the Medical Staff Service Lines,

committees with a quality review function, and other assigned activity groups, as described in the Performance Improvement Plan. Additionally, the Quality/Peer Review Committee shall ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to an individual's performance, the committee shall conduct peer review or an ongoing evaluation of the individual's competence and make recommendations accordingly.²⁸⁷ In addition, the Quality/Peer Review Committee shall perform the following specific functions:

- 9.9.2.1 Participate in an annual evaluation of the Hospital's Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program.²⁸⁸
- 9.9.2.2 Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also ensure that the activities address the scope of patient care provided and are effective by reviewing the reports of the Medical Staff Service Lines and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

9.9.3 MEETINGS AND REPORTING

The Quality/Peer Review Committee shall meet at least monthly, and shall report their recommendations and activities to the Medical Executive Committee.²⁸⁹

9.10 CONTINUING MEDICAL EDUCATION COMMITTEE

9.10.1 COMPOSITION

The Continuing Medical Education Committee shall be composed of voting members who shall be active Medical Staff members in good standing. The voting membership shall include two active Medical Staff members from each Service Line. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include the Medical Staff Services Coordinator and/or the Continuing Medical Education Coordinator.

9.10.2 DUTIES AND AUTHORITY

The Medical Education Committee shall perform the key function of Continuing Medical Education, as described in these Bylaws in Section 9.1.5, under the oversight and direction of the Medical Executive Committee. The Continuing Medical Education Committee shall plan, implement, coordinate and promote ongoing clinical and scientific education programs for Medical Staff members and other individuals with clinical privileges. In addition, the committee shall perform the following specific duties:

- 9.10.2.1 Establish liaison with the quality assessment and performance improvement program to identify the need for education based on the findings from the program;²⁹⁰
- 9.10.2.2 Assist in prioritizing plans for hospital-sponsored education;²⁹¹
- 9.10.2.3 Ensure provision of any required Medical Staff education, including:
 - 9.10.2.3.1 Education about illness, impairment, and health issues specific to physicians and other individuals with clinical privileges;²⁹²

²⁸⁷ MS.05.01.03; 42 C.F.R. §482.22(a)(1)

²⁸⁸ LD.03.03.01; LD.03.05.01; LD.04.04.01; PI.03.01.01

²⁸⁹ MS.02.01.01

²⁹⁰ MS.12.01.01

²⁹¹ MS.12.01.01

²⁹² MS.11.01.01

- 9.10.2.3.2 Education about safety and quality, including unprofessional or inappropriate conduct and its potential impact on patient safety;²⁹³
- 9.10.2.3.3 Central line–associated bloodstream infections and the importance of prevention;²⁹⁴
- 9.10.2.3.4 Education regarding anticoagulation therapy safety to those who prescribe;²⁹⁵
- 9.10.2.3.5 Health care–associated infections, multidrug-resistant organisms, and prevention strategies;²⁹⁶
- 9.10.2.3.6 Surgical site infections and the importance of prevention;²⁹⁷
- 9.10.2.3.7 Education about assessing and managing patients with pain.²⁹⁸
- 9.10.2.3.8 At a minimum, education about the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza;²⁹⁹
- 9.10.2.3.9 Education that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission;³⁰⁰
- 9.10.2.3.10 Education regarding a Practitioner’s role(s) in emergency response and to whom he or she reports during an emergency;³⁰¹
- 9.10.2.3.11 Education for Licensed Independent Practitioners who perform waived testing;³⁰²
- 9.10.2.3.12 Education regarding minimizing, eliminating and reporting environmental risks;³⁰³
- 9.10.2.3.13 Alternative procedures to follow when electronic information systems are unavailable;³⁰⁴

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

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

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

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

9.10.2.8 Provide liaison and oversee the affiliation with any graduate medical education programs, including overseeing the safety and quality of care provided by program participants, and related educational and supervisory needs.³⁰⁵

9.10.3 MEETINGS AND REPORTING

The Medical Education Committee shall meet at least quarterly, and shall report their recommendations and activities to the Medical Executive Committee.³⁰⁶ The Medical Education Committee shall communicate periodically with the Medical Executive Committee and the Board of

²⁹³ LD.03.01.01

²⁹⁴ NPSG.07.04.01

²⁹⁵ NPSG.03.05.01

²⁹⁶ NPSG.07.03.01

²⁹⁷ NPSG.07.05.01

²⁹⁸ MS.03.01.03

²⁹⁹ IC.02.04.01

³⁰⁰ APR.09.02.01

³⁰¹ EM.02.02.07

³⁰² WT.03.01.01

³⁰³ EC.03.01.01

³⁰⁴ IM.01.01.03

³⁰⁵ MS.04.01.01

³⁰⁶ MS.02.01.01

Trustees about the educational needs and performance of the participants in professional graduate education programs.³⁰⁷

9.11 BYLAWS COMMITTEE

9.11.1 COMPOSITION

The Bylaws Committee shall be composed of active Medical Staff members in good standing with a vote who are appointed by the President of the Medical Staff. The voting membership shall include the Immediate Past President who shall chair the committee, the President-Elect, and active Medical Staff Member(s) from each Service Line selected by the President of the Medical Staff. In addition to the Chief Executive Officer and the Chief Medical Officer, the ex-officio members without vote shall also include Medical Staff Services personnel appointed by the Chief Executive Officer.

9.11.2 DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in Section 9.1.6, under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws, the Rules and Regulations, and Medical Staff Policies with associated detail, and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all Service Line rules and regulations.

9.11.3 MEETINGS AND REPORTING

The Bylaws Committee shall meet at least annually, and shall report their recommendations and activities to the Medical Executive Committee.³⁰⁸

9.12 MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING COMMITTEE

9.12.1 COMPOSITION

The Medical Staff Leadership Development & Nominating Committee shall be composed of voting members who shall be active Medical Staff members in good standing appointed by the President of the Medical Staff. The voting membership shall include the President who shall chair the meeting, the Immediate Past President, and at least two (2) Service Line members and two (2) Past Presidents, whenever possible. The Chief Executive Officer and the Chief Medical Officer shall serve as ex-officio members without vote. No candidate for election may serve as a Member of the Medical Staff Leadership Development & Nominating Committee.

9.12.2 DUTIES AND AUTHORITY

The Medical Staff Leadership Development & Nominating Committee shall perform the key function of Medical Staff Leadership Development & Nominating, as described in these Bylaws in Section 9.1.7, under the oversight and direction of the Medical Executive Committee. The Medical Staff Leadership Development & Nominating Committee shall define desired leadership characteristics, identify and recruit future potential Medical Staff leaders from among the Active Medical Staff members of the Medical Staff, and shall advise the Chief Executive Officer, the Chief Medical Officer, and the Medical Executive Committee of the education and development needs of potential Medical Staff leaders so as to be successful in future roles. The Medical Staff Leadership Development & Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

9.12.3 MEETINGS AND REPORTING

³⁰⁷ MS.04.01.01, LD.01.03.01

³⁰⁸ MS.02.01.01

The Medical Staff Leadership Development & Nominating Committee shall meet at least every six months, and shall report their recommendations and activities to the Medical Executive Committee.³⁰⁹

³⁰⁹ MS.02.01.01

10 ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF YEAR

The Medical Staff year shall be the period from July 1 to June 30 of each year.

10.2 MEDICAL STAFF MEETINGS

10.2.1 REGULAR MEETINGS

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

10.2.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at the direction of the President of the Medical Staff and shall be called by the President at the request of the Medical Executive Committee or any ten members of the active Medical Staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the written notice or as otherwise expressly authorized in these Bylaws.

10.3 SERVICE LINE MEETINGS

10.3.1 REGULAR MEETINGS

Regular meetings of each Service Line shall be held at least quarterly, or more frequently as necessary to perform the functions of Service Lines as specified in Article Eight of these Bylaws.

10.3.2 SPECIAL MEETINGS

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

10.4 ATTENDANCE REQUIREMENTS

10.4.1 GENERALLY

Active Medical Staff members shall be required to attend twenty-five percent (25%) of the meetings of the Service Line to which they are assigned, and the annual general Medical Staff meeting. Attendance shall be considered at the time of reappointment when evaluating whether a Member has met the obligations associated with Medical Staff membership.

10.4.2 SPECIAL APPEARANCES

A Medical Staff Member or other individual with clinical privileges may be required to attend a meeting of a Medical Staff Committee for purposes of conducting peer review. Following receipt of proper notice of such an attendance requirement, failure to attend may be grounds for suspension, termination, or other actions on Medical Staff membership or clinical privileges.

10.5 MEETING PROCEDURES

10.5.1 NOTICE OF MEETINGS

Notice of the date, time and place of the annual Medical Staff meeting shall be given not less than seven (7) days nor more than thirty-one (31) days prior to a regular meeting, and not less than three (3) days prior to a special meeting of the general Medical Staff by written notice delivered personally or sent by facsimile or electronic mail to each Member of the active Medical Staff at his/her business address as shown in Medical Staff records. The Medical Executive Committee or the President of the Medical Staff may send notice to members of other categories of the Medical Staff, the Chief Executive

Officer, members of Administration and others. If mailed, notice shall be deemed to be delivered when deposited in the United States mail, postpaid.

Notice to a Medical Staff Member or other individual with clinical privileges who is being required to attend a meeting for quality review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

10.6 QUORUM

10.6.1 GENERAL MEDICAL STAFF MEETINGS

At least one-third of the active Medical Staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff meeting, except if less than such a number is present, a majority of the active Medical Staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

10.6.2 SERVICE LINE MEETINGS

At least one-third of the active Medical Staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff Service Line meeting, except if less than such a number is present, a majority of the active Medical Staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

10.7 MANNER OF ACTION

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

10.8 VOTING RIGHTS

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

10.9 RIGHTS OF EX-OFFICIO MEMBERS

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

10.10 MINUTES

Medical Staff Services employees, or designees, shall prepare minutes of each meeting of the Medical Staff and each committee of the Medical Staff which shall include a record of attendance and the vote taken on each matter. Minutes shall be approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Service Line Chairperson shall ensure that minutes are prepared for their respective Service Line meetings.

10.11 PROCEDURAL RULES

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

11 ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASE

11.1 AUTHORIZATIONS AND CONDITIONS

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

11.2 CONFIDENTIALITY OF INFORMATION

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

11.3 BREACH OF CONFIDENTIALITY

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

11.4 PRIVILEGES AND IMMUNITIES FROM LIABILITY

The Board of Trustees, any committees of the Medical Staff and/or of the Board of Trustees who conduct Professional Review Activities and any individuals within the Hospital authorized to conduct Professional Review Activities, hereby constitute themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said federal and state statutes. Any action taken by a Professional Review Body pursuant to these Medical Staff Bylaws shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any Applicant or Medical Staff Appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.³¹⁰

There shall, to the fullest extent permitted by law, absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from, nor shall any legal action be commenced with respect to any such act, communication, report,

³¹⁰ Example from [Healthcare Entity Bylaws and Related Documents](#), Second Edition, American Health Lawyers Association

recommendation, or disclosure. Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

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

11.5 RELEASES

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

11.6 SEVERABILITY

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

11.7 NONEXCLUSIVITY

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

12 ARTICLE TWELVE: ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

12.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Board of Trustees shall require the Medical Staff to adopt and enforce Bylaws to carry out its Medical Staff functions.³¹¹ The Board of Trustees shall require that the Medical Staff Bylaws, Rules & Regulations, and policies comply with local, State and Federal law and regulations, and the requirements of the Medicare hospital Conditions of Participation, and applicable accreditation standards.³¹² Medical Staff Rules and Regulations and Policies may contain the associated detail for provisions in the Medical Staff Bylaws. “Associated details” are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.³¹³

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Policies and the Board of Trustees shall uphold the Medical Staff Bylaws that have been approved by the Board of Trustees.³¹⁴

12.2 EXCLUSIVE MECHANISM

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

12.3 ADOPTION AND APPROVAL OF MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, AND POLICIES

Subject to approval by the Board of Trustees, the Medical Staff shall adopt Bylaws governing the organization, operation and self-discipline of the Medical Staff and such Rules and Regulations as may be necessary to implement the general principles found within such Bylaws, to promote the delivery of quality health care within the Hospital and to provide for the efficient operation of the Hospital. Each appointee to the Medical Staff shall exercise his or her clinical privileges within the Hospital subject to the provisions contained within such Bylaws and Rules and Regulations and further subject to the policies, procedures and directives of the Board of Trustees and any restrictions or limitations attached to his or her appointment or clinical privileges.³¹⁵

12.3.1 MEDICAL STAFF BYLAWS

Upon the request of the Medical Executive Committee, or the President of the Medical Staff, or the Bylaws Committee following approval by the Medical Executive Committee, consideration shall be given to the adoption, amendment, or repeal of these Bylaws. Amendments may also be proposed by any clinical Service Line, any Medical Staff committee, or by a petition signed by ten active Medical Staff members. If the proposed revision is made by the Medical Executive Committee, the Medical Executive Committee shall first communicate the revision via notice of the proposed change all Active Staff members to each member’s email address of record no less than thirty (30) days prior to conducting the vote.³¹⁶ If the proposed revision is made by clinical Service Line, any Medical Staff committee, or by a written petition of voting members of the Medical Staff, the Medical Staff members shall first communicate the revision via written notice of the proposed change to all members of the Medical Executive Committee no less than thirty (30) days prior to conducting the vote.³¹⁷ The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). Such action shall be taken at a regular or special meeting of the Medical Staff, provided that written notice of the proposed change was sent to all Members of the Active or Affiliate Staff no less than twenty (20) days prior to the meeting at which the Bylaws changes are to be voted upon. The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). If a quorum is present for the purpose of enacting a bylaw change, the

³¹¹ 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c)

³¹² 42 C.F.R. §482.12(a)(3), Interpretive Guidelines

³¹³ MS.01.01.01

³¹⁴ 42 C.F.R. §482.12(a)(3), 42 C.F.R. §482.22(c), MS.01.01.01

³¹⁵ Example from [Healthcare Entity Bylaws and Related Documents](#), Second Edition, American Health Lawyers Association

³¹⁶ MS.01.01.01

³¹⁷ MS.01.01.01

change shall require an affirmative vote of greater than fifty percent (50%) of the Members voting in person or by written ballot. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff Members shall be provided with a revised text.³¹⁸

Neither the Board of Trustees nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations, except as set forth below.³¹⁹ As required by the Medicare Conditions of Participation and other regulatory requirements, the Board of Trustees shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff.³²⁰

12.3.2 RULES & REGULATIONS AND MEDICAL STAFF POLICIES

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

12.3.2.1 Medical Staff Rules and Regulations and Medical Staff Policies: Subject to approval by the Board of Trustees, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Medical Staff Policies as may be necessary to implement these Bylaws, including, but not limited to the Policies appended to these Bylaws. The Medical Staff also has the ability to adopt Rules and Regulations and Medical Staff Policies and any amendments thereto by obtaining a written petition signed by at least ten active members of the Medical Staff. The Rules and Regulations and Medical Staff Policies proposed by petition shall then be communicated to the Medical Executive Committee and shall be subject to final approval of the Board of Trustees. The Rules and Regulations and Medical Staff Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Medical Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Medical Staff Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

In the event of a documented need for an urgent amendment of the Medical Staff Rules and Regulations or Medical Staff Policies to comply with law or regulation or accreditation standards, the Medical Executive Committee may provisionally adopt, and the Board of Trustees may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Medical Executive Committee of the urgent amendment within ten (10) days after the Board of Trustees has approved the amendment. The voting members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the Medical Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management shall be implemented, and a revised amendment shall be submitted to the Board of Trustees if necessary.³²¹

12.3.2.2 Service Line Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board of Trustees, each Service Line shall formulate its own Service Line Rules and Regulations and Policies for the conduct of its affairs and the discharge of its responsibilities. The members of the Service Line may also propose Service Line Rules and Regulations and Policies and any amendments thereto directly to the Board of Trustees after first communicating the proposal to the Medical Executive Committee and such proposal shall be subject

³¹⁸ MS.01.01.01, MS.02.01.01, LD.03.04.01

³¹⁹ MS.01.01.03

³²⁰ 42 C.F.R. §482.12

³²¹ MS.01.01.01

to final approval of the Board of Trustees. Such Service Line Rules and Regulations and Policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Policies of the Medical Staff or other policies of the Hospital and shall not conflict with the Governance Bylaws of the Board of Trustees.

12.4 TECHNICAL AND EDITORIAL AMENDMENTS

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

12.5 GENERAL PROVISIONS

12.5.1 GOVERNING LAW

These Medical Staff Bylaws shall be governed by, and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Colorado Peer Review Statute, and to the extent not so governed, with the other laws of the State of Colorado without giving effect to its conflict of laws principles.³²²

12.5.2 PRIORITY BETWEEN HOSPITAL BYLAWS AND MEDICAL STAFF BYLAWS

At all times and concerning all matters, The Hospital's Governance Bylaws take precedence over the Medical Staff Bylaws and rules and regulations of the Medical Staff.³²³

12.5.3 SUCCESSOR IN INTEREST

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

12.5.4 AFFILIATIONS

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

12.5.5 NONDISCRIMINATION

No person shall be denied appointment, clinical privileges, or any of the rights of membership simply on the basis of race, creed, color, religion, gender, sexual orientation, gender identity/expression, disability, age, veteran status, political belief or affiliation, ancestry, or national or ethnic origin.³²⁴

12.5.6 NO IMPLIED RIGHTS

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

³²² Example from [Healthcare Entity Bylaws and Related Documents](#), Second Edition, American Health Lawyers Association

³²³ Example from [Healthcare Entity Bylaws and Related Documents](#), Second Edition, American Health Lawyers Association

³²⁴ LD.04.01.01

12.5.7 NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

12.5.8 NO CONTRACT INTENDED

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

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

12.5.9 CONFLICT OF INTEREST

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

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

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

12.5.9.3 The fact that a Service Line Chairperson or Medical 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 Medical Staff member has a right to compel disqualification of another Medical Staff member based on an allegation of conflict of interest.

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

12.5.10 NO AGENCY

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

12.5.11 CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

12.5.12 CONFLICT MANAGEMENT/RESOLUTION

12.5.12.1 CONFLICTS BETWEEN THE BOARD OF TRUSTEES AND THE MEDICAL EXECUTIVE COMMITTEE³²⁵

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

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

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

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

³²⁵ MS.01.01.01; LD.02.04.01

of Trustees shall have the authority to act unilaterally on the issue that gave rise to the conflict.

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

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

12.5.12.2 CONFLICTS BETWEEN THE MEDICAL STAFF AND THE MEDICAL EXECUTIVE COMMITTEE³²⁶

The Medical Executive Committee, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendations to the Medical Executive Committee with a written petition signed by at least ten percent (10%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. The Medical Staff representing the Medical Staff's recommendations as set forth in the petition may also communicate directly with the Board of Trustees regarding the conflicting recommendations.³²⁷ If these informal discussions fail to resolve the conflict, the President of the Medical Staff, the dissenting representatives of the Medical Staff, or the Chairperson of the Board of Trustees may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

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

- Three officers of the Medical Staff
- Three voting members of the Medical Staff representing the recommendations in the written petition
- The Chairperson of the Board of Trustees
- The Chief Executive Officer or designee

If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the Medical Executive Committee and the Medical Staff within 30 days of the initial meeting, the Medical Executive Committee and the Medical Staff shall enter into mediation facilitated by an outside party. The Medical Executive Committee and the three voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in

³²⁶ MS.01.01.01

³²⁷ MS.01.01.01, EP 10

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

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

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

12.5.13 ENTIRE BYLAWS

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

13 CERTIFICATION OF ADOPTION AND APPROVAL

Approved and Adopted by the Medical Staff of The Medical Center of Aurora/Centennial Medical Plaza on December 10, 2013.

SIGNED: Joseph Forrester, MD
PRESIDENT OF THE MEDICAL STAFF

Approved and Adopted by the Board of Trustees of HealthONE on February 13, 2014.

SIGNED: John McWilliams
CHAIRPERSON OF THE BOARD OF TRUSTEES

14 APPENDICES

- 14.5 DEFINITIONS
- 14.6 MEDICAL STAFF POLICY ON LEAVE OF ABSENCE
- 14.7 MEDICAL STAFF POLICY ON OVERSIGHT OF INDIVIDUALS IN A GRADUATE PROFESSIONAL EDUCATIONAL PROGRAM
- 14.8 MEDICAL STAFF POLICY ON PRACTITIONER HEALTH AND WELLNESS
- 14.9 MEDICAL STAFF POLICY ON PROFESSIONAL CONDUCT
- 14.10 MEDICAL STAFF POLICY ON PROFESSIONAL PRACTICE EVALUATION (PENDING)
- 14.11 MEDICAL STAFF POLICY ON PEER REVIEW (PENDING)