CANYON VISTA
MEDICAL CENTER

Medical Staff Bylaws

CANYON VISTA MEDICAL CENTER
MEDICAL STAFF BYLAWS

I N D E X

MEDICAL STAFF BYLAWS

OF

CANYON VISTA MEDICAL CENTER

P R E A M B L E

WHEREAS, Canyon Vista Medical Center, hereinafter referred to as "Hospital," is operated by RCHP-Sierra Vista, Inc., hereinafter referred to as "Corporation," a private corporation organized under the laws of the state of Arizona and is lawfully doing business in Arizona, and is not an agency or instrumentality of any state, county, or federal government; and

WHEREAS no provider is entitled to membership and/or privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS the Medical Staff and Allied Health Professional Staff must cooperate with and are subject to the ultimate authority and direction of the Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff and Allied Health Professional Staff, management and the Board of Trustees are necessary to fulfill these goals.

NOW, THEREFORE, the practitioners practicing in Canyon Vista Medical Center hereby organize themselves into a Medical Staff conforming to these bylaws.

D E F I N I T I O N S

1. **"Active Staff"** members shall be those practitioners (DO's, MD's, and DPM) licensed in the state of Arizona that have the privilege of admitting patients, holding office and voting.

2. **"Allied Health Professional"** ("AHP") means an individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care per State licensure and who have been afforded privileges within their scope of practice to provide such care in the Hospital. Such AHPs include "Dependent AHPs," who are sponsored by and/or supervised or have a collaborating practitioner, and "Licensed Independent AHPs," granted appropriate privileges and permitted by law and by the Hospital to practice independently. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

3. **"Board"** means the Board of Trustees of Canyon Vista Medical Center.

4. **"Board Certification or Board Certified"** Is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS); the Bureau of Osteopathic Specialists certifying boards of the American Osteopathic Association (AOA); the American Board of Oral and Maxillofacial Surgery, The American Board of Podiatric Medicine (ABPM), the American Board of Podiatric Surgery (ABPS); the American Board of Foot and Ankle Surgery (ABFAS);the Royal College of Physicians and Surgeons of Canada (RCPSC); the American Dental Association (ADA), Oral and Maxillofacial surgeon, or for an Allied Health Professional, the designation conferred by a certifying body approved by the Hospital and accepted by the MEC and Board. The National Board of Physicians & Surgeons (NBPAS) may be used for recertification if initial certification was granted by one of the Member Boards of the ABMS or the Bureau of Osteopathic Specialists certifying boards of the AOA. For podiatrists, board certification shall mean certification of the American Board of Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or the American Board of Foot and Ankle Surgery (ABFAS). For dentists, board certification shall mean certification by the American Board of Oral/Maxillofacial Surgeons (ABOMS).

5. **"Chief Executive Officer"** ("CEO") means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

6. **"Chief Medical Officer"** ("CMO") means a physician member of the Senior Executive Team who acts as a liaison between the medical staff and management of the Hospital.

7. **"Chief of Staff"** means a member of the Active Medical Staff who is duly elected in accordance with these bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

8. **"Clinical Privileges"** means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of these bylaws.

9. **"Complete"** means in the context of an Application for Membership or Clinical Privileges that all questions presented to the applicant have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. A complete application for membership or clinical privileges will become incomplete if the need arises for new, additional, or clarifying information at any time.

10. **"Corporation"** means RCHP-Sierra Vista, Inc.

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

12. **"Days"** means calendar days

13. **"Dentists"** means a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD)

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

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

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

17. **"Good Standing"** means a practitioner who continues to meet all eligibility criteria and other qualifications for initial and renewed Medical Staff Membership and Clinical Privileges.

18. **"HCQIA"** means the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq.

19. **"Hospital"** means Canyon Vista Medical Center.

20. **"Medical Executive Committee"** ("MEC") means the Executive Committee of the Medical Staff.

21. **"Medical Staff"** or "**Organized Medical Staff"** means the body of the medical staff comprised of all physicians, dentists, oral maxillofacial surgeons who have been granted membership to the Medical Staff by the Board.

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

23. **"Medical Staff Year"** means the period from July 1st to June 30th each calendar year.

24. **"Member"** means any practitioner who has been granted initial or renewed membership in the Medical staff by the Board.

25. **"Notice"** means written communication by regular U.S. mail, email, facsimile, Hospital mail, or hand delivery.

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

27. **"Practitioner"** means a physician, dentist, or podiatrist who has been granted clinical privileges and/or Medical Staff membership at the Hospital.

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

29. **"Special Notice"** means a written notice sent by mail, certified mail (return receipt requested), overnight delivery service providing a receipt of delivery, or delivered by hand with a written acknowledgment of receipt.

30. **"Supervising/Collaborating Practitioner"** means a Practitioner with clinical privileges who has agreed in writing and has been approved by the appropriate licensure board to supervise or collaborate with an Allied Health Professional and to accept full responsibility for actions of the AHP while s/he is practicing in the Hospital.

31. **"Supervision"** means the supervision of (or collaboration with) an AHP by a supervising/collaborating practitioner, that may or may not require the actual presence of the supervising/collaborating practitioner, but that does require, at minimum, that the supervising/collaborating practitioner be readily available for consultation.

32. **"Telemedicine"** means the practice of medicine through the use of communication technologies to support clinical care at a location remote from the Hospital**.**

ARTICLE I - NAME

The name of this organization shall be the Medical Staff of Canyon Vista Medical Center.

ARTICLE II - PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

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

2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients.

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

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review, and evaluation of each practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs.

2.1(e) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill.

2.1(f) To promulgate, maintain and enforce bylaws and rules and regulations for the proper functioning of the Medical Staff.

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

2.1(h) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences.

2.1(i) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO; and

2.1(j) To accomplish its goals through appropriate committees and departments.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

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

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements.
(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted.
(3) Provide and participate in continuing medical education programs addressing issues of QAPI and including the types of care offered by the Hospital.
(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan.
(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPs.
(6) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted.
(7) Develop, administer, and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care.
(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment.
(9) Ensure that the functions delineated in these Bylaws are performed by appropriate standing or ad hoc committees of the Medical Staff; and
(10) Implement a process to identify and manage matters of individual provider health that is separate from the Medical Staff disciplinary function in accordance with the Provider Wellness Policy, which is incorporated herein and attached to these bylaws.
(11) Assisting the Board in maintaining the accreditation status of the Hospital.
(12) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

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

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

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

ARTICLE III - MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital and is not a right of any person. Membership on the Medical Staff or the exercise of privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws.

Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless s/he has been granted appropriate privileges to do so.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF MEDICAL STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in Arizona, who continuously

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital.
(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities.
(3) Comply and have complied with federal, state, and local requirements, if any, for their medical practice, and are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital, as determined by the MEC and Board.
(4) Have professional liability insurance in amounts not less than $1m/$3m.
(5) Are graduates of an approved educational institution holding appropriate degrees.
(6) Have successfully completed an approved residency program or the equivalent where applicable.
(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession.
(8) Show evidence of the following educational achievements: Relevant documentation for additional training specific to their board-certified specialty or the specialty they have been granted privileges to practice at the Hospital. The education should be related to the physician's specialty and to the provision of quality patient care in the Hospital; and
(9) Meet the following requirement, in addition to those listed above:

Board certification or board eligibility sufficiently related to the privileges sought.
Applicants are required to become board certified in the specialty in which they are seeking privileges, by an ABMS, AOA, ABPM, ABFAS or RCPSC recognized board, within the time frame required by their specialty board, not to exceed five (5) years from their first date of eligibility. Applicants who do not achieve board certification within this time frame will be automatically suspended and will not be eligible for reappointment. Any Active staff member who is not board certified by the adoption of these bylaws, shall attain board certification within five (5) years of acceptance of these bylaws on March 24, 2021

The above requirement shall not apply to any practitioner already a member of the Medical Staff as of April 2008.

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

(11)Practice in such a manner as not to interfere with the orderly and efficient rendering of services by the Hospital or by other practitioners within the hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, color, religion (creed), gender, gender expression, age, national origin (ancestry), marital status, or disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

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

3.3 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each member of the Medical Staff shall:

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

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization.

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies, and Rules & Regulations of the Medical Staff.

3.3(d) Discharge the staff, department, committee, and hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise.

3.3(e) Cooperate with other members of the Medical Staff, management, the Board of Trustees, and employees of the Hospital.

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital, including use of Computerized Physician Order Entry as required by the Rules and Regulations.

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

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

3.3(i) Abide by the ethical principles of his/her profession and specialty.

3.3(j) Refuse to engage in improper inducements for patient referral.

3.3(k) Notify the CEO or designee, and Chief of Staff within seven (7) days if:

(1) His/Her professional licensure in any state is investigated, suspended, sanctioned, modified revoked, relinquished, restricted or put-on probation after an investigation of competence, professional conduct, or patent care activities has commenced or in order to avoid such investigation, and including receipt of a sanction or notice of intent to sanction.
(2) His/Her professional liability insurance is modified or terminated.
(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or
(4) He/She has been excluded from any federal or state health program, including Medicare and Medicaid.
(5) His/her specialty board certification is surrendered or is revoked.
(6) He/She voluntarily or involuntarily relinquishes his/her national Drug Enforcement Agency (DEA) number or state licensure certificate.
(7) He/She has either voluntarily or involuntarily participated or is currently participating in any rehabilitation or impairment program or has ceased participation in such a program without successful completion.
(8) He/She has any criminal charges, other than minor traffic violations, brought or initiated against him/her, and any guilty pleas or convictions entered.
(9) There has been limitation, reduction, suspension, revocation, restriction, relinquishment, or loss of membership or clinical privileges on any Medical Staff after an investigation of competence, professional conduct, or patient care activities has commenced or in order to avoid such investigation, and including receipt of a sanction or notice of intent to sanction from any peer review or professional review body);
(10) He/She is subject to any current, pending, investigation or challenge to licensure, DEA certification, medical staff membership, or clinical privileges at any health care facility, or participation in any federal or state insurance program.
(11) His/Her professional licensure in any state, specialty board certification, or membership or clinical privileges on any Medical Staff are voluntarily relinquished, resigned, or allowed to expire where no investigation of competence, professional conduct, or patient care activities has commenced or is imminent and the relinquishment, resignation, or expiration is not done in order to avoid such investigation.

Failure to provide any such notice required in (1) through (10) above shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

Failure to provide any such notice required in (11) above shall result in automatic suspension of Medical Staff membership and clinical privileges, without right of fair hearing procedures, until such time as the

entity responsible for the practitioner's licensure, certification, membership, or privileges in question confirms in writing to the CEO or designee and Chief of Staff that no investigation of competence, professional conduct, or patient care activities had commenced or was imminent and the relinquishment, resignation, or expiration was not done in order to avoid such investigation, and the MEC takes action thereon. Failure to provide such notice shall also constitute grounds for corrective action pursuant to Article VIII and grounds for denial of reappointment,

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

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

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times.

The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

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

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

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

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible

disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

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

3.4 HISTORY AND PHYSICAL EXAMINATIONS

A medical history and physical examination must be completed and documented by a licensed practitioner or AHP. A history and physical examination for each patient must be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An H&P is required prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care.

When the history and physical examination is conducted within thirty (30) days before admission or registration, an update must be completed and documented by a licensed practitioner or AHP who is credentialed and privileged by the Medical Staff to perform a history and physical examination. An updated examination of the patient, including any changes in the patient's condition, must be completed, and documented within twenty-four (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 thirty (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 physician (as defined in Section 1861(r) of the Act) an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital policy.

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

If the history and physical and/or updates are completed by an AHP, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high-risk procedures.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient as clinically indicated to include:

(a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient's own words.
(b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints.
(c) medications, including both prescribed and over the counter remedies.
(d) allergies and intolerances, including a description of the effects caused by each agent.

(e) past medical and surgical history.
(f) review of systems to include health maintenance/immunization history.
(g) family history and social history as indicated, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges.
(h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system.
(i) diagnostic data that is either available or pending at the time of admission.
(j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and
(k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

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

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit must be performed no later than thirty (30) minutes after admission or sooner if warranted by the patient's condition.

3.5 DURATION OF APPOINTMENT

3.5(a) Duration of Initial Appointments

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

3.5(b) Reappointments

Reappointment to the Medical Staff or Allied Health Professional Staff shall be for a period not to exceed two (2) years.

3.5(c) Modification in Staff Category & Clinical Privileges

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

3.5(d) Declaration of Moratorium

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

thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

3.6 LEAVE OF ABSENCE

Licensed Independent Practitioners (LIPs) and Allied Health Practitioners (AHP) who are credentialed and privileged to provide professional healthcare services within the facility.

3.6(a) REQUEST FOR GRANTING OF LEAVE OF ABSENCE

(1) Medical Staff Members and Allied Health Professional Staff Members, with clinical privileges, may request a voluntary leave of absence for a period of not less than sixty (60) days nor to exceed one year by submitting a written request using the approved LOA form to the Chief of Staff, the Chief Medical Officer, the Department Chair, or Chief Executive Officer or designee. The written request must state the proposed beginning date and proposed ending date for the period of leave desired (not to exceed one year) and include the reasons for the request. The proposed length of LOA shall be appropriate and reasonable based on the reasons for the LOA. The LIP or AHP will provide information as to who will cover his/her patients while on leave. The Chief of Staff, Department Chair, the Chief Medical Officer, or the Chief Executive Officer or designee will present the request to the Medical Staff Office for Committee review.

(2) A leave of absence may be granted for the following reasons:

a. **Medical Leave of Absence:** Medical Staff Members and Allied Health Professional Staff, with clinical privileges must report to the Chief of Staff, Department Chair, or Chief Executive Officer or their delegate any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days when the reason for such absence is related to their physical or mental health or their ability to care for patients safely and competently. Individuals may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or health issue. If an individual is unable to request a medical leave of absence because of a physical or psychological condition or health issue, the Chief of Staff, or Chairperson of the individual's department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action.

b. **Military Leave of Absence:** Medical Staff Members and Allied Health Professional Staff Members with clinical privileges may request and be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist must submit a copy of deployment orders. Individuals who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

c. **Educational Leave of Absence:** Medical Staff Members and Allied Health Professional Staff with clinical privileges, or AHP with clinical privileges may request and be granted a leave of absence to pursue additional education and training. Requests must be made thirty (30) days prior to anticipated date of leave. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with this policy.

d. **Personal/Family Leave of Absence:** A Medical Staff Member, LIP with clinical privileges, or AHP with clinical privileges may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor such as contributing work to "Doctors Without Borders/USA") or family reasons (e.g., maternity leave, leave to care for a family member).

Requests must be made thirty (30) days prior to anticipated date of leave. Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

(3) The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Trustees, but in extenuating circumstances, such as military leave, the Chief Executive Officer, the Chief Medical Officer, and Chief of Staff have the authority to approve a leave of absence and their actions will be reported to the Medical Executive Committee and Board of Trustees.
(4) During the period of leave, the individual must not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities (e.g., meeting attendance, committee service, and emergency service call obligations) will be in abeyance.
(5) When the reasons for the leave of absence indicate that the leave is optional, the request will be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the individual requesting the leave.
(6) The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records. Exceptions shall be allowed only in the event that an individual has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters.

3.6(b) <u>REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE</u>

(1) The Medical Staff Member, LIP with clinical privileges or AHP with clinical privileges who is on leave of absence must request reinstatement of Medical Staff membership and/or clinical privileges by submitting a written request using the approved Request for Return from LOA form to the Chief of Staff, the Chief Medical Officer, the Department Chair, or Chief Executive Officer or designee. This request must be received not less than 30 days prior to expiration of the leave of absence. The request will be forwarded to the Medical Staff Office for committee review.
(2) The written request for reinstatement must include an attestation that no changes have occurred in the status of any of required credentials, or if changes have occurred, a detailed description of the nature of the changes. The individual must submit a summary of relevant activities during the leave, which shall include, but is not limited to, the scope and nature of professional practice during the leave period and any professional training completed.
(3) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. If the medical leave of absence was for purposes of treatment for a health issue, then the conditions of reinstatement shall require compliance with the Medical Staff policy addressing practitioner health issues.
(4) If the leave of absence has extended past the individual's reappointment/privilege renewal time, he/she will be required to submit an application for reappointment and/or renewal of clinical privileges. The request for reappointment will be submitted to the individual's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials Committee. The Credentials Committee will make a recommendation and forward it to the Medical Executive Committee. The Medical Executive Committee will forward a recommendation to the Board for approval. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff

category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges.

(5) An adverse decision regarding reinstatement of Medical Staff membership or renewal of any clinical privileges held prior to the leave will entitle the individual to a fair hearing and appeal as provided in the Medical Staff Bylaws. However, an untimely request for reinstatement shall not entitle the individual to the hearing and appeal rights.

(6) Absence for longer than the approved period of the leave of absence will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless the individual submits a written request for an extension of the leave of absence not less than 30 days before expiration of the leave of absence, and the extension is granted by the Chief of Staff or Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(7) Failure to request reappointment during a leave of absence will result in automatic relinquishment of Medical Staff appointment and clinical privileges and shall not afford the practitioner hearing and appeal rights.

(8) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the request for a leave of absence will result in automatic relinquishment of Medical Staff appointment and clinical privileges and the determination will be final, with no rights to a hearing and appeal as prescribed by the Medical Staff Bylaws.

3.6(c) If the staff member's period of appointment ends while the member is on leave, s/he must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for application for initial and re-appointment. Failure to request reappointment before the appointment period ends shall result in automatic termination of staff membership, privileges, and prerogatives without right of hearing or appellate review.

3.6(d) Failure to request reinstatement from the LOA in a timely manner shall result in automatic termination of staff membership.

3.6(e) Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action and shall not be reported to the National Practitioner Data Bank unless required by law.

3.7 RESIGNATIONS

Medical Staff or AHP Staff members should make a good faith effort to give at least thirty (30) days' notice of a resignation. Resignations must be submitted to the CEO, or designee, and Chief of Staff and shall become effective immediately upon receipt by the CEO, or designee, and Chief of Staff or, if indicated, upon the date indicated by the Medical Staff or AHP member in his/her notice. Resignation notices must be signed by the Medical Staff or AHP member.

ARTICLE IV - CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

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

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these bylaws.
(2) Are able to respond by being physically present within 30 minutes in order to be continuously available for provision of care to his/her patients (with the exception of ED providers and hospitalists), as determined by the Board; and
(3) Regularly admit to or are otherwise regularly involved in the care of at least 24 patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; or interpretation of any inpatient or outpatient diagnostic procedure or test. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations.
(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII.
(3) To vote on all matters presented at general and special meetings of the Medical Staff.
(4) To vote and hold office in the staff organization, departments and on committees to which he/she is appointed; and
(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3.
(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than thirty (30) minutes after admission or sooner if warranted by the patient's condition;

(3) Actively participate:

(i) in the QAPI program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital.
(ii) in supervision of other appointees where appropriate.
(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations and as recommended by the MEC and approved by the Board, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician.
(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
(v) in discharging such other staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and
(5) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the departments and committees of which he/she is a member.

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these bylaws.
(2) Are able to respond by being physically present within 30 minutes in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided.
(3) Do not admit or participate in the care of more than 23 patients in a calendar year. Courtesy members who admit or are involved in the care of more than 23 patients in a calendar year must transfer to active staff. The requirement to transfer to active staff may be waived by the Board for practitioners who have their primary practice outside the community and provide services not otherwise available in the community; and
(4) Are members of the Active Staff of another hospital where he/she actively participates in the QAPI program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a).
(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII.
(3) Attend meetings of the staff and any staff or hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she shall not be entitled to vote for Chairperson of any department and shall not vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3.
(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service; and
(3) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.4 CONSULTING STAFF

4.4(a) Qualifications

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

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:

(i) consult on patients within his/her specialty; and
(ii) attend all meetings of the staff and the applicable department that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.
(3) Consulting Staff members may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Consulting Staff members shall not admit patients to the Hospital, perform inpatient or outpatient procedures, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital.
(4) Are members of the Active Staff of another hospital where he/she actively participates in the QAPI program.

4.4(c) Responsibilities

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

4.5 EMERITUS STAFF

4.5(a) Qualifications

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

(1) Physicians who have retired from active hospital services, but continue to demonstrate a genuine concern for the Hospital; or
(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

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

4.5(b) Prerogatives

(1) Prerogatives of an Emeritus Staff member shall be:

(i) attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.

(2) Emeritus Staff members shall not under any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Emeritus Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.6 AFFILIATE STAFF

4.6(a) Qualifications

Appointees of the Affiliate Staff shall consist of those physicians who desire to be associated with the hospital, but who do not intend to care for or treat patients at this hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, including continuing education endeavors.

4.6(b) Prerogatives

Affiliate Staff Appointees:

(1) May refer patients for outpatient diagnostic testing and specialty services provided by the hospital.
(2) May refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment.
(3) May visit their hospitalized patients, review their hospital medical records and provide advice and guidance to the attending physician, but shall **NOT** be permitted to admit patients, to attend patients, to exercise any clinical privileges, to write orders or progress notes, to make any notations in the medical record or to actively participate in the provision of care or management of patients in the hospital. They are encouraged to attend educational programs sponsored by the hospital or Medical Staff and attend meetings of the full Medical Staff and the Department to which they are assigned; and
(4) Shall not vote on Medical staff matters (e.g., Bylaws, Election of Officers), or hold office, but may serve and vote on Medical Staff Committees, if assigned.

4.6(c) Responsibilities

Individuals requesting Affiliate Staff appointment shall be required to:

(1) Submit an application for initial appointment, or for reappointment no more than every two years as prescribed by Article VI of these Bylaws.
(2) Submit documentation of a current license, DEA certificate, malpractice insurance in the amounts required by Section 14.2 of these Bylaws and shall not currently be ineligible as defined in Section 6.3(d)(5) of these Bylaws. Affiliate Staff members are not granted clinical privileges; therefore, Board Certification is not required; and
(3) Acknowledge that appointment and reappointment to the Affiliate Staff is a courtesy which may be terminated by the Board of Trustees upon recommendation of the Medical Executive Committee with sixty (60) days' written notice, without right to a hearing or appeal as set forth in these Bylaws.

4.6(d) Reappointment Requirements

Individuals requesting re-appointment to the Affiliate Staff:

(1) Shall provide evidence of a current license and Drug Enforcement Agency (DEA) registration.
(2) Shall provide evidence of current malpractice insurance in the amounts required by Section 14.2
(3) Shall not currently be an ineligible person as defined in Section 6.3(d)(5) of these Bylaws; and
(4) Shall provide peer references from Medical Staff members who are members of the Hospital's Medical Staff and are familiar with the Affiliate Staff member's competence.

4.7 COVERAGE STAFF

4.7(a) Qualifications

The Coverage Staff shall consist of practitioners who may be appointed for a period of no longer than one (1) year and who:

(1) Meet the basic qualifications set forth in these bylaws.
(2) Provide coverage for other practitioners or service lines on a temporary basis, in specialties with otherwise limited availability in the community; and
(3) During the times when they are providing such coverage, are able to respond by being physically present within 30 minutes in order to be continuously available for provision of care to his/her patients (with the exception of ED providers and hospitalists), as determined by the Board.

4.7(b) Prerogatives

The prerogatives of a Coverage Staff member shall be:

(1) To admit patients to the Hospital, if granted the privileges to do so.
(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII; and
(3) Coverage Staff members shall not be eligible to vote on staff matters, hold office, or serve on Medical Staff Committees unless specifically invited to participate in a non-voting capacity.

4.7(c) Responsibilities

Each member of the Coverage Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3.
(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than thirty (30) minutes after admission or sooner if warranted by the patient's condition; and
(3) Actively participate:

    (i) in the QAPI program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital.
    (ii) in supervision of other appointees where appropriate.
    (iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations and as recommended by the MEC and approved by the Board, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician.
    (iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and
    (v) in discharging such other staff functions as may be required from time-to-time.

4.8 RESIDENTS

4.8(a) Qualifications

(1) Residents consist of physicians who are participants in a graduate medical education program approved by the Medical Executive Committee and Board.
(2) Residents shall be credentialed by the residency program in accordance with the Residency Policy Manual and the Resident Agreement. Residents engaged in the residency program will not have independent clinical privileges and must be supervised when in the Hospital by qualified faculty who are appropriately credentialed through the Medical Staff Bylaws according to the Residency Policy Manual.

4.8(b) Prerogatives

(1) The appropriate director of the residency program shall monitor the clinical and ethical performance of Residents.
(2) Residents shall at all times when performing duties and services at the Hospital be under the supervision of a member of the residency program's faculty who shall be a member in good standing on the Active or Courtesy Medical Staff.
(3) Residents may evaluate patients, perform procedures and make entries in the medical record under the supervision and signature of the supervising physician in accordance with Hospital policy. History and physical must be completed, and attested by the supervising physician, within twenty-four (24) hours of admission or registration with signature of the supervising physician within forty-eight (48) hours of admission or registration.

(4) The supervising physician to whom the Resident has been assigned must be primarily responsible for the care of the patient. It is the responsibility of the supervising physician to

document in the progress notes that he/she has seen the patient and participated in the care of the patient.

(5) Residents shall abide by all provisions of the Residency Policy Manual and Resident Agreement.

(6) Any decision to remove a Resident from service at the Hospital shall be accomplished pursuant to the Residency Policy Manual and the Resident Agreement. However, such administrative actions shall not entitle the Resident to any procedural rights pursuant to the Bylaws or the Fair Hearing Plan.

(7) Residents may not hold Medical Staff office. Residents may be allowed to participate in Hospital committees but shall have no voting rights. Residents may attend meetings of the Medical Staff but shall have no voting rights.

4.8(c) Qualifications and Prerogatives of Medical Students

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

4.8(d) Graduate Medical Education Committee

(1) The Graduate Medical Education Committee (GMEC) shall be responsible for the oversight of Graduate Medical Education including the Sponsoring Institution (Canyon Vista Medical Center) and all of its ACGME accredited residency programs. The GMEC oversees the clinical learning environment for Residents and Medical Students. A detailed description of the GMEC's role is outlined in the Residency Policy Manual. The DIO is the Chair of the GMEC. The MEC and Board shall approve the Residency Policy Manual and ensure that it complies with all applicable legal, regulatory and accreditation standards.

(2) The GMEC shall communicate with/report to the Medical Staff and Board concerning Residents and Students on at least an annual basis. Said communication/report shall include information concerning the safety and quality of patient care, treatment, and services provided by, and the related education and supervisory needs of, Residents and Medical Students.

4.9 NON-MEMBER PRACTITIONERS

Any practitioner applying for temporary privileges, emergency or disaster privileges, or telemedicine privileges shall be credentialed and privileged pursuant to Section 7.3, 7.4, or 7.5 of these Bylaws, as applicable, but shall not be granted the status, rights, or prerogatives of a Medical Staff member and shall not be designated in one of the categories listed in Article IV.

4.10 CHANGE IN STAFF CATEGORY

Upon request of a Medical Staff member pursuant to Section 6.5 of these Medical Staff Bylaws, or upon recommendation of a Department Chairperson, or upon its own initiative, the Medical Executive Committee may recommend a change in staff category of a Medical Staff member that is consistent with the requirements of these Bylaws. Such recommendation of the MEC shall be effective upon approval by the Board.

ARTICLE V - ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

Allied Health Professionals ("AHP") shall be identified as any person(s) other than physicians who are granted privileges to practice in the Hospital and are directly or indirectly involved in patient care. AHPs are designated into the following categories:

5.1(a) Dependent Allied Health Professionals ("Dependent AHPs") must be under the direct supervision and direction of a staff physician and not exceed the limitations of practice set forth by their respective licensure.

5.1(b) Licensed Independent Practitioners ("LIPs") may provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital.
(2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities.
(3) Have professional liability insurance in the amount required by these bylaws.
(4) Provide a needed service within the Hospital; and
(5) Unless permitted by law, and by the Hospital, to practice independently, the AHP must provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the Dependent AHP and responsibility for directing and supervising the Dependent AHP

5.3 PREROGATIVES

Upon establishing experience, training, and current competence, AHPs shall have the following prerogatives:

5.3(a) Dependent AHPs must:

(1) Exercise judgment within the Dependent AHP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care.

(2) Participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff.

(3) Participate as appropriate in-patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.
(4) Hold membership on committees as permitted in these bylaws.
(5) Hold no voting rights for department or medical staff meetings, and
(6) Not be permitted to accept nomination or election as an Officer as defined in these bylaws.

5.3(b) Independent AHPs must:

(1) Exercise judgment within the Independent AHP's area of competence.
(2) Participate directly, including writing orders to the extent permitted by law, in the management of patients.
(3) Participate as appropriate in-patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.
(4) Be provided the opportunity to hold membership on committees as permitted in these bylaws.
(5) Hold no voting rights for the Medical Staff, but may vote at Department or committee meetings; and
(6) Not be permitted to accept nomination or election as an Officer as defined in these bylaws.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of practitioners. Each AHP shall be assigned to one (1) of the clinical departments and shall be granted clinical privileges relevant to the care provided in that department. Each dependent AHP must have a reference on file at each appointment from the supervising/collaborating physician, and their practice protocols (scope of practice) must be submitted to the CEO, designee or Chief of Staff per Arizona State regulations. The practice protocols will be submitted by the dependent AHP at initial appointment and at the time of each reappointment. All dependent AHPs will be approved by their supervising/collaborating physician, the Department Chair (for Advanced Practice Nurses the CNO) of the Hospital before going before the Credentials Committee, MEC and BOT for approval of clinical privileges. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws

5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO.

5.4(c) **Remedy for Adverse Action**
Whenever activities, omissions, or any professional conduct of an AHP with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures, the following shall apply:

(1) Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the MEC with an opportunity to rebut the basis for termination. Upon receipt of a written request, the MEC shall afford the AHP an opportunity to be heard by the MEC concerning the AHP's grievance ("an interview"). Before the appearance**,** the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of the appearance shall be

made. The MEC shall, after conclusion of the investigation, submit a written decision simultaneously to the Board and to the AHP.

(2) The AHP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the MEC decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

5.4(d) Dependent AHP privileges shall automatically terminate upon revocation of the privileges of the Dependent AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the Dependent AHP and complies with all requirements hereunder for undertaking such supervision. In the event that a Dependent AHP's supervising physician member's privileges are significantly reduced or restricted, the Dependent AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon rather than the anesthesiologist, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

5.4(e) If the supervising practitioner employs or directly contracts with the Dependent AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the Dependent AHP, negligence of such Dependent AHP, the failure such Dependent AHP to satisfy the standards of proper care of patients, or any action by such Dependent AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the Dependent AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the Dependent AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

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

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable.

5.5(c) Discharge any committee functions for which he/she is responsible.

5.5(d) Cooperate with members of the Medical Staff, AHP staff, administration, the Board of Trustees and employees of the Hospital.

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

5.5(f) Participate in performance improvement activities and in continuing professional education.

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

5.5(h) Notify the CEO, designee, or Chief of Staff immediately if:

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

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

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

5.5(j) Refuse to engage in improper inducements for patient referral: and

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

5.6 CONFLICTS OF INTEREST

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

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

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

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

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

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

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

ARTICLE VI - PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated committees and departments shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating, or reducing staff membership or clinical privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists, and any other Provider whose scope of practice does not require a DEA registration/controlled substance certificate, as determined by the MEC and Board), signed Medicare penalty statement and a certificate of insurance must be submitted with the application. The application fee or Medical Staff dues (if any) shall be determined by the Medical Executive Committee. Applicants shall supply the Hospital with all information requested on the application.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. membership/fellowship in local, state or national professional organizations; or
b. specialty board certifications; or
c. license to practice any profession in any jurisdiction; or
d. Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists and any other Provider whose scope of practice does not require DEA number/controlled substance license as determined by the MEC and Board); or
e. Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges; or
f. the practitioner's management of patients which may have given rise to investigation by the state medical board; or
g. participation in any private, federal, or state health insurance program, including Medicare or Medicaid.

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

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

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

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

(13) **Request:** Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered.
(14) **Photograph:** A recent, color photograph of the applicant.
(15) **Citizenship Status:** Proof of United States citizenship or legal residency; and
(16) **Professional Practice Review Data:** For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant; and

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her request for an application form to the CEO or his/her designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that s/he shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges.
(2) Authorizes hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications.
(3) Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges s/he requests as well as of his/her professional ethical qualifications for staff membership.
(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.
(5) Acknowledges that if s/he is determined to have made a material misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, s/he shall have his/her medical staff membership and clinical privileges automatically removed, without fair hearing rights; The determination of materiality shall be in the sole discretion of the MEC and Board.
(6) Pledges to provide continuous care for his/her patients treated in the Hospital; and
(7) Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights.

6.3(c) Statement of Release & Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff or AHP Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall

be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff or AHP appointment and/or clinical privileges as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment and/or clinical privileges, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges, without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately relinquished my appointment and clinical privileges without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

    (i) applications for appointment or clinical privileges, including temporary privileges.
    (ii) periodic reappraisals.

    (iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action.
    (iv) summary suspension.
    (v) hearings and appellate reviews.
    (vi) medical care evaluations.
    (vii) utilization reviews.
    (viii) any other Hospital, Medical Staff, department, service, or committee activities.
    (ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, or behavior; and
    (x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff or AHP Staff and/or for the granting of clinical privileges, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff and AHP Staff. The term "third parties" means all individuals, including appointees to the Medical Staff and AHP Staff, and appointees to the Medical Staffs or AHP staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that:

(1) Medical Staff and AHP Staff appointments at this Hospital and clinical privileges are not a right.
(2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations.
(3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final.
(4) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and
(5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital.

Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed:

(1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff and AHP Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and
(2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or AHP Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to:

(1) refrain from fee-splitting or other inducements relating to patient referral.
(2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised.
(3) refrain from deceiving patients as to the identity of any practitioner or AHP providing treatment or services.
(4) seek consultation whenever necessary.
(5) abide by generally recognized ethical principles applicable to my profession.
(6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and
(7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) Submission of Application & Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the CEO or his/her designee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

(1) **Not Licensed.** The practitioner is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or AHP Staff; or
(2) **Privileges Denied or Terminated.** Within one (1) year immediately preceding the request, the applicant has had his/her application for Medical Staff or AHP Staff appointment at this Hospital denied, has resigned his/her Medical Staff or AHP Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or
(3) **Exclusive Contract or Moratorium.** The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicant's specialty; or
(4) **Inadequate Insurance.** The practitioner does not meet the liability insurance coverage requirements of these bylaws; or
(5) **Ineligible for Medicare Provider Status**. The applicant has been excluded, suspended or debarred from any government payer program or is currently the subject of a pending investigation by any government payer program; or
(6) **No DEA number.** The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists or any other Provider whose scope of practice does not require a DEA number/controlled substance license as determined by the MEC and Board); or
(7) **Continuous Care Requirement.** For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within the geographical area required by these bylaws; or
(8) **Application Incomplete.** The practitioner has failed to provide any information required by these bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application.

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

In the event that none of the above apply to the application, the CEO or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO or his/her designee shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

Medical Staff or AHP Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the hospital. Each practitioner or AHP who is appointed to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

6.3(f) Recommendation of Department Chairperson

The Chairperson of the appropriate department shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her, and shall transmit to the Credentials Committee on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. Documentation shall be transmitted with the report.

6.3(g) Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Department Chairperson and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(h) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(l). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

6.3(i) Effect of Medical Executive Committee Action

(1) **Deferral:** Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

(2) **Favorable Recommendation:** When the recommendation of the MEC is favorable to the applicant, the CEO, designee, or Chief of Staff shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chairperson. The Board shall act upon the recommendation at its next scheduled meeting or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) **Adverse Recommendation:** When the recommendation of the MEC is adverse to the applicant, the CEO, designee or Chief of Staff shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan or for AHPs, the procedure outlined in 5.4(b) and 5.4(c). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b) and 5.4(c).

6.3(j) Board Action

(1) **Decision; Deadline.** The Board of Trustees may accept, reject, or modify the MEC recommendation. The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee approves the application, that decision shall take immediate effect and the full Board shall approve that decision

at its next regular meeting and the provider may begin to practice. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

i. The applicant submits an incomplete application.
ii. The MEC makes a recommendation that is adverse or with limitation.
iii. There is a current challenge or previously successful challenge to licensure or registration.
iv. The applicant has received an involuntary termination of medical staff or AHP staff membership at another organization.
v. The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
vi. There has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce the full Board's decision to writing and shall set forth therein the reasons for the decision. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(l). The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

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

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

If the Board's action is materially more restrictive than the MEC's recommendation after the evidentiary hearing, the affected Practitioner may request for a reconsideration of the Board's decision pursuant to the appellate procedure outlined in these Bylaws and Fair Hearing Plan. Such reconsideration shall be based on the record of the preceding evidentiary hearing.

6.3(k) Interview

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(l) Reapplication After Adverse Appointment Decision

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

6.3(m) Time Periods for Processing

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Department Chairperson upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process.

6.3(n) Denial for Hospital's Inability to Accommodate Applicant

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

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

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the CEO, designee or Chief of Staff shall promptly so inform the applicant of the opportunity by special notice.

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

6.3(o) Appointment Considerations

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in areas such as the following:

(1) **Patient Care** with the expectation that practitioners, and AHPs provide patient care that is compassionate, appropriate, and effective.
(2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others.
(3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence, and experience to improve patient care practices.
(4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Hospital Administration and employees, and others.
(5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and
(6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of a practitioner's present staff appointment, the CEO or his/her designee shall provide the practitioner a reapplication form for use in considering reappointment. The practitioner or AHP who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form shall result in automatic termination of membership and clinical privileges at the expiration of the practitioner or AHP's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) **Education:** Continuing training, education, and experience during the preceding appointment period that qualifies the staff member for the privileges sought on reappointment.
(2) **License:** Current licensure.
(3) **Health Status:** Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of staff membership or to exercise the privileges requested. Vaccination and testing as required by policy;[144]
(4) **Program Participation:** Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program or termination of participation in such a program without successful completion.

(5) **Previous Affiliations:** The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding appointment period.

(6) **Professional Sanctions:** Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or
(ii) specialty board certification; or
(iii) license to practice any profession in any jurisdiction; or
(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists and any other Provider whose scope of practice does not require a DEA/controlled substance certificate as determined by the MEC and Board); or
(v) Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges; or
(vi) the practitioner's management of patients which may have been given rise to investigation by the state medical board; or
(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(7) **Information on Malpractice Experience:** Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period.

(8) **Criminal Charges:** Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or please during the preceding appointment period.

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

(10) **Current Competency:** Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by the Department Chairperson and by one (1) other Medical Staff member who is not a partner, employer, employee or relative of the practitioner or two (2) Medical Staff members who are not partners, employers or employees, or relatives, and results from the QAPI process of the Medical Staff. Such evidence shall include the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners and AHPs who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner's professional practice review, volumes and outcomes from organizations that currently privilege the and where they have actively practiced during the prior period of appointment.

Practitioners and AHPs who refer their patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing the above information in the form of quality profiles from other facilities where the practitioner has actively practiced during the prior appointment period; quality profiles from managed care organizations with whom the practitioner has been associated during the prior appointment period, or by submitting relevant medical record documentation from his/her office or other practice locations that demonstrates current competency for the privileges they are seeking. Practitioners or AHPs who refer their patients to a Hospitalist for inpatient treatment shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist shall provide his/her evaluation of the practitioner's or AHPs care based upon

consultation and interaction with the practitioner with regard to the practitioner's or AHP's hospitalized patients. The Hospitalist shall provide his/her opinion as to the practitioner's or AHP's current competency based upon the condition of the practitioner's or AHPs patients upon admission/readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission.

(11) **Fraud:** Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period.

(12) **Notification of Release & Immunity Provisions:** The acknowledgments and statement of release.

(13) **Information on Ethics/Qualifications**: Such other specific information about the staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the hospital; and

(14) **References:** The names of at least two (2) practitioners (excluding when feasible partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others.

6.4(c) Verification of Information

The CEO or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in the hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the CEO or his/her designee shall transmit the Reapplication Form and supporting materials to the Chairman of the appropriate department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Article VI as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and AHPs and with patients, results of the hospital monitoring and evaluation process, including practitioner- or AHP-specific information

compared to aggregate information from QAPI activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO, designee or Chief of Staff. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No staff member may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Notwithstanding the foregoing, a staff member may not request modification of his/her staff category more than once in any two (2) year appointment term.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

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

6.6(b) Requirements for Service

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

6.6(c) Termination

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

6.7 CREDENTIALS VERIFICATION ORGANIZATION

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

ARTICLE VII - DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner or AHP providing direct clinical services at this hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically

granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner, and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff or AHP must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner or AHP's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff or AHP Staff membership, each practitioner or AHP must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a practitioner or AHP for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner or AHP's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from QAPI activities, when available. For practitioners or AHPs who have not actively practiced in the hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(10) herein. In addition, those practitioners seeking new, additional, or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical or AHP Staff membership as described in these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for each provider.

7.2(c) Procedure

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

7.2(d) Limitations on Privileges

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

7.2(e) Initial and Additional Grants of Privileges

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

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

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

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: TEMPORARY PRIVILEGES

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

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Department Chair and pending MEC review and Board approval. "New applicant" includes an individual applying for clinical privileges at the Hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

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

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

7.4(b) Temporary Privileges – Important Patient Care Need – No Pending Application

Temporary privileges may be granted by the CEO or designee upon recommendation of the Chief of Staff or the Chairperson of the applicable department, when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of

time, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately. Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily providing services to cover an important patient care, treatment, or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred twenty (120) consecutive days of service or one hundred twenty (120) days of service within a calendar year. All practitioners providing coverage for other practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

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

7.4(c) <u>Proctoring Privileges</u>

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

7.4(d) <u>Conditions</u>

Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner or AHP's qualifications, ability, and judgment to exercise the privileges granted. Special requirements of consultation and reporting

may be imposed by the Chief of Staff, including a requirement that the patients of such practitioner or AHP be admitted upon dual admission with a member of the Active Staff. Before temporary privileges are granted, the practitioner or AHP must acknowledge in writing that he/she has received and read the Medical Staff Bylaws and Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.4(e) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner or AHP's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Chief of Staff terminate any or all of such practitioner or AHP's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the practitioner or AHP, the termination may be affected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the practitioner or AHP's patients then in the Hospital shall be assigned to another practitioner or AHP by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner or AHP.

7.4(f) Rights of the Practitioner

A practitioner or AHP shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary or proctoring privileges or because of any termination or suspension of such privileges.

7.4(g) No term of temporary or proctoring privileges shall exceed a total of one hundred twenty (120) consecutive days or one hundred twenty (120) days in a calendar year

7.5 CLINICAL PRVILEGES HELD BY NON-MEDICAL STAFF MEMBERS: DISASTER PRIVILEGES

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

Disaster privileges may be granted by the CEO or Chief of Staff when, and for so long as, the Hospital's emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner or AHP, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The CEO and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

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

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

7.6(a) Scope of Privileges

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

7.6(b) Telehealth Physicians

Any physician who renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telehealth procedure (the "telehealth physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception as outlined below for those circumstances in which the practitioner's distant-site entity or distant-site hospital is Joint Commission accredited and the Hospital places in the practitioner's credentialing file a copy or written documentation confirming such accreditation.

In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telehealth physician's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telehealth physician ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

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

(2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42CFR§482.12(e), furnished the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services.
(3) The distant-site organization is either Medicare-participating hospital or a distant-site telehealth entity with the medical staff credentialing and privilege process and standard that at least meet the standards set forth in the CMS Hospital Conditions of Participation and the Joint Commission Medical Staff (MS) chapter for hospital or ambulatory care organizations, as applicable.
(4) The telehealth physician is privileged at the distant-site entity or distant-hospital providing the telehealth services, and the distant-site entity or distant hospital provides the hospital with a current list of the telehealth physician's privileges at the distant-site entity or distant-site hospital.
(5) The telehealth physician holds a license issued or recognized by the State of Arizona; and
(6) The hospital has evidence or will collect evidence, of an internal review of the telehealth physician' performance or telehealth privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including a minimum, all adverse events that result from telehealth services provided by the telehealth physician and all complaint the Hospital has received about the telemedicine physician) for use in the periodic appraisal of the telehealth physician by the distant-site entity or the distant-site hospital.

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

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

ARTICLE VIII - CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the Chairperson of the Department of which the practitioner is a member, by the CEO, or the Board Chair. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a

physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

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

8.1(c) Investigation by the Medical Executive Committee

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

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting the request for corrective action.
(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician.
(3) Issuing a warning or a reprimand to which the practitioner may write a rebuttal if he/she so desires.
(4) Recommending terms of probation or required consultation.
(5) Recommending reduction, suspension, or revocation of clinical privileges.
(6) Recommending reduction of staff category or limitation of any staff prerogatives.
(7) Recommending a period of focused professional practice evaluation (FPPE); or
(8) Recommending suspension or revocation of staff membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6), (7), or (8) (where such action materially restricts a physician's or dentists exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) (4), or (7) (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

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

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these bylaws or other hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

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

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

8.2(b) Medical Executive Committee Action

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

8.2(c) Procedural Rights

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

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

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

8.3 AUTOMATIC SUSPENSION

8.3(a) License

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

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

Any practitioner or AHP (except a pathologist or any other Provider whose scope of practice does not require a DEA number/controlled substance license or state equivalent, as determined by the MEC and Board) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended, relinquished, or expired shall immediately and automatically be suspended from the staff and practicing in the Hospital until such time as the registration is reinstated.

8.3(c) Medical Records

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

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

8.3(d) Malpractice Insurance Coverage

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

8.3(e) Failure to Appear/Cooperate

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

8.3(f) Exclusions/Suspension from Medicare

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

8.3(g) Contractual Prohibitions

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

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

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

8.3(g) Chief of Staff

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

8.4 ADMINISTATIVE REMOVAL FROM LEADERSHIP POSITIONS

The Board may, in its sole discretion, remove any Medical Staff leader, including Department Chairpersons, from his/her leadership position whenever his/her activities, omissions, or any professional conduct are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures. The Board, in its sole discretion, may also remove any Medical Staff leader, including Department Chairpersons, from his/her leadership position in the event that he/she is no longer in good standing with the Medical Staff. Any such administrative removal from a leadership position shall not affect the individual's Medical Staff membership or clinical privileges, nor shall it entitle the individual to any grievance or hearing rights.

8.5 CONFIDENTIALITY

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

8.6 PROTECTION FROM LIABILITY

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

8.7 SUMMARY SUPERVISION

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

8.8 REAPPLICATION AFTER ADVERSE ACTION

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

8.9 WITHDRAWAL AFTER SUBMITTING A COMPLETED APPLICATION

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

8.10 FALSE INFORMATION ON APPLICATION

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

ARTICLE IX - INTERVIEWS & HEARINGS

9.1 INTERVIEWS

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

9.2 HEARINGS

9.2(a) Procedure

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

9.2(b) Exceptions

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

9.3 ADVERSE ACTION AFFECTING AHPS

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

ARTICLE X - OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) Chief of Staff.
(2) Chief of Staff Elect.
(3) Secretary/Treasurer; and
(4) Immediate Past Chief of Staff.

10.1(b) Qualifications

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

(1) Be members in good standing on the Active Staff and have served on the Active Staff for at least three years and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
(2) Have no pending adverse recommendations concerning medical staff appointment or clinical privileges.
(3) Not presently be serving as Medical Staff officers, Board members, department chairs, or section chiefs at any other hospital and shall not so serve during their terms of office.
(4) Be willing to faithfully discharge the duties and responsibilities of the position.
(5) Have experience in a leadership position, or other involvement in performance improvement functions for at least two years.
(6) Attend continuing education relating to medical staff leadership and/or credentialing functions prior to or during the term of office.
(7) Have demonstrated an ability to work well with others.

Failure of an officer to maintain such status shall immediately create a vacancy in the office. Before taking office, the Board must approve the appointment, approval of which will not be unreasonably withheld.

10.1(c) Nominations

The Chief of Staff shall appoint a Nominating Committee consisting of at least the Chief of Staff, the Chief of Staff Elect, and two preceding past Chiefs of Staff as available. The committee shall convene at least 45 days prior to the election and shall submit to the Chief of Staff the names of one or more qualified nominees for each office. Nominations of any qualified candidate may be made by any member of the medical staff at any time during and after the previous medical staff meeting up to two weeks prior to the election. Following the close of the nomination period, the medical staff at large will be notified of all qualified candidates who have accepted the nomination. Notice of the nominees shall be provided to the medical staff two weeks prior to the election. In order for the nomination to be placed on the ballot, the candidate must meet the qualifications as described in Section 10.1(b) and be willing to serve. Nominations from the floor shall not be accepted.

10.1(d) Election

Officers shall be elected at the annual meeting of the Medical Staff and when otherwise necessary to fill vacancies. Only members of the Active Staff shall be eligible to vote. Voting shall be by secret written ballot or electronic mail (email) ballot and will be accepted at the annual meeting or as otherwise specified in the meeting notice. All ballots must be signed (via wet or email signature) by the voting member. Ballots may be presented to the Chief of Staff or designee in advance of the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board of Trustees, which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff. Reasons for removal may include but shall not be limited to violation of these bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action

10.1(f) Term of Elected Officers

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

Following the Chief of Staff's two-year term of service s/he will become the Immediate Past Chief of Staff.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If a vacancy occurs, the officer elected to fill the vacancy will only serve the remaining term of the departing officer. If there is a vacancy in the office of Chief of Staff, the Chief of Staff Elect shall serve out the remaining term before serving his/her full term as Chief of Staff. The process to fill vacant officer positions will follow Sections 10.1(c) and 10.1(d).

10.1(h) Duties of Elected Officers

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

(i) appoint multi-disciplinary Medical Staff committees.

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

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

(iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and hospital management committees.

(v) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff.

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

(vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff.

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

(ix) assist in coordinating the educational activities of the Medical Staff.

(x) confer with administrative leaders and Department or Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

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

(2) **Chief of Staff Elect:** The Chief of Staff Elect shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

(3) **Secretary/Treasurer:** The duties of the Secretary/Treasurer shall be to:

(i) give proper notice of all staff meetings on order of the appropriate authority.
(ii) prepare accurate and complete minutes for MEC and Medical Staff meetings.
(iii) assure that an answer is rendered to all official Medical Staff correspondence.
(iv) be responsible for the preparation of financial statements and report status of Medical Staff funds, if any; and
(v) perform such other duties as ordinarily pertain to his/her office.

(4) **The Immediate Past Chief of Staff** shall be a member of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board. The Immediate Past Chief of Staff will serve a term not to exceed a two-year period of time. This position may periodically be vacant.

10.1(i) Conflict of Interest of Medical Staff Leaders

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

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

Annually, on or before August 1st, each Medical Staff leader shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff leader, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

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

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical

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

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

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

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

ARTICLE XI - CLINICAL DEPARTMENTS & SERVICES

11.1 DEPARTMENTS & SERVICES

11.1(a) There shall be clinical departments of:

(1) Medicine, including internal medicine, family medicine, general practice, radiology, psychiatry, and emergency department and all subspecialties thereof including outpatient and ambulatory care physicians.
(2) Surgery, including general surgery and all subspecialties thereof, pathology, anesthesia and outpatient services; and
(3) Maternal/Child, including OB/GYN and pediatrics

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

11.2 DEPARTMENT FUNCTIONS

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

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

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

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

11.2(d) Monitor on an ongoing basis the compliance of its department members with these bylaws, and the rules and regulations, policies, procedures and other standards of the Hospital.

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

11.2(f) Coordinate the patient care provided by the department's members with nursing, administrative, and other non-Medical Staff services.

11.2(g) Foster an atmosphere of professional decorum within the department.

11.2(h) Review all deaths occurring in the Department and all unexpected patient care events and report findings to the MEC; and

11.2(i) Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:

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

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

11.3 SERVICES

In addition to the departments of the Medical Staff, there shall be services within the departments of the Medical Staff. The various services within the Medical Staff (e.g., anesthesiology service, radiology service, emergency service, pathology service, etc.) shall not constitute departments as that term is used herein without the express designation by the MEC and the Board of Trustees. Each service shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these bylaws. The purpose of the services shall be to provide specialized care within the Hospital and to monitor and evaluate the quality of care rendered in the service and to be accountable to the department to which such service is assigned for the discharge of these functions.

11.4 DEPARTMENT CHAIRPERSONS

11.4(a) Each Department shall have a Chairperson and Vice-Chairperson, who shall be approved by the Board after election by the department members and shall be a member of the Active Staff, qualified by training, certification by an appropriate specialty board or equivalent, (as described in Section 3.2(a)(9),

experience and administrative ability for the position. Department Chairpersons and Vice Chairs will be elected on odd years unless there is a vacancy. If a vacancy occurs the elected Department Vice-Chairperson will only serve the remaining term of the departing Chairperson and must be re-elected during odd year elections. Department Chairpersons and Vice Chairs may be removed by affirmative vote of two-thirds (2/3) of the Department members as provided for removal of officers in Section 10.1(e).

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

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

11.4(c) Department Chairpersons and Vice Chairs shall be elected and serve for a term of two (2) years.

11.5 DEPARTMENT VICE-CHAIRPERSONS

The Department Vice-Chairperson shall assume all the duties and have the authority of the Department Chairperson, in the absence of the Department Chairperson. S/he shall perform such additional duties as may be assigned to him/her by the Department Chairperson, or the Chief of Staff.

11.6 ORGANIZATION OF DEPARTMENT

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

11.6(c) Each staff member, at the beginning of each year, shall designate his/her primary department and he/she may only vote for the Chairperson of that Department. The practitioner's designation of department shall be approved by the MEC and shall be the department in which the practitioner's practice is concentrated. Should the practitioner exercise privileges relevant to the care in more than one (1) department, each department shall make a recommendation to the MEC regarding the granting of such privileges.

11.7 SERVICE CHIEF

11.7(a) Chiefs of Service shall be selected by the Department Chair in consultation with the Chief of Staff and must be approved by the Board. Chiefs of Service may be removed by affirmative vote of two thirds (2/3) of the Board for those reasons described in these Bylaws with respect to removal of Medical Staff officers. The chief of each service shall have the following duties with respect to his/her service:

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

ARTICLE XII - COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

12.1(c) All information pertaining to activities performed by the Medical Staff and its committees and departments shall be privileged and confidential to the full extent provided by law.

12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson.
(2) The Chief of Staff Elect.
(3) The Immediate Past Chief of Staff.
(4) The Chiefs of Departments, or Vice Chiefs of Departments in the absence of the Chief of the Department. Vice Chiefs of the Department may attend any MEC meeting as an ex-officio member without a vote if the Chief of the Department is present.
(5) Secretary/Treasurer to the Medical Staff.
(6) The CEO and CMO, ex-officio, or their designees.
(7) Other individuals by invitation as ex-officio without a vote; and
(8) The MEC may appoint up to 2 members at large from the Active Medical Staff to serve as voting members. The appointment will be for 12 consecutive months, or until their successor is elected.

12.2(b) Functions

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

(1) Receiving and acting upon department and committee reports.
(2) Implementing the approved policies of the Medical Staff.
(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action.
(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital.
(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions.
(6) Assuring regular reporting of QAPI and other staff issues to the MEC and to the Board of Trustees and communicating findings, conclusions, recommendations, and actions to improve performance to the Board and appropriate staff members.
(7) Assuring an annual evaluation of the effectiveness of the Hospital's QAPI program is conducted.
(8) Developing and monitoring compliance with these bylaws, the rules and regulations, policies, and other Hospital standards.
(9) Recommending action to the CEO on matters of a medico-administrative nature.

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

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

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

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

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

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

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

12.2(c) Meetings

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

12.2(d) Special Meeting of the Medical Executive Committee

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

12.2(e) Removal of MEC Members

All members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership positions. Officers of the Medical Staff who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e). Department Chairpersons and Vice Chairs who are ex-officio members of the MEC shall be removed in accordance with the procedures described in Section 11.4(a). At-large members of the MEC shall be removed by two-thirds vote of the MEC for the reasons provided in Section 10.1(e).

12.3 MEDICAL STAFF FUNCTIONS

12.3(a) Composition of Committees

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

12.3(b) Functions

The functions of the Medical Staff are to:

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

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

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

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

(14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers.
(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis.
(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges.
(17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments.
(18) Investigate any breach of ethics that is reported to it.
(19) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and
(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

12.3(c) Execution of Functions

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

12.4 CONFLICT RESOLUTION COMMITTEE

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

ARTICLE XIII - MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be held in June, at a date, time and place determined by the MEC.

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting.
(2) Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Department Chairperson.
(3) The election of officers and other officials of the Medical Staff when required by these bylaws.

(4) Recommendations for maintenance and improvement of patient care; and
(5) Other old or new business.

13.2 REGULAR MEDICAL STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet quarterly. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

13.2(c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the Chief of Staff or CEO and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally, by electronic mail, fax, or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

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

13.4(b) Committee Meetings

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

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Members of the Medical Staff are encouraged to attend the regular and special meetings of the Medical Staff as well as the meetings of those departments and committees of which they are members. Active staff shall be required to attend fifty percent (50%) percent of meetings of the Medical Staff. A member shall be deemed present at a meeting if he/she participated by conference telephone, speaker telephone, or other method by which all persons participating in the meeting can hear one another at the same time. However, to ensure that confidentiality is not waived, no member may deliberate or vote as to any issue involving physician credentialing, corrective action, or medical care evaluation, unless personally present. Members must also attend one-third (1/3) of committee and departmental meetings in which they are a member or be subject to the fine as described in policy.

13.7(b) Absence from Meetings

Any member who is compelled to be absent from any Medical Staff, departmental or committee meeting shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence. Unless excused for a good cause. to meet the attendance requirements of these bylaws shall be grounds for fine as described in policy.

13.7(c) Special Appearance: Cooperation with Medical Executive Committee

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice shall and/or failure to comply with any reasonable directive of the MEC, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV - GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS & POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

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

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

14.1(b) Provisional Adoption by MEC

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

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

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

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet, as needed, with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

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

14.1(d) Final Authority of the Board

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

14.2 PROFESSIONAL LIABILITY INSURANCE

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

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

14.3 CONSTRUCTION OF TERMS & HEADINGS

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

14.4 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.4(a) Reports to be Confidential

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

14.4(b) Release from Liability

No representative of the hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.

14.4(c) Action in Good Faith

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

ARTICLE XV - ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

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

15.2 ADOPTION, AMENDMENT & REVIEWS

The bylaws shall be reviewed and revised as needed. When necessary, the bylaws and rules and regulations will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended, or repealed by the affirmative vote of a two-thirds (2/3) of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written or electronic notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

15.2(b) Board

The Medical Staff Bylaws may be adopted, amended, or repealed by the affirmative vote of two-thirds (2/3) of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.

15.3(c) Technical Revisions

Formatting changes, punctuation corrections and/or corrections of proper terminology in these bylaws may be adopted by the MEC, without vote by the Medical Staff, subject to approval by the Board of Trustees.

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

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