

MARY LANNING MEMORIAL HOSPITAL  
MEDICAL STAFF BYLAWS



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*MLH Medical Staff Bylaws*

*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*

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## DEFINITIONS

1. **“Agents”** and **“Employees”** means all employees, consultants, attorneys, staff, staff members, and volunteers who assist the Hospital to perform peer review, or staff or assist a peer review committee or function.
2. **“Applicant”** means a practitioner who has made application for appointment or reappointment to membership on the Medical Staff or for the granting, expansion or renewal of clinical privileges.
3. **“Board”** means the Board of Trustees of Mary Lanning Healthcare.
4. **“Chief Executive Officer”** or **“CEO”** means the individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital and includes his/her designee as appropriate.
5. **“Chief Medical Officer”** means a qualified individual who is responsible for the oversight of the provision of safe, effective, high-quality patient care. The CMO shall also serve as liaison between MLH and the Medical Staff. The CMO must adhere to the MLH values of Integrity, Trust, Compassion, Enthusiasm, Courage and Perseverance. This Executive is also to participate in the development of corporate strategies and objectives, assuring that all direct reports know and adhere to the same.
6. **“Clinical Privileges”** or **“Privileges”** means the permission granted by the Board to Licensed Independent Practitioners and other practitioners providing a medical level of care to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental or podiatry services.
7. **“Days”** means calendar days.
8. **“Department”** means a clinical grouping of privileged practitioners in accordance with their specialty or major practice interest, as specified in these Bylaws.
9. **“Ex officio”** means service as a member of a body by virtue of an office or position held and does not have voting privileges, unless otherwise expressly provided.
10. **Focused Review** means the time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner’s ability to provide safe, high-quality patient care.
11. **“Hospital”** means Mary Lanning Healthcare (MLH). Unless otherwise specifically stated it shall mean all of the facilities, services and locations licensed or accredited as part of Mary Lanning Healthcare.

**“Hospitalist”** means a Physician whose primary professional focus is the general medical care of hospitalized patients, including the admission and ongoing in-Hospital care to unassigned patients or those patients who need admissions, and who have the responsibility and duty to collaborate with nursing, discharge planning, social services, and all others involved in patient care. Hospitalists are

members of the Active Staff and/or Courtesy Staff (as applicable) with all privileges appropriate to their responsibilities as set forth in Article V.

12. **“Occurrence Report”** (or risk management or variance report or incident report) means a report of an incident involving injury or potential injury to a patient as a result of patient care provided by a health care provider, including both an individual who provides healthcare and an entity that provides healthcare, that is created specifically for and collected and maintained for the exclusive use by a Peer Review Committee of a health care entity and that is within the scope of the functions of that committee.
13. **“Investigation”** means, for the purposes of reporting to the National Practitioner Data Bank or to the Nebraska Health and Human Services System, Regulation and Licensure Division, a member has been notified that an investigation is being conducted and has been given the notice of and opportunity to provide information to the investigative body. Once commenced, an investigation is deemed ongoing for so long as the investigation or any resulting corrective action process or related hearing or appeals process under Article VII of these Bylaws is ongoing.
14. **“Medical Executive Committee” or “MEC”** means the Executive Committee of the Medical Staff.
15. **“Medical Staff” or “Staff”** means those privileged practitioners collectively organized into a formal staff structure under these Bylaws and the Bylaws of the Hospital to carry out the purposes described in these Bylaws. Medical Staff includes Member physicians appointed to membership in the Medical Staff, as well as nonmember privileged practitioners who have not been appointed to membership, but who have been granted clinical privileges pursuant to these Bylaws.
16. **“Medical Staff Office” or “Medical Staff Services”** refers to the Hospital employee(s) assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges; for maintaining documents related to the credentialing process and medical staff committee actions; and for providing management support services to the Medical Staff in order to carry out its required functions.
17. **“Member”** means a physician who is specifically appointed by the Board to membership on the Medical Staff and who, therefore, enjoys the prerogatives established for Medical Staff Members. Not all Members hold privileges.
18. **“MLH”** means “Mary Lanning Healthcare”.
19. **“Nonmember Privileged Practitioner” (NMPP)** means a practitioner who holds clinical privileges granted by the Board, but has not been appointed by the Board to membership on the Medical Staff.
20. **“Peer Review Committee”** means a utilization review committee, quality assessment committee, performance improvement committee, tissue committee, credentialing committee, or other committee established by the Board of Trustees of the Hospital which is a health care provider that does either of the following:
  - a. Conducts professional credentialing or quality review activities involving the competence of, professional conduct of, or quality of care provided by a health care provider, including both an individual who provides health care and an entity that provides health care; or

- b. Conducts any other attendant hearing process initiated as a result of a Peer Review Committee's recommendations or actions.
21. **"Peer Review"** means the procedure by which health care providers evaluate the quality and deficiency of services ordered or performed by other health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, root cause analysis, claims review, underwriting assistance, and the compliance of a hospital, nursing home or other health care facility by a health care provider with the standards set by an association of health care providers and with applicable laws, rules, and regulations plus all functions treated as Peer Review under Nebraska law including, but not limited to the Nebraska Health Care Quality Improvement Act, all activity to assess or study care under Neb. Rev. Stat § 71-3401 to 3403; all activity to enforce and apply the responsibilities of membership, the terms and qualifications for membership, and the terms and qualifications for clinical privileges under these Bylaws; all activity to enforce Hospital policy as if affects a practitioner or practitioners or as such activity is otherwise eligible for immunity under the Federal Health Care Quality Improvement Act. Peer Review is a cooperative effort and includes the activities of officers, trustees, agents, and employees of Hospital, as well as members of the Medical Staff, privileged practitioners and AHPs, and representatives of accrediting organizations.
22. **"Peer Review Records"** means all proceedings, records, minutes and reports to or by a Peer Review Committee and includes without limitation reports or descriptions of any complaints or incidents being investigated (including incident or variance reports) and the deliberations, testimony, decisions, conclusions, findings, recommendations, evaluations, work product or opinions of a Peer Review Committee. All such peer review records are deemed to be covered by the provisions of (The) Nebraska Health Care Quality Improvement Act (the Act of that name adopted as LB 431 and approved by the Governor on April 26, 2011) or the corresponding provisions of any subsequent federal or state statute providing a privilege against disclosure.
23. **"Physician"** means an individual with an M.D. or D.O. degree who is licensed to practice medicine.
24. **"Practitioner"** means, unless otherwise expressly provided, any physician, dentist, podiatrist, licensed psychologist (doctoral level), advance practice registered nurse, certified nurse midwife, certified registered nurse anesthetist, physician assistant, or other individual applying for or exercising clinical privileges to provide a medical level of care in the Hospital.
25. **"Privileged Practitioner"** means a Practitioner who has been granted clinical privileges by the Board.
26. **"President"** means the President of the Medical Staff and is synonymous with Chief of Staff.
27. **Construction of Terms and Heading:** All pronouns and any variations thereof in these Bylaws or associated Rules and Regulations, or Policies and procedures shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.



## Preamble

**WHEREAS**, Mary Lanning Healthcare is a nonprofit corporation organized under the laws of the State of Nebraska; and

**WHEREAS**, the Medical Staff of Mary Lanning Healthcare is a division of MLH, and is the body to which the Board delegates; the responsibility to oversee care, treatment, and services provided by practitioners with privileges;

**WHEREAS**, the purposes of the Medical Staff are

- 1.2.1 To assure that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive quality health care services;
- 1.2.2 To assure an appropriate level of professional performance of all practitioners authorized to practice in the Hospital through delineation of the clinical privileges that each privileged practitioner may exercise in the Hospital and through an ongoing review and evaluation of each privileged practitioner's performance in the Hospital;
- 1.2.3 To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;
- 1.2.4 To initiate and maintain rules and regulations for self-governance of the Medical Staff;
- 1.2.5 To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board and the Chief Executive Officer.

**THEREFORE**, the Medical Staff Members and privileged practitioners practicing in this Hospital have organized into a Medical Staff in conformity with these Bylaws and subject to the general authority of the Board.

These Bylaws were originated by the Medical Staff and are effective upon approval by the Board. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws, or rules and regulations. These Bylaws are adopted and periodically revised in order to provide a framework for the Medical Staff's self-governance, define its responsibilities, and establish the mechanisms through which it will discharge its responsibilities. These Bylaws provide the structure for Medical Staff operations and relations with the Board, practitioners, and applicants for medical staff membership and/or clinical privileges. These Bylaws shall guide the Hospital and the Medical Staff in conducting covered affairs, but do not constitute a contract. None of the Hospital, the Medical Staff, nor any representative of the Medical Staff conducting delegated responsibilities shall be liable for failure to strictly comply with the terms of these Bylaws or the Rules and Regulations adopted hereunder.

While the Board is ultimately responsible for the quality and safety of care at the Hospital, the Board, Medical Staff, and administration collaborate to provide safe, quality care. The Board (or its designees) shall adequately inform the Medical Staff of MLH activities which affect the discharge of Medical Staff responsibilities and provide the Medical Staff with a meaningful opportunity to participate in deliberations concerning matters which do, or could, affect the discharge of Medical Staff responsibilities.

*MLH Medical Staff Bylaws*

*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*

**ARTICLE I  
MEDICAL STAFF ORGANIZATION**

**SECTION 1. NAME**

The name of this medical staff shall be the Medical Staff of Mary Lanning Healthcare.

**SECTION 2. NATURE OF THE ORGANIZED MEDICAL STAFF**

The organized medical staff is a single, self-governing medical staff and has the responsibility to oversee care, treatment, and services provided by practitioners with privileges. The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges, and providing leadership in performance improvement activities within the organization. It is structured to have the ability to function in guiding and governing its members.

As a division of MLH, the organized Medical Staff is accountable to the MLH Board of Trustees, which has the ultimate authority and responsibility for the oversight and delivery of health care in the Hospital. The Medical Staff is not a separate legal entity or association and is not capable of suing or being sued in its own name. Representative of the Medical Staff conducting functions assigned under these Bylaws do so as representatives of the Hospital.

**SECTION 3. RESPONSIBILITIES OF THE MEDICAL STAFF**

**1.3.1** The organized medical staff oversees the quality of patient care, treatment and services provided by privileged practitioners. Such responsibilities include:

1.3.1.1 Oversight in the process of analyzing and improving patient satisfaction

1.3.1.2 Oversight to ensure practitioners practice only within the scope of their privileges

1.3.1.3 Specifying minimal content of medical histories and physical examinations (H&Ps) (which may vary by setting or level of care, treatment, and services), monitoring the quality of medical H&Ps, and defining who may perform H&Ps (with or without countersignature)

1.3.1.4 Defining written policies and procedures for appraisal, treatment and referral of emergencies at off-campus locations

1.3.1.5 Determining qualifications of the radiology staff who use equipment and administer procedures

1.3.1.6 Approving the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

**1.3.2** The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care treatment and services and patient safety. Leadership is provided for measuring, assessing and improving processes that primarily depend on the activities of one or more privileged practitioners and includes:

1.3.2.1 Medical assessment and treatment of patients

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1.3.2.2 Use of information about adverse privileging decisions for any privileged practitioner

1.3.2.3 Use of medications

1.3.2.4 Use of blood and blood components

1.3.2.5 Operative and other procedures

1.3.2.6 Operative and other procedures

1.3.2.7 Appropriateness of clinical practice patterns

1.3.2.8 Significant departures from established patterns of clinical practice

1.3.2.9 The use of developed criteria for autopsies

1.3.2.10 Sentinel event data

1.3.2.11 Patient safety data

**1.3.3** The organized medical staff participates in the following organization-wide performance improvement activities:

1.3.3.1 Education of patients and families

1.3.3.2 Coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care, treatment and services of an individual patient

1.3.3.3 Accurate, timely and legible completion of patient's medical records

1.3.3.3.1 The medical history and physical examination are completed and documented by a physician, or other qualified licensed individual in accordance with state law (NE State Operations Manual, A-0359), CMS CoPs (Section 482.22(c)(5)(i)) and hospital policy. (c.f. Medical Staff Rules and Regulations, Section 1, Part 7.2; Joint Commission Standard PC.01.02.03, EPs 4 and 5, and MS.01.01.01, EP 16; and MLH Policy HIM210, Medical Record Standards.)

1.3.3.3.2 A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

1.3.3.3.3 An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when

the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

- 1.3.3.4 Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence
- 1.3.3.5 Communication of findings, conclusions, recommendations and actions to improve performance to appropriate staff members and the governing body.
- 1.3.4** The organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member of a professional graduate education program(s).
- 1.3.5** The organized medical staff is responsible for planning and implementing a privileging process. This process typically entails:
  - 1.3.5.1 Developing and approving a procedures list
  - 1.3.5.2 Processing the application
  - 1.3.5.3 Evaluating applicant-specific information
  - 1.3.5.4 Submitting recommendations to the Board for applicant-specific delineated privileges
  - 1.3.5.5 Notifying the applicant, relevant personnel, and external entities (as may be applicable by law) of privileging decisions
  - 1.3.5.6 Monitoring the use of privileges and quality of care issues
- 1.3.6** The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.
- 1.3.7** The organized medical staff provides oversight for the quality of care, treatment and services by recommending members for appointment to the Medical Staff.
  - 1.3.7.1 The organized medical staff develops criteria for medical staff membership, which includes information provided by peers.
- 1.3.8** The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.
  - 1.3.8.1 The focused evaluation process (FPPE) is defined by the organized medical staff to:

- 1.3.8.1.1 Evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization.
- 1.3.8.1.2 Evaluate an individual's ability to provide safe, appropriate quality patient care when a question arises regarding a privileged practitioner's performance.
- 1.3.8.2 The organized medical staff is responsible for reviewing and assessing results of ongoing professional practice evaluations (OPPE) to support recommendations for maintenance, revision or revocation of existing privileges, and acting on reported concerns regarding a privileged practitioner's clinical practice and/or competence.
- 1.3.9 The organized medical staff is responsible for developing and implementing a fair hearing and appeal process addressing quality of care issues.
- 1.3.10 The organized medical staff is responsible for implementing a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.

**ARTICLE II  
MEDICAL STAFF MEMBERSHIP**

**SECTION 1: NATURE OF MEDICAL STAFF MEMBERSHIP**

- 2.1.1** Membership on the Medical Staff of Mary Lanning Healthcare is a privilege which shall be extended only to fully licensed, professionally competent physicians who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, Rules and Regulations and Policies of the Medical Staff and MLH.
- 2.1.2** No distinction shall be made on the basis of color, race, sex, religion, disability or national origin in Medical Staff appointment or accommodations provided, use of equipment and other facilities, or the assignment of personnel providing services.
- 2.1.3** No physician shall be entitled to membership on the Medical Staff merely by virtue of the fact that he/she is duly licensed to practice a profession in Nebraska or in any other state, or to perform specific procedures within an area of licensure, or that he/she is a member of any professional organization, or is certified by any Board, or that he or she had in the past, or presently has such membership or privileges at another hospital or healthcare organization.
- 2.1.4** Medical Staff membership is specifically extended to qualified individual applicants, and is not held by all privileged practitioners, provided however, that all privileged practitioners are subject to these Bylaws, and all other policies, procedures and rules and regulations adopted by the Medical Staff.
- 2.1.5** Medical Staff membership in and of itself does not confer any particular clinical privileges. Clinical privileges are specifically granted pursuant to the applicant's demonstrated qualifications, experience and competence, in accordance with these Bylaws, and only for the term stated.

## **SECTION 2: QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP**

The following constitute continuing qualifications for membership in the Medical Staff, and these professional criteria shall apply uniformly to all applicants/members.

- 2.2.1** Be currently licensed by the state of Nebraska to practice medicine
- 2.2.2** Actively engaged in the practice of medicine or surgery.
- 2.2.3** Maintain eligibility/ability to participate in Medicare, Medicaid or other federal or state governmental health care programs.
- 2.2.4** Agree to adhere to the ethics of the profession, the Bylaws, Rules & Regulations, Code of Conduct, Credentials Policies and other policies of the Medical Staff and to the policies and procedures of the Hospital.
- 2.2.5** Provide accurate, current, and thorough information in connection with the appointment, reappointment, or in response to inquiries from the Credentials Committee, Executive Committee or the Board. Failure to authorize release of information constitutes automatic withdrawal of the application or withdrawal of membership.
- 2.2.8** Meet such additional criteria for membership or staff category as established by the Board from time to time following recommendation by the Medical Staff.

## **SECTION 3: RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**

- 2.3.1** Discharge such medical staff, committee, departmental and hospital functions for which he/she is responsible based on staff category, assignment, appointment, election, or otherwise obligated.
- 2.3.2** Pay dues and other assessments as determined from time to time by the MEC.
- 2.3.3** Participate in orientation activities and programs required by the Medical Executive Committee or the Board of Trustees, as may be applicable.
- 2.3.4** Participate in medical staff quality/performance improvement and patient safety activities and in discharging other Medical Staff functions as may be required from time to time.
- 2.3.5** Actively support the mission and goals of Mary Lanning Healthcare.
- 2.3.6** Abide by these Medical Staff Bylaws, Hospital Bylaws, Medical Staff Rules and Regulations and applicable Hospital and Medical staff policies.

## **SECTION 4: TERMS AND CONDITIONS OF APPOINTMENT**

The Board shall make all initial appointments and reappointments to Medical Staff membership and all grants of clinical privileges. All such Board actions shall follow receipt of a recommendation from the Medical Staff as provided in these Bylaws.

Initial appointment to membership and/or grant of privileges and renewal of membership and/or privileges shall be for a period of not more than twenty-four (24) months, and shall be defined by the Medical Staff for each applicant

### **ARTICLE III MEDICAL STAFF MEMBERSHIP CATEGORIES / DESIGNATIONS**

Medical Staff appointees consist of physicians, dentists, oral surgeons and podiatrists. Medical Staff members shall be divided into Active and Courtesy categories. At the time of initial appointment and at the time of each reappointment, the Medical Staff Member's staff category will be recommended by the Medical Executive Committee and approved by the Board.

#### **SECTION 1: ACTIVE STAFF CATEGORY**

- 3.1.1.** Qualifications: The Active Medical Staff shall consist of physicians (MD, DO) who hold privileges at MLH, who regularly admit to or provide medical services at the Hospital, and who reside within thirty (30) minutes driving of the Hospital (except as provided in Article IV, Section 3, Waiver/Exemption). The Active Staff category is responsible for oversight of care, treatment and services provided by the Medical Staff, and Active Staff appointees must be willing to be actively involved in the governance of the Medical Staff through participation (when requested) in activities such as peer review, committee participation, and/or attendance at meetings necessary to fulfill the Medical Staff's required functions. Failure of Active Staff appointees to fulfill the responsibilities of active staff appointment may result in reclassification to Courtesy Staff.
- 3.1.2** Prerogatives of Active Staff: Members of the Active Staff shall be eligible to vote, to hold office, and to serve on Medical Staff committees (including the Medical Executive Committee), and shall not be required to attend General Medical Staff or Department meetings.
- 3.1.3** Obligations of Active Staff: Each member of the Active Staff shall discharge the basic obligations of staff members as required in these Bylaws and any future changes to these Bylaws; accept emergency on-call coverage for emergency care services within his/her medical staff department; actively participate in the quality assessment and performance improvement activities of the Hospital; attend such committees to which they may be assigned; and perform such further duties as may be required of him/her under these Bylaws or Rules and Regulations, and comply with directives issued by the Medical Executive Committee.

#### **SECTION 2: COURTESY STAFF CATEGORY**

- 3.2.1** Qualifications: The Courtesy Staff shall consist of those practitioners qualified for Staff membership who: (1) Are involved in fewer than thirty-five (35) patient contacts ("patient contacts" defined as any admission, consultation, procedure, care, or treatment

of a patient) per year in any licensed hospital or ambulatory surgical center in Hastings, Nebraska or combination thereof; **OR** (2) Are considered active staff by the applicable bylaws of an accredited hospital in the city where their primary practice is located and desire to be Active Staff at MLH. The Courtesy Staff practitioner may be granted privileges at MLH, but it is not a requirement for membership.

- 3.2.2** Members of the Courtesy Staff whose status is granted according to subsection (1) under Section 3.2.1, must provide consultation, admission, care, treatment or referral of at least one patient but not more than 35 patients at MLH per year. If said Courtesy Staff member provides more than 35 patient contacts per year at any licensed hospital or ambulatory surgical center in Hastings, Nebraska or combination thereof, the Department Chair will make an evaluation at the end of the appointment period, or at any time when it is determined the staff member's activity has significantly increased, to determine if reassignment to the Active Staff category is warranted.
- 3.2.3** Members of the Courtesy Staff whose status is granted according to subsection (2) under Section 3.2.1 above are not subject to limitation of activity at Mary Lanning Healthcare in terms of numbers of patient contacts.
- 3.2.4** If a Courtesy Staff member fails to provide any patient encounters during an appointment period, the Medical Executive Committee may consider such lack of activity as a voluntary resignation of medical staff membership (and clinical privileges, as may be applicable).
- 3.2.5** Any physician who resides within thirty (30) minutes driving of the hospital and operates a health care clinic within the same thirty (30) minute driving time frame, regardless of the physician's medical staff status at another hospital, may be eligible for Active Staff status at Mary Lanning. (*cf. MLH Administrative Policy ADM222.00 v.5: "Emergency Medical Treatment and Active Labor Act"; and MLH Administrative Policy ADM221.00 v.5: "EMTALA/Provision of Call Coverage for the Emergency Department."*)

### **SECTION 3: AFFILIATE STAFF CATEGORY**

- 3.3.1** Qualifications: The Affiliate Staff shall consist of Physicians who meet the general qualifications set forth in Article II, Section 2 of these Bylaws, and who do not provide patient care in this Hospital.
- 3.3.2** Prerogatives: Except as otherwise provided herein, the Affiliate Staff members shall be entitled to:
  - 3.3.2.1 Refer patients to the Hospital for outpatient testing and/or procedures;
  - 3.3.2.2 Refer patients to Active Staff members, including Hospitalists for inpatient treatment. Affiliate Staff may visit their referred patients in the Hospital, have view-only access to such patients' medical records and receive information concerning such patients' medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record;



3.3.2.3 Attend meetings of the Medical Staff and the department of which he/she is a member, including open committee meetings, in a voting capacity and participate in Medical Staff governance according to existing Bylaws and Rules and Regulations;

3.3.2.4 Order tests and perform outpatient diagnostics for patients in the outpatient setting only; and

3.3.2.5. Attend continuing medical education program at the Hospital.

**3.3.3** Limitations:—Affiliate Medical Staff shall not be eligible to:

3.3.3.1 Admit and/or treat patients;

3.3.3.2 Initiate orders on inpatients; or

3.3.3.3 Exercise any Clinical Privileges

**3.3.4** Responsibilities: Affiliate Staff will be expected to:

3.3.4.1 Adhere to the ethics of their respective professions;

3.3.4.2 Be able to work cooperatively with others;

3.3.4.3 Complete initial appointment and reappointment requirements, and pay applicable fees and dues specific or appropriate to this medical staff category, [which may be discounted at the discretion of the MEC] ;

3.3.4.4 Provide the following information when referring a patient for a diagnostic test or study: (a) Physician name, State license number, office address and telephone number, and (b) a written order from the Physician's office; and

3.3.4.5 Review all results of tests ordered and provide for such further outpatient medical care as the patient's condition may indicate. Since such patient care shall occur outside of the Hospital, neither the Medical Staff nor the Hospital shall be responsible for reviewing such care through the Performance/Quality Improvement Process or otherwise.

**SECTION 4: TELEMEDICINE STAFF CATEGORY**

**3.4.1** Qualifications: Telemedicine Staff consist of Physicians who diagnose or treat patients from a Distant Site (as defined under Section 4.8.1) via a telecommunication system, and:

3.4.1.1 Who meet the general qualifications set forth in Article II, Section 2; and

3.4.1.1 Demonstrate a willingness to provide services through the use of Telemedicine (as further described in Section 4.8.1).

**3.4.2** Prerogatives: Telemedicine Staff shall be entitled to:

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3.4.2.1 Initiate orders for hospitalized patients;

3.4.2.2 Order tests for hospitalized patients only;

3.4.2.3 Diagnose and treat hospitalized patients; or

3.4.2.4 Attend meetings of Medical Staff and the department of which he/she is a member, including open committee meetings, in a non-voting capacity.

**3.4.3** Limitations: Telemedicine Staff may not:

3.4.3.1 Vote or hold office in the Medical Staff or MEC;

3.4.3.2 Be a member of any Medical Staff committee; or

3.4.3.3 Admit patients, or perform surgery.

**3.4.4** Responsibilities: Telemedicine Staff shall have the following responsibilities:

3.4.4.1 Meet the general qualifications set forth in Article II, Section 2;

3.4.4.2 Be cognizant of the needs of the Hospital by responding in a timely manner regarding request for diagnosis, orders, tests or other medical treatment to a patient through the appropriate Telemedicine technology;

3.4.4.3 Pay all dues, initial appointment and reappointment fees specific or appropriate to this medical staff category, [or such dues and fees as may be discounted at the discretion of the MEC];

3.4.4.4 Comply with standardized credentialing processes for Medical Staff membership, initial appointment and reappointment; and

3.4.4.5 Comply with applicable Telemedicine laws and regulations, including any application requirements set forth in Section 8.

**SECTION 5: SENIOR ACTIVE STAFF**

**3.5.1** Members of the Active Staff who are at least 65 years of age with ten (10) years' proximate service at Mary Lanning Healthcare may request removal from responsibility for providing specialty coverage in the Emergency Department call rotation. Membership as Senior Active Staff shall be limited to two (2) years' duration. The department chair shall recommend to the Medical Executive Committee whether to grant these requests based on need and the effect on others who serve on the call roster for that specialty. The Medical Executive Committee's recommendation shall be subject to final action by the Board of Trustees.

(Ref. Medical Staff Policy 3.12 Senior Active Staff Responsibilities, Medical Staff Rules and Regulations, p. 94)

## **SECTION 6: OTHER DESIGNATIONS**

Other practitioner designations are often referred to within the general context of the Medical Staff. These designations are acknowledged, but are not considered Categories of the Medical Staff, and are not subject to any credentialing process for Medical Staff membership. (A credentialing process is applicable for any requests for delineated clinical privileges, as defined in Article V.)

- 3.6.1** Honorary Status. Practitioners who have retired from medical practice and who are recognized for their noteworthy contributions to health and medical sciences, or previous long-standing service to the Hospital, may be considered by the Medical Executive Committee for Honorary Status. Honorary Staff members shall not be eligible to admit or treat patients, to vote, or to hold office. Honorary Staff members need not satisfy the requirement that they apply for Medical Staff membership or otherwise qualify for clinical privileges. Honorary Medical Staff membership is subject to revocation without due process. Honorary practitioners may attend social and educational functions of the Medical Staff.
- 3.6.2** Allied Health Staff: Allied Health Professionals (AHPs) in disciplines designed by the Board may be credentialed, designated as AHPs and granted clinical privileges through the Medical Staff process. AHPs are not eligible for Medical Staff membership nor procedural rights, except as may be specifically set forth in these Bylaws. Those Allied Health Professionals who have been granted delineated clinical privileges must abide by these Bylaws, Rules and Regulations.
- 3.6.3** Locum Tenens Staff: Practitioners who are granted delineated privileges to provide temporary or periodic coverage for a Medical Staff Member or for a vacancy in patient care services at the Hospital are often referred to as Locum Tenens Staff. These practitioners are not eligible for Medical Staff membership, except as may be specifically set forth in these Bylaws. Locum Tenens Staff who have been granted delineated clinical privileges must abide by these Bylaws, Rules and Regulations.
- 3.6.4** Non-Member Privileged Practitioner: Medical Staff Membership is not a qualification for or a precondition to the grant of clinical privileges. Accordingly, The Medical Staff, as defined, includes privileged practitioners who are not Members and who are not assigned to any of the membership categories. However, all privileged practitioners are governed by these Medical Staff Bylaws, Medical Staff policies and procedures and Medical Staff rules and regulations, regardless of appointment to Medical Staff membership. For ease of reference, such practitioners shall be referred to as "Non-Member Privileged Practitioners".

## **ARTICLE IV CLINICAL PRIVILEGES**

### **SECTION 1. EXERCISE OF PRIVILEGES**

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Only practitioners who can document current compliance with the foregoing qualifications sufficiently to indicate to the Medical Staff and the Board that any patient treated by them in the Hospital will receive an acceptable quality of professional care shall be qualified to exercise clinical privileges. No practitioner shall be entitled to exercise particular clinical privileges in the Hospital merely by virtue of the fact of licensure to practice a profession in Nebraska or in any other state, or to perform specific procedures within an area of licensure, or that he/she is a member of any professional organization, or has had such privileges at this or any other organization.

Every practitioner practicing at the Hospital shall be entitled to exercise only those clinical privileges specifically granted to such privileged practitioner by the Board, except as provided in Sections 9 and 10 of this Article.

## **SECTION 2. BASIS AND QUALIFICATIONS FOR CLINICAL PRIVILEGES**

**4.2.1 Basis:** Before clinical privileges are granted, renewed, or revised by the Board, the Medical staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information (when available):

4.2.1.1 Applicants who perform operative or invasive procedures, types of operative and invasive procedures performed as the surgeon of record and appropriate outcomes;

4.2.1.2 Applicants in non-surgical fields, types and outcomes of medical conditions as the responsible physician;

4.2.1.3 The applicant's clinical judgment and technical skills;

4.2.1.4 Any evidence or unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant;

4.2.1.5 Relevant practitioner-specific data compared to aggregate data;

4.2.1.6 Morbidity and mortality data;

4.2.1.7 Results of Focused Professional Performance Evaluation (FPPE) and Ongoing Professional Performance Evaluation (OPPE);

4.2.1.8 Such other information as may be determined by the medical staff or Board to make an informed recommendation/approval.

**4.2.2 Qualifications:** The following constitute continuing qualifications for the exercise of privileges at the Hospital. Each member and applicant for clinical privileges shall:

4.2.2.1 **Licensure.** Be currently licensed by the State of Nebraska to practice in a health care profession authorized to provide a medical or surgical level of care (physician, dentist, podiatrist, advanced practice nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, physician assistant or doctoral level

clinical psychologist, or other authorized practitioner fields as may be recognized by the Board).

- 4.2.2.2 **Medications.** Hold current authority to prescribe and administer all medications in this state, including controlled substances, typically used by practitioners in the same field.
- 4.2.2.3 **Education/Training.** For physicians, clinical privileges to perform any surgery or medical management, shall require a minimum three-year post-graduate clinical residency or fellowship. For other practitioners, education/training appropriate to the privileges held or sought is required.
- 4.2.2.4 **Board Certification.** For physicians, be ABMS, AOA, or appropriate specialty board certified or actively pursuing board certification (eligibility period based on ABMS/AOA or appropriate specialty board eligibility requirements) in a specialty relating to the clinical privileges held or sought.
- 4.2.2.5 **Current Competence.** Possess demonstrated competence, including current knowledge, judgment, and technique in his/her licensed or certified profession and/or specialty area, and for all privileges held or applied for.
- 4.2.2.6 **References.** Furnish favorable recommendations from professional colleagues who are in a position to observe and form an informed opinion about the practitioner's current qualifications and ability to exercise the privileges held or applied for.
- 4.2.2.7 **Liability Coverage.** Maintain in full force and effect a valid policy of personal professional liability insurance issued by an insurance company authorized to do business in the State of Nebraska and meeting the minimum required by the Nebraska Excess Liability Fund at that time. Practitioners who do not participate under the Nebraska Hospital-Medical Liability Act must carry coverage in the amounts of \$1 million per occurrence/\$3 million aggregate, issued by an insurance company authorized to do business in the State of Nebraska.
- 4.2.2.8 **Information.** Provide accurate, current, and thorough information in connection with the appointment, reappointment, and privileging process, or in response to inquiries from the Credentials Committee, Executive Committee or Board. Failure to authorize release of information constitutes automatic withdrawal of the application or withdrawal of privileges.
- 4.2.2.9 **Health.** Be free of any substance abuse, or be free of, or have fully under control, any significant physical, mental, or behavioral impairment that interferes with, or presents a substantial probability of interfering with, patient care, the exercise of privileges, the assumption and discharge of required responsibility, or cooperative working relationships, and cooperate openly and fully in any required health assessment.
- 4.2.2.10 **Legal Authority.** Be authorized to function independently in terms of authority to give binding directions to nursing and other hospital staff such that all staff, when carrying out such directions, will do so on lawful authority.

- 4.2.2.11 **Alternate Coverage.** Designate an alternate privileged practitioner in the applicant's field and specialty who has privileges at the Hospital at least coextensive with those held or applied for by the applicant and who has an agreement with the applicant to provide coverage to patients of the applicant when the applicant is unavailable. If the relationship for alternate coverage changes, the applicant or member must notify the Hospital.
- 4.2.2.12 **Hospital Need.** Practice in a field or specialty which is consistent with the purposes, treatment philosophy, methods, and resources of the Hospital and the needs of the community, and for which the Hospital is equipped and staffed to provide care, consistent with the recommendations of the Medical Executive Committee.
- 4.2.2.13 **Reimbursement.** Be licensed in a specialty which generally assures the Hospital that services initiated by or under the authority of the practitioner will be reimbursable under the federal Medicare and Medicaid programs, the Nebraska Blue Cross program, and programs and policies of private insurers.
- 4.2.2.14 **Eligibility.** Maintain eligibility/ability to participate in Medicare, Medicaid or other federal or state governmental health care programs.
- 4.2.2.15 **Continuous Care.** Reside and maintain an office or other place of business in such proximity to the Hospital as to assure his/her availability to the patient commensurate with the privileges held or applied for; provide or arrange for continuous appropriate care for all patients under his/her care; and avoid inappropriate delegation of responsibility for diagnosis, treatment, or follow-up care.
- 4.2.2.16 **Language Proficiency.** Be proficient in written and spoken English.
- 4.2.2.17 **Health Care Operations.** Qualify to participate in Hospital health care operations, such as Hospital and Medical Staff quality improvement, utilization management, peer review and other functions requiring use of protected health information, either as a member of the work force, a participant in an organized health care arrangement with the hospital or by executing a business associate agreement. Qualification under this standard is described in the Rules and Regulations.
- 4.2.2.18 **Responsibilities.** Demonstrate a willingness and ability to abide by the responsibilities and requirements defined in the Medical Staff Bylaws, Rules and Regulations and policies.
- 4.2.2.19 **Additional Criteria.** Meet such additional criteria for privileges as established by the Board from time to time following recommendation by the Medical Staff and by individual clinical departments relating to the exercise of specific clinical privileges.

### **SECTION 3. WAIVER/EXEMPTION**

Privileged practitioners who have been fully credentialed by the Medical Staff as of September 30, 1994, including privileged practitioners who may have been on a leave of absence for reason of illness, are

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exempt from certain requirements, by virtue of having been appointed to the Medical Staff and having been granted clinical privileges before the adoption of the identified requirements. Criteria exemptions are limited to the requirements for board certification, for completion of clinical residency, and to reside within thirty (30) minutes driving of the Hospital. Waiver of a criterion may be recommended from time to time with regard to a particular application if the applicant is otherwise qualified and there is a community need for the applicant's professional services.

#### **SECTION 4. ADMITTING PRIVILEGES**

Admitting privileges are clinical privileges of the Hospital, granted to qualified practitioners in the same manner as other privileges. The admitting practitioner is responsible for certifying to the medical necessity of hospitalization and services in order to support reimbursement under Medicare, Medicaid, Blue Cross, and other programs. In order to be eligible for admitting privileges, the practitioner must meet the following requirements:

- 4.4.1** Hold, or apply for and be qualified to hold, clinical privileges.
- 4.4.2** Be licensed to perform the history and physical examination and to assume overall medical responsibility for a patient's care in the Hospital;
- 4.4.3** Be authorized by law to prescribe and administer all medications used for patient diagnosis and treatment in the Hospital;
- 4.4.4** Be licensed in a health care profession authorized under prevalent third-party payor programs to provide the physician's certification of diagnosis and of medical necessity for all inpatient services connected with a patient's care, including overnight hospitalization, ancillary services, tests, pharmaceutical agents, and supplies;
- 4.4.5** Hold, or apply for and be qualified for Medical Staff membership on the Active or Courtesy Staff; (Exception - Locum Tenens physician who has been granted the privilege to admit, based on the coverage being provided.) and
- 4.4.6** Reside within twenty (20) miles of the Hospital in order to assume continuous care for admitted patients, or have sufficient, pre-determined coverage to provide continuous care for admitted patients

#### **SECTION 5. CO-ADMITTING PRIVILEGES – NON-PHYSICIANS**

- 4.5.1** **Dentists and Podiatrists:** Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chairman of the Surgery Department. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. Dentists and Podiatrists must have arrangement with a physician member of the Active Staff with admitting privileges to admit the patient and be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

#### **SECTION 6. PRIVILEGE DELINEATION**

**4.6.1 Privilege Form:** Clinical privileges may be granted only upon formal request on forms provided by the Hospital with subsequent processing and approval. Such forms shall describe those Hospital-specific privileges available, and shall include criteria specific to the privileges offered. Applicants may only apply for those privileges for which adequate evidence of training and current competence can be demonstrated. The applicant has the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence and other qualifications and for resolving any doubts or questions raised by appropriate Medical Staff leaders, committees, or the Board of Trustees.

**4.6.2 Application:** Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article V of these Bylaws. Clinical privileges shall be delineated on an individual basis. The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of patients.

## **SECTION 7: TEMPORARY PRIVILEGES**

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time. Temporary clinical privileges shall be granted on a case by case basis, to appropriately licensed practitioners, when it is in the best interest of patient care and the Hospital. Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications and current competence to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Medical Staff President. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

**4.7.1 Conditions and Authority for Granting Temporary Privileges.** There are two circumstances in which temporary privileges may be granted, "Pendency of Application" and "Important Patient Care Need", and each circumstance has different criteria for granting privileges. All temporary privileges shall be time-limited, as specified for the type of temporary privileges, and shall automatically terminate at the end of the specific time period for which they were granted. Temporary privileges shall be specifically delineated and may include the privilege to admit patients. A request for temporary privileges shall be made in writing, on forms approved for that purpose.

All temporary privileges are granted by the Chief Executive Officer (or authorized designee), on the recommendation of the Medical Staff President (or authorized designee). Individuals practicing based on temporary privileges shall act under the supervision of the appropriate Department Chair to which he/she is assigned. Temporary privileges will not be granted at the time of reappointment for renewal of existing privileges.

**4.7.2 Pendency of Application:**

**4.7.2.1 Applicant for new clinical privileges (with or without medical staff membership):**

Temporary privileges for a new applicant for clinical privileges may be granted when it would serve the best interests of patient care and/or the Hospital and when the following conditions have been met:



4.7.2.1.1 **Criteria:** The completed application for membership and/or clinical privileges (as defined in Article IV of these Bylaws) raises no concerns, and meets the following criteria:

- Application is complete, with no blanks, and all required explanatory or supporting documents are attached;
- All required primary source verifications have been completed;
- There are no current challenges or previously successful challenges to licensure or registration;
- There is no evidence of involuntary termination of medical staff membership or involuntary limitation, reduction, denial or loss of clinical privileges at any healthcare organization;
- The applicant does not have an unusual pattern of, or excessive number of, professional liability actions (pending or final judgment)
- There are no other controversial issues identified in the credentials file (to include but not be limited to adverse peer recommendations, criminal background, sanction information)

4.7.2.1.2 **Recommendation/Approval:** The applicant has received a favorable recommendation from the appropriate Department Chair and the Credentials Committee (optional); and

- the applicant is awaiting review by the Medical Executive Committee and action by the Governing Board.
- "Applicant for New Privileges" is defined as an individual applying for clinical privileges at the Hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; or an individual who is in the reappointment/re-privileging process and is requesting one or more additional privileges.

4.7.2.1.3 **Term:** Temporary privileges for new applicants may be granted for a period not to exceed the pendency of the application, but in no case will temporary privileges under this condition, exceed 120 days. At the next regularly scheduled meeting of the Medical Executive Committee, the application will be presented for a recommendation to the Board. Following an affirmative action by the Board, the temporary privileges will be automatically terminated and privileges granted by the Board will become effective.

4.7.2.2 **Locum Tenens Applicant:** An appropriately licensed practitioner who is providing locum tenens services at the Hospital on behalf of another privileged practitioner or under contract to the Hospital may, without applying for medical staff membership or regular clinical privileges, be granted temporary privileges to provide such locum tenens coverage.

4.7.2.2.1 For routine locum tenens, members of the Medical Staff seeking to provide coverage through locum tenens physicians or Hospital departments contracting for services shall, whenever possible, advise the Medical Staff Services Department at least thirty days in advance of the identity of the locum tenens practitioner and the dates during which the locum tenens

services will be utilized in order to allow adequate time to complete the credentialing process. To be eligible for temporary privileges, the practitioner will be required to complete an application in accordance with the requirements noted in Article V of these Bylaws, and the application must raise no concerns and meet criteria as defined in Sections 4.6.1 and 4.6.2 above. Upon review and favorable recommendation from the appropriate Department Chair, the Chief Executive Officer (or designee) may, upon recommendation by the Medical Staff President (or designee) grant temporary privileges. Temporary privileges may be granted for the duration of the anticipated coverage period, not to exceed 120 days, and may not be extended. If it is determined that the practitioner may be providing locum tenens coverage for a prolonged period of time, or the practitioner will be providing coverage more than once in a calendar year, the practitioner may be invited to apply for clinical privileges (without membership) through the regular credentialing process. Whenever temporary privileges have been granted for locum tenens coverage, this information will be conveyed to the Medical Executive Committee and Governing Board for informational purposes.

4.7.2.2.2 In rare instances when there is an immediate locum tenens requirement that has been designated as an important patient care, treatment or service need, the process defined in Section 4.7.3. below should be followed; however, as soon as practical a complete credentialing process should be undertaken.

**4.7.3 Important Patient Care, Treatment, and Service Need:** Temporary privileges may be granted to an appropriately licensed practitioner who is not an applicant for membership and/or privileges when there is a documented important patient care, treatment or service need. Specifically, temporary privileges under this definition would include:

- a) the care of a specific patient;
- b) provision of specific treatment or consultation;
- c) the purpose of proctoring or teaching; or
- d) to fulfill a specific service need on a temporary basis.

At a minimum an abbreviated application form as well as verification of current license, relevant training or experience, current competence and ability to perform the privileges requested will be obtained prior to the granting of temporary privileges under this condition. Temporary privileges shall be for a time period sufficient to address the specific need, and the time period will be defined on a case by case basis. At no time will temporary privileges under this condition be for a period exceeding 120 days. If it is determined that services under this condition may be for a prolonged period of time, temporary privileges may be extended, or the practitioner may be invited to apply for clinical privileges through the regular credentialing process. Whenever temporary privileges have been granted under this condition, a report will be made to the Medical Executive Committee and the Governing Board for informational purposes.

**4.7.4 Termination of Temporary Privileges:** On the discovery of any information or the

occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the CEO may, after consultation with the Medical Staff President and/or the Department Chair, terminate any or all of said practitioner's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment or service by the practitioner, the termination may be affected by any person entitled to impose summary suspensions under Article VI Section 6.6.1 of these Bylaws. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Medical Staff President or by the Department Chair. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner.

**4.7.5 Rights of the Practitioner:** A practitioner shall not be entitled to the procedural rights afforded by Article VII of these Bylaws because of his/her inability to obtain temporary privileges or because of any limitation, reduction, termination or suspension of temporary privileges.

## **SECTION 8. TELEMEDICINE PRIVILEGES.**

**4.8.1. General.** Telemedicine refers to the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications that allows a duly credentialed and privileged provider at the "distant site" to fully assess aspects of a patient's condition at the "originating site" in connection with, but not limited to, chart reviews, videoconferencing or other means. "Distant site" is defined as the site at which the physician or other licensed health care practitioner delivering the services is located at the time the service is provided via the telecommunications system. "Originating site" is defined as the location of an eligible Medicare beneficiary at the time the telemedicine service furnished via a telecommunication system occurs. The distant site telemedicine provider would engage, as requested by an originating site provider, in the care of the patient in connection with, but not limited to, direct order writing, review of records, making health care recommendations that the originating site provider has the option of accepting or rejecting or through other means as deemed acceptable by the Medical Staff.

**4.8.2. Distant Site Agreements.** Telemedicine services must be provided through a formal written agreement between either a distant site hospital or distant site telemedicine entity and the originating site. A "distant site telemedicine entity" means an entity that (i) provides telemedicine services; (ii) is a Medicare-participating hospital; and (iii) provides contracted services in a manner that enables a hospital using its services to meet all applicable Conditions of Participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital. Such written agreement entered between a distant site hospital or distant site telemedicine entity and the Hospital must include the following:

4.8.2.1 The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

4.8.2.2 If the distant site is a telemedicine entity, the medical staff credentialing and privileging process and standards meet the requirements at 42 C.F.R. 482.12(a)(1) through (a)(7) and 42 C.F.R. 482.22(a)(1) through (a)(2).

4.8.2.3 The distant site physician or practitioner is privileged at the distant site hospital or telemedicine entity providing the telemedicine services, and the distant site agrees to provide a current list of the distant-site hospital or telemedicine entity's physician's or practitioner's privileges at the distant-site hospital or telemedicine entity to the Hospital.

4.8.2.4 The individual distant-site physician or practitioner holds a license issued or recognized by the state of Nebraska in connection with the telemedicine services.

4.8.2.5 With respect to a distant-site physician or practitioner who holds current privileges at the Hospital in connection with patients receiving telemedicine services, the Hospital provides evidence of an internal review of the physician's or practitioner's performance of these privileges and sends the distant-site hospital or telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or practitioner.

4.8.2.6 To the extent telemedicine services are furnished by a distant site telemedicine entity, a provision that requires the distant site telemedicine entity, in accordance with 42 C.F.R. 12(e), to furnish telemedicine services in a manner that permits the Hospital to comply with all applicable conditions of participation in connection with the telemedicine services, including, but not limited to, those set forth in subsection 4.8.2.2 above.

#### **4.8.3. Qualification**

4.8.3.1 Board certification/eligibility in a specialty recognized by the bylaws of the governing body at the applicable distant site hospital or telemedicine entity.

4.8.3.2 Fully credentialed and privileged at the applicable distant site hospital or telemedicine entity

4.8.3.3 Originating site utilizes delegated credentialing from the distant site

#### **4.8.4. Prerogatives**

4.8.4.1 May not hold office at any level of the Medical Staff organization or Medical Staff committee.

4.8.4.2 May not vote on matters presented at general and special meetings of the Medical Staff or committees.

4.8.4.3 May be responsible for dues and assessments at the discretion of the Medical Staff leadership.

#### **4.8.5. Responsibilities**

4.8.5.1 Must participate as needed in caring for indigent patients.

#### **4.8.6. Process**

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4.8.6.1 Applications for telemedicine privileges will be processed in accordance with the provisions of this Article IV in the same manner as for any other Applicant, except that the Hospital may, in accordance with 42 C.F.R. 22(a)(3), utilize and rely on the recommendations regarding credentialing information provided by the distant site hospital, provided that the distant site hospital is a Medicare participating hospital and provides a current list of all privileges granted to the distant site hospital practitioner or physician. To the extent a distant site telemedicine entity provides telemedicine services, the Hospital, in accordance with 42 C.F.R. 22(a)(4), may grant privileges to such distant site telemedicine entity's physicians and practitioners based on its recommendation, which the Hospital may rely on in connection with the telemedicine services.

4.8.6.2 Once the telemedicine services begin, Hospital shall provide, upon written request, information relevant to assessing the quality of care, treatment, and services provided as a result of the telemedicine services. If required, the information shall include sentinel events, and complaints received from patients, licensed independent practitioners, and Staff at Hospital.

## **SECTION 9. EMERGENCY PRIVILEGES**

In the case of a medical emergency posing an imminent danger of death or serious bodily harm to the patient in the absence of immediate treatment, and in the absence of any member of the Medical Staff with appropriate privileges to treat such patient, any practitioner who would be eligible for membership or privileges by virtue of licensure may be permitted and assisted to attend and treat the patient within the scope of his/her license, using the facilities of the Hospital, without regard to whether such individual has privileges at the Hospital. As soon as practical, the patient will be assigned to a member of the Medical Staff with admitting privileges. The emergency authority available under this Section are not clinical privileges of the Hospital and are exclusively for the benefit of the patient.

## **SECTION 10. DISASTER PRIVILEGES**

**4.10.1** In the case of a disaster and activation of the hospital's emergency management plan in which the hospital is unable to handle immediate patient care needs, disaster privileges may be granted by the chief executive officer or his/her designee, or the President or his/her designee to licensed independent practitioners. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification and at least one of the following:

4.10.1.1 A current picture identification card from a health care organization that clearly identifies professional designation;

4.10.1.2 A current license to practice;

4.10.1.3 Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If due to extraordinary

circumstances, primary source verification of licensure cannot be completed within 72 hours the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

4.10.1.4 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal response organization or group

4.10.1.5 Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances or

4.10.1.6 Confirmation by a licensed independent practitioner currently privileged by the hospital or a medical staff member with personal knowledge of the practitioner's ability to act as a licensed independent practitioner during a disaster

4.10.1.7 MLH Medical Staff are required to wear their MLH identification name badge and all volunteer practitioners will be given a disaster specific name badge to be worn at all times during the disaster until privileges are terminated.

The granting of disaster privileges will be determined on a case by case basis by the chief executive officer or President and will terminate immediately when the disaster ends as determined by the chief executive officer (or his designee). All volunteer practitioners will be assigned to a MLMH medical staff member who will serve as their mentor during the disaster. Disaster privileges may be terminated by the chief executive officer or President (or the designee of either) if problems arise or are uncovered during the verification process.

Based on oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.

## **SECTION 11. ADDITIONS / MODIFICATIONS**

Additions or modifications to clinical privileges may be requested at any time by an individual with clinical privileges, but such requests must be in writing and supported by documentation of training and/or experience supportive of the request. In processing such a request, the National Practitioner Data Bank will be queried and the response used by the Medical Staff in considering the request. Peer reference, insurance information, continuing education and board certification specific to the request will also be considered in the deliberations which increasing privileges.

## **SECTION 12. CRITERIA DEVELOPMENT FOR NEW PROCEDURES**

When new procedures that have not been previously performed at the Hospital are requested, the Credentials Committee shall review the applicant's written request and process the request based on Medical Staff Policy.

### **SECTION 13. HARVESTING OF ORGANS.**

Authority may be granted to any physician qualified to harvest organs, who has been approved by any organ retrieval program affiliated with the Hospital, to do so regardless of whether such physician has privileges at the Hospital.

### **SECTION 15. NON-STAFF ORDERS FOR OUTPATIENT PROCEDURES.**

Medical Staff membership or privileges is not required to order certain low risk outpatient procedures at the Hospital. Such low risk outpatient procedures may be performed upon the order of any licensed practitioner, including physicians licensed in bordering states, provided that they have not established an office in the state of Nebraska. However, outpatient procedures involving a certain level of risk are to be identified by the Medical Staff from time to time, and will be performed only upon the order of a Medical Staff member with appropriate clinical privileges. Procedures for accepting orders are specified in Hospital Policy.

## **ARTICLE V CREDENTIALING**

### **SECTION 1: APPLICATION FOR APPOINTMENT / REAPPOINTMENT OR GRANTING / RENEWAL OF CLINICAL PRIVILEGES**

**5.1.1. Application Form:** All applications for appointment or reappointment to the Medical Staff and/or for initial granting or renewal of clinical privileges shall be in writing shall be signed by the applicant, and shall be submitted on a form prescribed by the Medical Executive Committee, which shall be advised by the Credentials Committee. Such forms shall be designed to allow, at a minimum, confirmation of current licensure, relevant training or experience, and current competence.

5.1.1.1 For initial appointment or initial granting of clinical privileges, the application shall be designed to allow confirmation of licensure, relevant training or experience, and current competence. The application shall require detailed information concerning the applicant's professional qualifications, including:

- the name of professional peers who have current direct knowledge and experience in observing and working with the applicant and who can provide adequate reference pertaining to the applicant's professional competence and ethical character (number of peers to be defined in Credentialing Policy/Procedure),
- information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, or not renewed at any other hospital or institution,
- information as to whether the applicant's license to practice any profession in any jurisdiction, or other certification has ever been voluntarily or involuntarily suspended, reduced or terminated.
- information concerning the applicant's malpractice experience (including claims made or pending or judgments entered against the applicant),

- information concerning any felony convictions or other criminal charges (convictions, “no contest” pleading, or pending charges) other than minor traffic violations; and
- the applicant’s statement regarding ability to physically/mentally perform the essential functions of the profession for which he/she is seeking privileges, with or without reasonable accommodations.
- a consent to release of information from any person or entity who may have information relevant to the applicant’s qualifications and competence.
- if applicable, a request for the specific clinical privileges sought at the Hospital by the applicant.
- Such other information as may be deemed applicable to the Medical Staff in determining the applicant’s qualifications for medical staff membership and/or clinical privileges.

5.1.1.2 For reappointment and/or renewal of clinical privileges the application shall be designed to, at a minimum, confirm current licensure, additional relevant training or experience, and current competence, as well as identify any changes or additions to the information provided in the initial application or most recent reappointment application. If request for renewal, addition, or modification of privileges is being sought, the application package will include a complete itemization of privileges sought.

**5.1.2 Conditions.** By applying for clinical privileges and/or Medical Staff membership, each applicant thereby signifies his/her willingness to appear for interviews in regard to the application; authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on the applicant’s competence, character and ethical qualifications; and the applicant consents to the Hospital’s inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested as well as of his/her moral and ethical qualifications for staff membership and/or clinical privileges, if applicable. The application form should contain a statement that fully informs the applicant of the scope and extent of the authorization, release, and consent provisions and of the immunity provisions contained in these Bylaws, Rules and Regulations.

**5.1.3 Binding Documents.** The application form shall include a statement that the applicant has received and read the Bylaws, and Rules and Regulations of the Medical Staff, and that the applicant agrees to be bound by the terms thereof if granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not granted membership and/or clinical privileges in all matters relating to consideration of the application.

**5.1.4 Applicant’s Burden.** The applicant shall have the burden of producing adequate information for proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. The applicant shall completely fill in all parts of the application, or adequately explain any failure to do so. Falsification of the application in any material respect shall void the application, and it shall be removed from consideration.

**5.1.5. Withdrawal of Application / Failure to Cooperate.** It is anticipated that applicants will be requested to furnish additional or clarifying information, from time to time, during application proceedings. Promptly complying with requests for additional or clarifying information is a condition for the ongoing processing of an application. When an applicant fails or refuses to provide additional or clarifying information, including an interview or a health assessment which



may be requested in connection with application proceedings, the Executive Committee (or the Credentials Committee if at that stage of the application proceedings) may, upon prior notice and opportunity to correct by the practitioner, determine that the application is incomplete and that the practitioner has abandoned the application process, and thereupon discontinue application proceedings. Termination of the application process under this section shall not be grounds for hearing or appeal.

**5.1.6 Previously Denied, Terminated or Withdrawn Applications:** Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges by the hospital, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership and/or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated or deemed withdrawn, then the application shall be deemed insufficient by the Credentials Committee and returned to the applicant as unacceptable for processing. No application shall be processed and no right of hearing or appeal shall be available in connection with the return of such application. Whenever a request for expanded privileges has been denied, this section shall not apply if the applicant certifies and provides supporting documentation that he or she has fulfilled any required conditions to reapply for such expanded privileges.

## **SECTION 2: VERIFICATION PROCESS.**

**5.2.1 Submission.** The completed application and all supporting material shall be submitted to the Medical Staff Office which will examine the application and supporting materials for completeness and inform the applicant within five (5) days of any missing information or attachments. The applicant shall have up to thirty (30) calendar days thereafter in which to furnish the requested information, or the application will be deemed withdrawn and returned to the applicant. Once all of the required information is provided, the Medical Staff Office will verify appropriate information (see 5.2.2 below). The applicant may be notified of problems in verifying the application and asked to assist. Whenever possible, verification should be completed within sixty (60) calendar days of receipt of the application. If the application cannot be verified within a reasonable period of time, the application may be returned to the applicant and deemed withdrawn.

**5.2.2 Verification of Information:** When the application is determined to contain all requested information, the Medical Staff Office will verify appropriate information on the application for membership and/or clinical privileges from the primary source or equivalent source (applicable to initial and renewal of appointment and/or privileges). Verifications are applicable to initial and renewal applications, unless otherwise specified, and may be obtained by letter, secure electronic communication, or telephone communication if documented. Verifications will include, but not be limited to:

- Licensure: Nebraska license to practice profession, including any sanction information
- Education, Training, Board Certification: For new applicants, completion of education and training applicable to the practitioner's healthcare profession, including specialty board certification, if applicable; (for foreign medical school graduates, verification through the ECFMG is also required); for renewal of privileges, any additional training received during the appointment period and re-verification of specialty board certification

- Continuing Education: If applying for initial or renewal of privileges, information regarding the topics and content of the practitioner's continuing education will be requested from the applicant
- NPDB: Information reported pursuant to the HCQIA shall be obtained from the National Practitioner's Data Bank at initial appointment and at least every two years thereafter.
- Sanction Reports: The OIG Sanction Report and the State Exclusion List shall be checked to ensure that the applicant is not listed
- DEA: For individuals requesting prescribing privileges, federal DEA registration
- Liability Insurance: If applying for clinical privileges, proof of liability insurance in an amount specified by the Board of Trustees
- Claims History: If applying for clinical privileges, history of professional liability claims (open, closed, pending)
- Peer References: Letters of reference from the applicant's peers; such letters of reference will request, at a minimum, information related to patient care, medical/clinical knowledge, interpersonal and communication skills, and professionalism (The applicant's health status as applicable to his/her ability to perform the clinical privileges requested shall be verified as part of the information requested from the applicant's peers.)
- Performance Evaluation/Competence: If applying for clinical privileges, data and information regarding professional performance from available sources, including relevant applicant's specific data as compared to aggregate data, and morbidity and mortality data (when available)
- Such other information as may be deemed appropriate by the Medical Staff, or as may be defined in a Credentialing Policy
- Verification of expirable information, as defined in the Credentialing Policy, will be obtained at time of initial appointment, reappointment, and at time of expiration.

**5.2.3 Additional Inquiry:** At any point during the credentialing process, an application will be considered incomplete if the need arises for new, additional, or clarifying information at any time. Additional inquiry may be conducted by the Medical Staff Office, Department Chair, Credentials Committee or Medical Executive Committee, and may include a personal interview with the applicant, a request for a letter of explanation from the applicant, further contact with sources of information, and/or any other means appropriate to resolving questions about the application.

**5.2.4 Verification of Identity:** The Medical Staff Office (or designated department) shall take reasonable steps to verify that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following: a current picture hospital ID card, or a valid picture ID issued by a state or federal agency (e.g., driver's license or passport) (c.f. *The Joint Commission, MS.06.01.03, EP5*). Such verification is typically performed by the applicant providing the documentation in person, prior to performing any requested privileges.

**5.2.5 Review for Completeness.** An application shall be deemed complete and verified once the Medical Staff Office has determined (i) that the application form itself and supporting materials are complete, and (ii) the application is satisfactorily verified. The application, together with supporting materials and verifications, shall then be made available to the appropriate individuals/committees for review; recommendation and approval (see 5.3 below).

### **SECTION 3: REVIEW, RECOMMENDATION & APPROVAL**

The review, recommendation and approval process defined below applies to medical staff appointment and reappointment as well as granting or renewing of clinical privileges. At any point during the review process, the Department Chair, Credentials Committee, or Medical Executive Committee may request additional information or an interview with the applicant (see 5.2.3 above).

**5.3.1 Department Review.** Within thirty (30) days after receipt of the completed application, the department chair shall make a written report of its review to the Credentials Committee. If more than one (1) department chair examines the application (based on scope of privileges requested), each shall report separately. Prior to making a report, the department chair shall examine the evidence of the character, professional competence, qualifications, and ethical standing of the practitioner and shall determine, through information contained in references given by the practitioner and from other sources available to the department, whether the practitioner has established and meets all of the necessary qualifications for the clinical privileges requested, and the category of Staff membership, if applicable. Every clinical area in which the practitioner seeks clinical privileges shall be reviewed by the department and written recommendations for delineating the practitioner's clinical privileges shall be made a part of the report. Together with its report, the department chair shall transmit to the Credentials Committee the completed application and a recommendation that the practitioner be granted (with or without conditions) or denied, Medical Staff membership and/or clinical privileges, as applicable; or that the application be deferred for further consideration or additional information (see 5.2.3 above). Any recommendation for conditions to, or denial of, privileges or membership must define the basis for the recommendation.

**5.3.2 Credentials Committee Review:** Upon receipt of the application and the report and recommendation of the department chair(s), the Credentials Committee will review whether the practitioner has established and meets all of the necessary qualifications for the clinical privileges requested, and the category of Staff membership, if applicable. The Credentials Committee shall make a recommendation to the Medical Executive Committee that the practitioner be granted (with or without conditions) or denied medical staff membership and/or clinical privileges, as applicable, or the application be deferred for further consideration or additional information (see 5.2.3 above). Any recommendation for conditions to, or denial of, privileges or membership must define the basis for the recommendation.

**5.3.3 Executive Committee Recommendation.** The Executive Committee, in turn, shall review the reports and recommend to the Board of Trustees that the practitioner be either granted (with or without conditions), or denied medical staff membership and/or clinical privileges, ~~and~~, as applicable, or that the application be deferred for further consideration or additional information (see 5.2.3 above). The recommendation of the Executive Committee should be appropriately communicated within sixty (60) days following notice from the Medical Staff Office that the application is complete and ready for the review process.

**5.3.3.1 Defer Action.** When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up at the next regular meeting of the Executive Committee with a subsequent favorable recommendation for grant (with or without conditions) of specified clinical privileges and Medical Staff membership, as applicable, or an adverse recommendation.

5.3.3.2 **Favorable Recommendation.** When the recommendation of the Medical Executive Committee is favorable to the practitioner, the chief executive officer shall promptly forward it, together with supporting information, to the Board of Trustees.

5.3.3.3 **Adverse Recommendation.** When the recommendation of the Executive Committee is adverse to the practitioner in respect either to membership or clinical privileges, the chief executive officer shall promptly so notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board until after the practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in other Articles of these Bylaws. Any notice given under this subsection shall comply with the requirements of Notice of Adverse Action or Recommendation set forth in Article VII, Section 2, of these Bylaws. Thereafter, the procedure set forth in Article VII shall govern.

**5.3.4 Board Action.** At its first regular meeting after receipt of a favorable recommendation from the Medical Executive Committee or a recommendation from a Hearing Committee, the Board or its executive committee shall act on the matter.

5.3.4.1 **Favorable Decision:** If the Board of Trustees' action is favorable, it shall send notification to the Medical Staff Office, who shall, on behalf of the Board and/or the chief executive officer, send written notice of such decision to the practitioner.

5.3.4.2 **Adverse Decision:** If the Board's decision is adverse to the practitioner in respect to either membership or clinical privileges, the chief executive officer shall promptly notify the practitioner of such adverse decision by certified mail, return receipt requested; and such adverse decision shall be held in abeyance until the practitioner has exercised appeal rights or until the Board has made a final decision. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

5.3.4.3 **Board Action in Contested Case.** At its first regular meeting after all the practitioner's rights under these Bylaws have been exhausted or waived, the Board or its duly authorized committee shall act on the matter. The Board's decision shall be conclusive, except that the Board may defer final determination by referring the matter back to the Medical Executive Committee or the Hearing Committee for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. At its next regular meeting after receipt of such subsequent recommendation and new evidence in the matter, if any, the Board shall make a decision either to grant the privileges (with or without conditions) and/or appoint the practitioner to membership, or to reject the application. All such favorable decisions regarding privileges shall include a delineation of the clinical privileges the practitioner may exercise. When the Board's decision is final, it shall send notice of such decision.

**5.3.5 Board of Trustees Expedited Credentialing Action:** The purpose of an expedited approval process for uncomplicated applications for appointment or reappointment to the medical staff and/or for granting, modifying or renewal of clinical privileges is to more efficiently process those applications with no controversial issues and to utilize medical staff and hospital staff time

more effectively. The Board may delegate the authority to render those decisions to a committee of at least two voting members of the Board to review and act on applications where all criteria have been met and a favorable recommendation, without limitation, has been received from the Medical Executive Committee. A written Summary of Actions will be forwarded for affirmation to the Board of Trustees and such affirmation will be recorded in the minutes of the next regularly scheduled Board meeting. (This process is not considered “temporary privileges”.)

5.3.5.1 **Criteria:** The Medical Executive Committee shall approve the criteria for an expedited process and will utilize such criteria when making recommendations to the Board. The expedited approval process shall only apply when the application meets all of the following criteria:

- Application is complete, with no blanks, and all required explanatory or supporting documents are attached;
- All required primary source verifications have been completed;
- There are no current challenges or previously successful challenges to licensure or registration;
- There is no evidence of involuntary termination of medical staff membership or involuntary limitation, reduction, denial or loss of clinical privileges at any healthcare organization;
- The applicant does not have an unusual pattern of, or excessive number of, professional liability actions (pending or final judgment);
- There are no other controversial issues identified in the credentials file (to include but not be limited to adverse peer recommendations, criminal background, sanction information);

#### **SECTION 4. REAPPOINTMENT/RENEWAL**

**5.4.1 Process:** As identified in Sections 1 and 2 above, applications for reappointment to the medical staff and/or renewal of privileges will be processed the same as initial applications, and the review and approval process will be the same as that noted in 5.3 above. In reviewing applications for reappointment and/or renewal of privileges, the Credentials Committee, Medical Executive Committee and Board will not be limited to review of information supplied within or in support of the application, but may review and consider any other records and information deemed relevant to their review. Matters and events from an earlier term of appointment are relevant if they help demonstrate a pattern or explain matters and events from a current term.

**5.4.2 Modification in Staff Category and/or Clinical Privileges:** The Medical Executive Committee may recommend to the Board that a change in staff category of a current practitioner or the granting of additional privileges to a current practitioner be made in accordance with the procedures for initial appointment as outlined in this Article.

**5.4.3 Effect of Reappointment/Renewal Application.** Unless otherwise modified, suspended, or revoked under these Bylaws, upon receipt of a complete, timely application for reappointment and/or renewal of privileges, the existing membership and/or privileges will remain effective until the anniversary date for the practitioner’s membership and/or privileges or the date the

Board deems the reappointment/renewal effective date, as long as the appointment/privilege grants do not exceed two years.

## **SECTION 5. RESIGNATION.**

A practitioner may resign his or her membership or clinical privileges as follows:

**5.5.1 Voluntary Resignation.** A voluntary resignation is a decision by an individual to surrender one or more clinical privileges and/or Medical Staff membership based on that individual's personal preference. Resignation shall apply to membership and clinical privileges, as applicable to the particular practitioner. A practitioner may submit a voluntary resignation at any time, and such resignation is effective upon acceptance by the Medical Executive Committee. The Medical Executive Committee may condition acceptance upon the orderly completion of records or other pending responsibilities of such practitioner.

**5.5.2 Resignation While Under Investigation.** A resignation by a privileged practitioner (i) who is under investigation as defined in Article VI, of these Bylaws, (ii) in lieu of conducting an investigation, or (iii) where such resignation is part of the terms or conditions of the negotiated resolution of peer review activity, shall not be effective until submitted to and approved by the Board. The Board may condition acceptance upon the orderly completion of records or other pending responsibilities of the privileged practitioner or the fulfillment of negotiated terms.

5.5.2.1 Reporting. The chief executive officer in consultation with the Medical Executive Committee and in accordance with state and federal regulations shall determine when a resignation under this Section requires reporting to the Board of Medical Examiners or other relative Boards, or the National Practitioner Data Bank and take steps to ensure timely reporting.

## **SECTION 6. LEAVE OF ABSENCE.**

**5.6.1 Voluntary:** Any practitioner, whether suffering from incapacity or for other reasons, may request a voluntary leave of absence from membership and/or privileges, during which he/she shall have no admitting or other clinical privileges and during which he/she shall not be required to attend meetings or pay dues/fees. Reinstatement of membership and/or privileges shall be at the discretion of the Medical Executive Committee and subject to such conditions as it may impose, including the requirement of reapplication. The practitioner on leave of absence must request reinstatement before the Medical Executive Committee will consider the matter. (Reference the Medical Staff Policy 3.12, Leave of Absence)

**5.6.2 Involuntary:** Any notice of involuntary leave of absence by the Medical Executive Committee shall comply with the requirements of Notice of Adverse Action or Recommendation set forth in Article VII, Section 2, of these Bylaws. Thereafter, the procedure set forth in Article VII shall govern.

## **ARTICLE VI PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION**

## **SECTION 1. PROFESSIONAL PRACTICE EVALUATION – OVERVIEW**

- 6.1.1 Scope:** All individuals with delineated clinical privileges will participate in the professional practice evaluation process. Such process includes:
- 6.1.1.1 Focused Professional Practice Evaluation (FPPE) for new privileges granted, when a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence;
  - 6.1.1.2 Ongoing Professional Practice Evaluation (OPPE) provides continuous evaluation of a practitioner’s performance, allowing any potential problems with a practitioner’s performance to be identified and resolved as soon as possible, and also fosters a more efficient, evidence-based privilege renewal process.
  - 6.1.1.3 Focused Professional Practice Evaluation (FPPE) requires a more intensive review/investigation in instances where questions may arise regarding a practitioner’s professional practice during the course of initial or ongoing evaluation.
- 6.1.2 Immunity:** To the fullest extent permitted by law, absolute immunity is extended to professionals with privileges, the hospital and its authorized representatives, and to any third parties with respect to any acts, communications or documents, recommendations or disclosures, and/or for any request for disclosure of information made in good faith and relating to peer/ professional practice evaluation activities.

## **SECTION 2. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE).**

Ongoing evaluation information is factored into the decision to maintain an existing privilege, to revise an existing privilege, or to revoke an existing privilege prior to or at the time of renewal. Information resulting from this evaluation is used to determine whether to continue, limit, or revoke an existing privilege. Practitioner-specific evaluation reports (at Mary Lanning Healthcare, these reports are identified as “Physician Performance Profiles” or “Practitioner Performance Profiles”) shall be created every eight months for each practitioner with privileges. Any evaluation referencing focused review or quality concern issues shall be reviewed by the Department Chair and submitted to the Medical Staff Excellence Committee at its next meeting; however, the Department Chair or his/her designee shall, at any time, immediately act upon any reported concern regarding a privileged practitioner’s clinical practice and/or competence.

Ongoing professional practice evaluation procedures and functions are outlined in the Medical Staff **Ongoing Professional Practice Evaluation Policy 3.6.**

**6.2.1 Factors to be considered:** The criteria used in ongoing professional practice evaluation include but are not limited to the following:

- Concurrent review of the practitioner’s assessment and treatment of patients;
- Review of invasive and non-invasive clinical procedures performed and their outcomes;
- Patterns of blood and medication usage;
- Length of stay patterns, morbidity and mortality data;
- Requests for tests and procedures; use of consultants; medical records compliance;

- Other relevant criteria as directed within these Bylaws and/or by the MEC.

**6.2.2 Data Sources:** Information used in ongoing professional practice evaluation may be obtained through, but is not limited to, the following:

- Concurrent and/or targeted medical record review;
- Direct observation;
- Monitoring/proctoring;
- Discussion with other practitioners involved in the care of specific patients;
- Data collected and assessed through quality improvement indicators;
- Sentinel event data;
- Any applicable focused review data.

### **SECTION 3. FOCUSED PROFESSIONAL PRACTICE EVALUATION**

The Medical Staff is organized in a manner in which professional practice evaluation functions are undertaken for the purpose of improving the care and safety of patients and reducing morbidity and mortality. Such evaluation includes but is not limited to: the necessity, timeliness, and appropriateness of patient care; the quality of patient care; and the extent to which complications and deaths are prevented. All focused professional practice evaluation functions are performed by the medical staff under the direction and authority of the Board of Trustees. The Board of Trustees shall receive and act upon the reports and recommendations of all committees and individuals so assigned to provide such information.

Focused professional practice evaluation shall be performed in the various Departments, Clinical Services and divisions of the Medical Staff and by any committee of the Medical Staff so designated, including those committees described in the Hearing and Appeal process found in Article VII. Focused professional practice evaluation procedures and functions are outlined in the Medical Staff **Focused Professional Practice Evaluation Policy 3.7**.

All information and data collected by or for individuals and/or committees assigned a professional practice evaluation activity shall be confidential; shall be used only for carrying out the function of professional practice evaluation; and shall be withheld from any individual or entity not assigned to perform or participate in professional practice evaluation. Such records, data and knowledge shall be entitled, without limitation, to the protection of the applicable state and federal regulations protecting peer review.

### **SECTION 4. INVESTIGATIONS AND CORRECTIVE ACTION.**

**6.4.1 Grounds for Investigations.** When information, including the results of quality assurance or performance improvement activities, Ongoing Professional Practice Evaluation, and/or Focused

*MLH Medical Staff Bylaws*

*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*



Professional Practice Evaluation indicates any of the following:

- a question or concern related to the demonstrated clinical competence of any practitioner with privileges; or
- cause to question the care or treatment of a patient(s) or management of a case by any professional with delineated clinical privileges; or
- possible detriment to patient safety; or
- appears to be below applicable professional standards; or
- non-compliance with clinical pathways, standards or indicators accepted by the Medical Staff of Mary Lanning Healthcare

the Medical Staff Excellence Committee shall assure a sufficient inquiry with appropriate involvement of the Department Chair and other applicable individuals, to satisfy the Committee that the concern or question is credible. The investigation may involve an interview with the practitioner and/or an interview of other individuals or groups deemed appropriate by the Committee.

**6.4.2 Investigation by the Medical Staff Excellence Committee.** An investigation by the Medical Staff Excellence Committee shall comply with the procedure outlined in the Focused Professional Practice Evaluation policy and may include a review of the medical record, aggregate performance data as deemed necessary by the Committee, comparative data when available, and any other information material to the matter being investigated.

**6.4.3 Action by the Medical Staff Excellence Committee.** Should it be determined that there are credible concerns, action to improve performance or to correct the concerns may be initiated by the Committee including:

- Informal discussions or formal meetings regarding the concerns raised about conduct or performance with written notification of expectations for improvement;
- Written letters of guidance, reprimand or warning regarding findings and / or concerns about conduct or performance;
- Notification that future conduct or performance shall be monitored and notification of expectations for improvement;
- Recommendations for continuing education, consultations, or other assistance in improving performance;
- Warnings regarding the potential consequences of failure to improve conduct or performance, and/or,
- Report of findings with recommendations for action to the Medical Executive Committee.

A written report of the investigation, including all material evidence, action taken, and recommendations shall be made available to the Medical Executive Committee by the Medical Staff Excellence Committee.

**6.4.4 Procedure thereafter.** If the Medical Executive Committee assumes responsibility for conducting additional investigation, it may assign the task to a Medical Staff officer, department, ad hoc team, or other organizational component. External third parties may be utilized.

After considering the results of the investigation, if the findings warrant, the MEC may:

- issue a written warning;
- issue a letter of reprimand;
- impose terms of probation, further training, or mandatory supervision;
- impose a requirement for mandatory consultation;
- recommend reduction of clinical privileges;
- recommend suspension of clinical privileges for a specified time; or
- recommend revocation of staff appointment or clinical privileges.

Any recommendation by the MEC for reduction of clinical privileges, for suspension of clinical privileges, mandatory consultation, or for revocation of staff appointment or clinical privileges shall entitle the affected individual to the procedural rights provided in Article VII. Such a recommendation shall be forwarded to the Chief Medical Officer who shall promptly notify the affected individual by certified return-receipt mail, in accordance with the requirements set forth in Article VII. The Medical Executive Committee shall then hold the recommendation until after the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII after which the Chief Medical Officer shall forward the recommendation, together with all supporting documentation, to the MEC. The chairperson of the MEC or his/her designee shall be available to the appropriate committee to answer any questions that may be raised with respect to the recommendation.

If the action of the MEC is less severe than reduction of clinical privileges, suspension of clinical privileges, mandatory consultation, or revocation of staff appointment or clinical privileges, the action shall take effect immediately without action of the Board of Trustees. A report of the action taken and reasons therefore shall be made to the Board of Trustees through the Chief Medical Officer and the action shall stand unless modified by the Board of Trustees. In the event the Board of Trustees determines to consider modification of the action of the MEC, and the Board of Trustees' modification would impose mandatory consultation, reduce clinical privileges, suspend clinical privileges for fourteen days or more, or revoke staff appointment, the Board of Trustees shall so notify the individual, through the Chief Executive Officer (CEO) in accordance with the requirements set forth in Article VII, and the Board of Trustees shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article VII.

The chairperson of the MEC shall keep the Chief Medical Officer, the Chief Executive Officer and MEC members fully informed.

**6.4.5 Actions Not Subject to Procedural Rights:** Neither voluntary nor automatic relinquishment of clinical privileges or Medical Staff membership as provided for elsewhere in these Bylaws, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the MEC or the Board of Trustees, nor a Hospital decision to eliminate a service or Clinical Service, which has the effect of nullifying privileges, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

## **SECTION 5. CORRECTIVE ACTION FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF MEMBERS AND NON-MEMBER PRIVILEGED PRACTITIONERS**

**6.5.1. Grounds For Action:** When the Chief of Staff, the Chief Medical Officer, a Department Chair, a Medical Staff leader, or Mary Lanning Healthcare President:

- knows or has reason to suspect violation by any Medical Staff member or privileged practitioner of applicable ethical standards, Mary Lanning Healthcare Corporate Bylaws, or its Standards of Conduct;
- has evidence of violation of the Medical Staff Bylaws, Rules or Regulations, Policies;
- concludes that behavior or conduct on the part of any Medical Staff member or privileged practitioner is less than the standards of Mary Lanning Healthcare or disrupts the orderly operation of Mary Lanning Healthcare or its Medical Staff, including the inability of the member or privileged practitioner to work harmoniously with others; or,
- has cause to believe that the practitioner is excluded or otherwise ineligible for participation in federal health care programs, including Medicare and Medicaid;

he/she will complete a written request for an investigation of the matter. The request will be addressed to the Chief Medical Officer making specific reference to the activity or conduct that gave rise to the request.

**6.5.2 Investigative Procedure:** The Chief Medical Officer shall initiate an investigation as soon after receiving the request as practical and shall determine the necessity of appointing a subcommittee or an investigating committee. An investigating committee shall consist of three persons, any of whom may or may not hold appointments to the Medical Staff. This investigating committee shall not include partners, associates, or relatives of the affected individual, any member of the MEC, or anyone in direct economic competition with the individual in question.

The Chief Medical Officer, the subcommittee or the investigating committee, if used, shall have available to them the full resources of the Medical Staff and the Hospital to aid in their work, as well as the authority to use outside consultants as required.

The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Chief Medical Officer, subcommittee, or investigating committee before it makes its recommendation. At this meeting (but not as a matter of right, in advance of it) the individual shall be informed of the evidence supporting the investigation requested, and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws, with respect to hearings, shall apply.

A summary of the investigation will be documented by the Chief Medical Officer including a report of interviews, findings and recommendation by a sub-committee or the investigating committee, and reported to the MEC. The MEC may accept, modify, or reject the recommendation received from the Chief Medical Officer.

## **SECTION 6. SUMMARY SUSPENSIONS.**

### **6.6.1 Grounds for Summary Suspension:**

**6.6.1.1.** When a privileged staff member or non-member privileged practitioner demonstrates such poor performance, incompetence, or inappropriate conduct that appears to require immediate action so as to protect the life or well-being of a patient(s), or to reduce a substantial and immediate likelihood of significant impairment of the health or safety of any patient, prospective patient or other person, the President of the Medical Staff, appropriate Department Chairperson or Chief Medical Officer may impose a summary suspension or restriction on the clinical privileges of the individual. Unless otherwise stated, such suspension or restriction shall become effective immediately upon imposition and the person responsible for imposing the suspension or restriction shall promptly give written notice to the Chief Executive Officer and the Medical Executive Committee. In addition, the affected individual shall be provided with a written notice of the action within one day of the imposition. This initial notice shall include a summary of facts and issues regarding the individual's conduct that lead to the summary suspension or restriction and shall not substitute for the notice required in Article VII.

**6.6.1.2.** At any time during a Focused Professional Practice investigation, the MEC, with approval of the Chief Medical Officer, may suspend all or any part of the clinical privileges of the person being investigated.

**6.6.1.3** A summary suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall remain in effect during the investigation only, shall not indicate the validity of the charges, and shall remain in force, without appeal, during the course of the investigation. If such a suspension or reduction in privileges lasts longer than 29 days, the person affected shall have the procedural rights set forth in Article VII.

**6.6.2 Disposition of Patient Care:** When the individual being suspended or restricted is a licensed independent practitioner with privileges, the practitioner's Department Chair or the President of the Medical Staff shall arrange for alternative medical coverage of a suspended practitioner's patients in the Hospital and for coverage of affected patient care. The wishes of the patient shall be considered in the selection of an alternative practitioner. When the individual being suspended or restricted is an Allied Health Professional with privileges, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the Allied Health Professional.

**6.6.3 Investigation / Peer Review Process:** The Medical Executive Committee shall request that the Medical Staff Performance Excellence Committee investigate the charge pursuant to Article 6.4.2 and 6.4.3 of these Bylaws.

## **SECTION 7. AUTOMATIC SUSPENSION OR TERMINATION.**

**6.7.1: Practitioner Self Reporting:** Each privileged practitioner shall report any of the following events in writing within ten (10) days of their occurrence. The report shall be furnished to the President of the Medical Staff. Failure to report such events will be grounds for automatic suspension or termination. Reportable events are:

6.7.1.1 The payment by or on behalf of the privileged practitioner of any money in judgment or settlement of any professional liability claim against such practitioner (regardless of whom made the payment);

6.7.1.2 Involuntary denial, loss, or curtailment of the privileged practitioner's license or certification to practice his/her profession or the privileged practitioner's registration to prescribe controlled substances and any voluntary acceptance of any such action or result during an investigation or sanction proceeding against such privileged practitioner;

6.7.1.3 Exclusion from the Medicare and/or Medicaid program, suspension of the right to receive reimbursement from any government program, or debarment from any federal program or programs; or

6.7.1.4 Involuntary denial, suspension, or termination of membership on the medical staff or denial, suspension, termination, or curtailment of clinical privileges at another hospital or healthcare facility lasting thirty (30) calendar days or longer and any voluntary acceptance of any such action or result during an investigation or in return for not conducting an investigation of such practitioner.

**6.7.2 Refusal to Provide Information:** If at any time a practitioner fails to provide required information pursuant to a formal request by the Credentials Committee, the Executive Committee or the Chief Executive Officer, the privileged practitioner's clinical privileges shall be automatically relinquished until the required information is provided to the requesting party. For purposes of this Section "required information" shall refer to (1) physical or mental examination as specified elsewhere in these Bylaws; (2) information necessary to explain an investigation, professional review action, or resignation from another facility or agency (3) information from a practitioner's private office that is necessary to address and/or resolve questions that have arisen during the Hospital's credentialing and/or peer review processes; or (4) information pertaining to professional liability actions involving the practitioner.

**6.7.3 Misrepresentation:** When it is discovered that an individual misrepresented, omitted, or erred in answering the questions on an initial application for Medical Staff membership or clinical privileges, or in answering interview queries and the error is a material or substantive misrepresentation as judged by the Medical Executive Committee, the individual shall be notified that processing of the application shall be automatically terminated. Whenever it is discovered that an individual misrepresented, omitted, or erred in answering questions on a reappointment application, and the error is a material or substantive misrepresentation as judged by the MEC, the individual shall be notified that the application for renewal

of membership and/or clinical privileges shall be automatically terminated. Substantial or material misrepresentation of the applicant's qualifications, competence or character may be grounds to permanently disqualify an individual from future application for membership or clinical privileges at MLH or to pursue corrective action prior to the practitioner's scheduled application for renewal of membership or privileges.

**6.7.4 Licensure:** If a practitioner's license to practice is revoked or suspended by a State licensing authority, or if an individual fails to maintain a current license, he/she shall be immediately automatically suspended from practicing in the hospital/clinical and his/her staff membership shall be automatically suspended.

**6.7.5 Controlled Substance Registration:** If a privileged practitioner's DEA registration is revoked, suspended, or involuntarily restricted, or if an individual fails to maintain a current DEA registration, he/she shall be automatically suspended from prescribing controlled substances and may be automatically suspended from practicing in the Hospital.

**6.7.6 Liability Insurance:** If a practitioner with delineated clinical privileges professional liability insurance is revoked or the practitioner fails to maintain ongoing coverage as required by the Board of Trustees, he/she shall be immediately automatically suspended from practicing in the hospital/clinic.

**6.7.7 Eligibility to Participate in Federal Programs:** The occurrence of any of the following events shall result in immediate automatic suspension from practicing in the Hospital and its clinics: a) Becoming an "Excluded Person" as that term is used by the Office of the Inspector General (OIG); b) A criminal conviction other than a misdemeanor.

**6.7.8. Medical Records:** A medical record is considered to be delinquent when it has not been completed for any reason within thirty (30) calendar days following a patient's discharge, or within timeframes specified in Medical Staff Rules and Regulations (**Rules and Regulations sections 7.2-1, 7.8-1, and 7.10.**) Language governing the suspension of privileges in the event of failure to complete medical record(s) in a timely manner is found in **Medical Staff Rules and Regulations, Section 7.10** and Mary Lanning Healthcare policy HIM 110.00 v.1 **Medical Records Standards.**

**6.7.9 Criminal Arrest:** In the event that an individual is arrested for alleged criminal acts, an immediate review of the circumstances of the arrest shall be made. The MEC shall review or appoint an ad hoc committee to review the circumstances leading to the arrest and may determine if further action is warranted prior to the outcome of the legal action. If the MEC recommends use of a corrective action that fits the definition of an adverse action, this shall entitle the individual notification and the right to a hearing and appeal as set forth in Article VII.

**6.7.10 Reinstatement of Privileges Pending Review.** A practitioner whose clinical privileges have been summarily suspended or limited or who has accepted voluntary limitations in lieu of summary action may, at any time during corrective action proceedings, request reinstatement of those privileges by delivering a written request to the Medical Executive Committee. Reinstatement of privileges pending completion of the corrective action proceeding shall be a matter solely within the discretion of the Medical Executive Committee, subject to the ultimate authority of the Board. A practitioner who is not at that time involved in corrective action proceedings, but who has voluntarily requested limitations may, at any time, request permission to remove the limitation which he/she originally requested by

delivering a written notice to the Medical Executive Committee. The Medical Executive Committee shall treat such a request as an application for new or expanded privileges.

## **SECTION 8. REPORTABLE ACTIONS.**

**6.8.1** Administrative actions that do not involve a professional review action (such as automatic suspensions/revocations) are not reportable to the National Practitioner's Data Bank (NPDB). Only actions resulting from professional (peer) review and lasting more than 30 calendar days that are related to the professional competence or professional conduct of a practitioner should be reported to the NPDB.

## **ARTICLE VII HEARING AND APPELLATE REVIEW PROCEDURE**

### **SECTION 1. GROUNDS FOR HEARING.**

Only the following actions constitute grounds for hearing:

- 7.1.1** Action or recommendation by the Executive Committee with respect to an applicant, member or other privileged practitioner to:
- 7.1.1.1 Deny an application for membership or privileges (including an application for expanded privileges) based on the competence or professional conduct of the individual practitioner;
  - 7.1.1.2 Deny an application for reappointment or for continued privileges in connection with the reappointment process;
  - 7.1.1.3 Revoke, terminate, or suspend privileges;
  - 7.1.1.4 Revoke, terminate, or suspend membership or reclassify a member to a lower category of membership or deny a member's request for advancement in his/her category of membership; or
  - 7.1.1.5 Impose significant restrictions on the exercise of privileges by a privileged practitioner, other than those required by these Bylaws or permitted under Article VI, Section 9 a-j, or other than for purposes of observation and evaluation.
- 7.1.2** Action by the Board to impose any of the actions outlined in the preceding subparagraph "a", when such action is contrary to a prior favorable recommendation of the Executive Committee and the practitioner has not already had a hearing.

### **SECTION 2. NOTICE OF ADVERSE ACTION OR RECOMMENDATION.**

Whenever the Executive Committee, Hearing Committee, or Board takes action (or makes an adverse recommendation) entitling the practitioner to a hearing or appellate review, the body making the recommendation or taking the action shall furnish the affected practitioner with formal Notice of Adverse Action or Recommendation. This notice shall be furnished in writing by the chief executive

officer via certified mail, return receipt requested, or by personal delivery to the affected practitioner. Such notice shall:

- 7.2.1** Advise the practitioner of the action or proposed action or recommendation and of the grounds on which it is based;
- 7.2.2** Advise the affected practitioner of his/her right to a hearing or appellate review pursuant to this Article VII;
- 7.2.3** Specify that the affected practitioner shall have thirty (30) days following the date of receipt of such notice within which to request a hearing or ten (10) days following receipt of such notice within which to request an appellate review, whichever is applicable;
- 7.2.4** State that failure to request a hearing within the specified time period shall constitute a waiver of the practitioner's rights to same; and
- 7.2.5** Furnish the affected practitioner with a summary of his/her rights in the hearing, by providing a copy of the applicable provisions of these Medical Staff Bylaws.

### **SECTION 3. NOTICE OF HEARING.**

The chief executive officer shall schedule the hearing. The Executive Committee and the affected practitioner shall be given written notice stating the place, time and date of the hearing not less than thirty (30) days prior to the scheduled date thereof, together with a written list of the witnesses the other party proposes to call at such hearing. If either party requires an extension of time, such extension shall be requested within ten (10) days following receipt of notice of the date scheduled by the chief executive officer.

### **SECTION 4. HEARING COMMITTEE OR HEARING OFFICER.**

- 7.4.1 Composition of Hearing Committee.** Approximately twenty (20) days after receipt of a request for hearing, or as soon thereafter as the date of hearing is reasonably known, the chief executive officer, after consultation with the President, shall appoint a Hearing Committee and provide each member of the Hearing Committee with copies of the action or recommendation, the notice to the affected practitioner, and the practitioner's request for hearing. The Hearing Committee shall be formed under the following guidelines:
  - 7.4.1.1** The Committee shall be composed of not fewer than three (3) practitioners, a majority of whom must be physicians, and none of whom should be in direct economic competition with the affected practitioner as that term is defined by the hospital. The Committee should, to the extent possible, be comprised of privileged practitioners at the Hospital, but this guideline shall not control when its application would result in insufficient Committee members, or would require appointment to the Committee of a practitioner who has initiated the complaint.
  - 7.4.1.2** By mutual written agreement between the affected practitioner and the chief executive officer in consultation with the President of the Medical Staff, the composition of the Committee may be varied from the requirement of the preceding sentence in any



manner, but the affected practitioner will be deemed to have consented to any time delay attributable to such variance.

- 7.4.1.3 When the affected practitioner is a non-member privileged practitioner, reasonable efforts will be made for at least one (1) member of the Hearing Committee to be a non-member privileged practitioner, preferably but not necessarily of the same profession as the affected practitioner. A practitioner who is not affiliated with the Hospital may be appointed to fill this position, if necessary.
- 7.4.1.4 The affected practitioner shall be given reasonable advance notice of the composition of the Hearing Committee and shall have the right to raise any conflicts of interest within two (2) days of receipt of such notice. No person will be disqualified from serving on the Hearing Committee because of prior knowledge regarding the facts of the case, provided, however, that disqualification will result from participation in imposing the adverse action or adverse recommendation from which the hearing rights arise.
- 7.4.1.5 One member of the Hearing Committee will, at the time of appointment, be designated chairman of the Committee by the chief executive officer after consultation with the President of the Medical Staff, and will be provided with a list of witnesses who are at that time expected to testify at the hearing in support of the action or recommendation.
- 7.4.1.6 If the hearing is based on action by the Board rather than action by the Executive Committee, one (1) member of the Hearing Committee may be a lay member of the Board or another non-practitioner.

#### **7.4.2 Hearing Officer.**

7.4.2.1 As an alternative to a Hearing Committee (e.g., in cases involving nonmember privileged practitioners or which do not require clinical training or professional licensure to decide the issue in dispute) the chief executive officer, after consulting with the President of the Medical Staff (and the President of the Board if the hearing was occasioned by a Board determination), may appoint a Hearing Officer to perform the functions that would otherwise be carried out by a Hearing Committee. The Hearing Officer shall preferably be a licensed health care professional, an attorney at law, judge, retired judge or other person with appropriate training, but who shall not be the Hospital's legal counsel or a participant in the hearing in any other capacity.

7.4.2.2 The Hearing Officer shall not be in direct economic competition with the affected practitioner, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he/she must not represent a client in direct economic competition with the affected practitioner. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the "Hearing Committee" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

**7.4.3 Authority of Hearing Committee.** The Hearing Committee (through its Chairman or Presiding Officer) shall have authority to:

- 7.4.3.1 Establish the time, place, manner, and procedure for conducting the hearing, consistent with these Bylaws;

- 7.4.3.2 Hold a preliminary meeting or prehearing conference with the parties for the purpose of clarifying issues, establishing procedures, or otherwise aiding the Committee;
- 7.4.3.3 Rule on the admissibility of the evidence, and determine the weight to be accorded to evidence which is admitted;
- 7.4.3.4 Request other members of the Medical Staff, other privileged practitioners or outside experts to examine questions within their respective specialties or knowledge where a dispute exists between the position of the affected practitioner and the Executive Committee, and report to the Hearing Committee their opinions and the basis for those opinions;
- 7.4.3.5 Conduct a hearing, consider and receive evidence, and deliberate and reach a determination in the form of a final recommendation;
- 7.4.3.6 Direct the attendance and participation of witnesses, and the submission and introduction of documentary evidence, whether or not preferred by the Executive Committee or the affected practitioner; and
- 7.4.3.7 Take such other actions as will facilitate its business.

**7.4.4 Decision of Committee.** The Hearing Committee's final decision or recommendation will be submitted to the Board. The decision of the Hearing Committee shall be determined by the majority of the hearing Committee members present and qualified to vote. There may be no voting by proxy. Upon reaching a decision, the Committee must reduce it to writing setting forth the recommendation or action and the grounds on which it is based. Only Committee members who have attended all parts of the hearing will be entitled to participate in the deliberations or vote of the Committee. A quorum for the purposes of the Committee's deliberations and decision consists of not less than a majority of the Committee members who have attended the principal parts of the hearing.

## **SECTION 5. CONDUCT OF HEARING.**

**7.5.1 Principles.** The hearing shall be conducted according to the following principles:

7.5.1.1 **Cross-Examination and Rebuttal.** No testimony shall be offered or submitted to the Committee by the other party or by individuals called upon for information by the Committee itself, without both the affected practitioner and a representative of the Executive Committee having the opportunity to be present, to question the witness, to respond, and to rebut the evidence.

7.5.1.2 **Evidence.** No evidence, testimony, or documentation shall be considered by the Committee which has not been received as evidence at a meeting at which both sides have been present. The decision of the Committee shall be based upon the evidence. In the interest of efficiency and economy, and in place of discovery proceedings in advance of the hearing, the parties shall prepare and submit to the Committee and to the other party at least seven (7) days prior to the date of the hearing written

statements of their respective positions on the issues presented and a list of witnesses with an abstract of each witness's expected testimony and the foundation for and relevancy of such testimony. Testimony that deviates materially from that submitted in advance of the hearing shall be admitted for purposes of rebuttal, and is otherwise subject to exclusion in the Committee's discretion.

- 7.5.1.3 **Representation.** The Executive Committee or the Board, whichever body rendered the decision affecting the practitioner, shall name a spokesperson to represent it at the hearing. Each party shall be entitled to be accompanied by and represented at the hearing by an attorney or other representative. The hearing shall otherwise be closed to the public.
- 7.5.1.4 **Chairman's Role.** The chairman of the Hearing Committee, or the Presiding Officer if one is appointed, shall conduct the hearing. The chairman shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, and shall generally maintain decorum. The chairman shall determine the scope of the hearing and the order of procedure during the hearing, and have the authority, in his/her discretion and in accordance with these Bylaws, to make all rulings on questions which relate to matters of procedure and to relevancy and admissibility of evidence. If a person other than the chairman of the Hearing Committee acts as Presiding Officer, he/she may, upon request of the Hearing Committee, participate in deliberations as a consultant, but shall not be entitled to vote on the decision of the Committee. The chairman and all other members of the Hearing Committee shall vote.
- 7.5.1.5 **Rules of Evidence.** The hearing will not be conducted according to the Rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. Although relevant, evidence may be excluded by the Committee in its discretion if the value of the evidence is substantially outweighed by the danger of confusing the issues or by considerations of undue delay, waste of time or needless presentation of cumulative evidence. Nevertheless, each party will have the right to submit memoranda concerning any issue of procedure or fact, and such memoranda will become a part of the hearing record.
- 7.5.1.6 **Right of Both Sides.** At the hearing, both sides have the right to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the affected practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.
- 7.5.1.7 **Burden of Going Forward and Proof.** At any hearing resulting from an action or recommendation during corrective action proceedings, the spokesman for the Board or the Executive Committee will have the initial burden of producing evidence in support of the action or recommendation. At any hearing resulting from an action or recommendation during the original application or reappointment/renewal processes, and at any hearing following corrective action proceedings once the spokesperson has produced the evidence in support of the action or recommendation, the individual requesting the hearing will have the ultimate burden of proving by the substantial

weight of evidence provided at the hearing that the proposed action or recommendation lacked foundation in fact or was otherwise arbitrary, capricious or unreasonable.

- 7.5.1.8 **Committee Members.** Members of the Hearing Committee are actively encouraged to take a participatory role in the proceedings, to question witnesses, to call upon witnesses for information within their possession, to direct the submission of additional evidence and documentation, to question a representative of the Executive Committee and the affected practitioner, and to see that the record contains all information that the Committee considers necessary in order to reach a decision.
- 7.5.2 **Attendance.** The affected practitioner's withdrawal of the request for appeal or failure without good cause to appear and proceed at the hearing shall be deemed to constitute voluntary acceptance of the action or recommendation of the Executive Committee. Failure without good cause of the Board or Executive Committee or its designee to appear and proceed at such a hearing will be deemed to constitute a withdrawal of the recommendation or action involved.
- 7.5.3 **Record.** The Committee will maintain a record of the hearing by a court reporter. The Committee may order that oral evidence be taken only on oath or affirmation administered by an individual who is entitled to administer such oaths in this state. The affected practitioner is entitled to a copy of the record upon payment of any reasonable charges associated with the preparation thereof.
- 7.5.4 **Postponement and Extensions.** In addition to any postponements resulting from change in composition of the Hearing Committee by agreement, postponements and extensions of the time for the hearing may be requested by any person. Such requests may be granted by the chairman for good cause shown.
- 7.5.5 **Presiding Officer.** The Hearing Committee may, in its discretion, appoint an attorney or other person knowledgeable of general rules of hearing procedure, who shall not be the Hospital's legal counsel or a participant in the hearing in any other capacity, to act as Presiding Officer. If the affected practitioner desires preparation of a transcript of the hearing, he or she shall bear the reasonable cost thereof. If appointed, the Presiding Officer shall carry out all the procedural duties otherwise assigned to the chairman, with the same authority the chairman would otherwise have, including the conduct of the preliminary meeting and the hearing, in which case references to the chairman in these Bylaws shall refer as appropriate to the presiding officer. The Hearing Committee may obtain separate legal counsel regardless of whether that counsel acts as Presiding Officer. The Presiding Officer shall be charged with conducting a due process hearing as efficiently and economically as possible, consistent with the provisions of Article VII.
- 7.5.6 **Recess and Deliberations.** The Hearing Committee may recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, memoranda, and proposed findings, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations in private session and outside the presence of the individual who requested the hearing. At any time prior to rendering its decision, the Committee may in its discretion, upon fair notice to each party, reconvene the hearing and hear additional evidence or argument.

**7.5.7 Written Statement.** Both parties may submit written statements at the conclusion of the hearing, within time limits established by the Committee. Such statements shall not constitute evidence.

**7.5.8 Decision.** A copy of the written decision of the Hearing Committee setting forth the grounds on which it is based shall be transmitted to the chief executive officer who will promptly furnish a copy to the Board, the affected practitioner and the Executive Committee. If the decision entitles the affected practitioner to appellate review, the chief executive officer shall ensure that the furnishing of such copy complies with the requirements of Notice of Adverse Action or Recommendation. The decision of the Committee constitutes the final recommendation to the Medical Staff. Either the affected practitioner or the Executive Committee may appeal the decision of the Hearing Committee to the Board. The Board may accept or reject the decision of the Hearing Committee.

## **SECTION 6. ACTION BY THE BOARD.**

When the hearing is based upon action by the Board, the hearing will be conducted by a Hearing Committee appointed by the President of the Board and consisting of not fewer than three (3) individuals. At least one (1) member of the Committee will be a physician. If the affected practitioner is a non-member privileged practitioner, a reasonable effort should be made to place a non-member privileged practitioner with the same training or licensure as the affected practitioner on the Committee, in addition to physician members. The procedure established for hearing based upon final action and recommendation of the Executive Committee shall be applicable to hearings based upon action by the Board.

## **SECTION 7. TIME LIMITS.**

Reasonable effort should be made to conduct the hearing within ninety (90) days following the action or recommendation of the Executive Committee or the action of the Board which prompted the hearing. However, when the request for hearing is received with respect to a member or privileged practitioner then under summary suspension or limitation, the hearing should be convened as soon as the arrangements may reasonably be made, but not later than thirty (30) days following the action or recommendation which prompted the hearing, and all stated time limits may be shortened accordingly by the Hearing Committee. Upon reasonable notice, either party may request an additional thirty (30) days for preparation for the hearing. The decision of the Hearing Committee shall be rendered within ten (10) days following the close of the hearing and submission of all post-hearing memoranda, briefs, or information. The Hearing Committee's decision shall be furnished through the chief executive officer to the affected practitioner, the Executive Committee and the Board.

## **SECTION 8. APPEAL TO THE BOARD.**

**7.8.1 Request for Appellate Review.** Within ten (10) days after receipt of notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, he/she may, by written notice to the Board delivered through the chief executive officer by certified mail, return receipt requested, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the affected practitioner's

written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

- 7.8.2 Waiver.** If such appellate review is not requested within ten (10) days, the affected practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 2 of this Article VII.
- 7.8.3 Scheduling Review.** Within five (5) days after receipt of such written request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the chief executive officer, by written notice, hand delivered or sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than fifteen (15) days, nor more than forty-five (45) days, from the date of the receipt of the notice of request for appellate review or the transcript of the hearing, whichever is later, except that when the affected practitioner is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than twenty (20) days from the date of receipt of such notice or transcript, whichever is later.
- 7.8.4 Board or Board Committee.** The appellate review shall be conducted by the Board, or, in the case of corrective action recommended or imposed directly by the Board, by a duly appointed appellate review committee of the Board consisting of not less than three (3) members, all of whom shall be members of the Board.
- 7.8.5 Preparation; Written Statement.** The affected practitioner shall have access to the transcript, if any, and all other evidence that was considered in making the adverse recommendation or decision. If the affected practitioner desires a copy of the transcript, he or she shall bear the reasonable cost of copying the prepared transcript. The affected practitioner shall have ten (10) days to submit a written statement in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board through the chief executive officer by hand delivery, e-mail or certified mail, return receipt requested, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the chairman of the Hearing Committee appointed by the Board, and if submitted, the chief executive officer shall provide a copy thereof to the affected practitioner at least three (3) days prior to the date of such appellate review by hand delivery, e-mail or by certified mail, return receipt requested.
- 7.8.6 Function of Board.** The Board or its appointed review committee shall act as an appellate body. Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to act. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subsection 8-e, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision,

and shall answer questions put to him/her by any member of the Board. The Executive Committee or the Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

**7.8.7 New Matters.** New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the hearing record, shall only be introduced at the appellate review under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

**7.8.8 Decision by Board.** If the appellate review is conducted by the Board, it may affirm, modify, or reverse its prior decision, or, in its discretion, refer the matter back to the Executive Committee for further review and recommendation within ten (10) days. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve specified disputed issues.

**7.8.9 Decision by Committee.** If the appellate review is conducted by a committee of the Board, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify, or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within ten (10) days. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Board as above provided.

**7.8.10 Completion.** The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 8 have been completed or waived.

## **SECTION 9. FINAL DECISION BY THE BOARD.**

**7.9.1** Within fourteen (14) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the chief executive officer, to the affected practitioner, by certified mail, return receipt requested.

**7.9.2** Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any single matter which shall have been the subject of action by the Executive Committee of the Medical Staff or by the Board or by a duly authorized committee of the Board, or by both.

**7.9.3** The Board is solely responsible for making the final decision.

## **SECTION 10. REPORTING.**

**7.10.1** Following conclusion of the proceedings, the chief executive officer will make any required report under state or federal law, indicating any final adverse action involving the membership or privileges of the affected practitioner.

**ARTICLE VIII  
AUTHORITY OF BOARD OF TRUSTEES**

- 8.1.** All Medical Staff matters and actions are subject to the authority of the Board of Trustees of the Hospital.
- 8.2** The Board is ultimately responsible for all operations within the Hospital, and both the Board and the Medical Staff recognize that matters affecting the Medical Staff may in some circumstances be most appropriately addressed directly by the Board or the CEO. For example, direct action by the Board or CEO may be most appropriate when:
- 8.2.1 The MEC is unable or unwilling for any reason to take necessary action, or the MEC or the President of the Medical Staff requests the involvement of the Board or CEO; or
- 8.2.2 The matter at hand relates to general organizational, labor, health or safety standards of the Hospital, or involves other issues of a type that can be properly evaluated by laymen and do not require professional medical judgment or expertise.
- 8.3** Accordingly, the Board reserves the authority to act directly, itself or through the CEO or another committee appointed by the Board, to address matters otherwise delegated in the first instance to the Medical Staff, whenever the Board Chairperson determines, after carefully considering the opinions and desires of the President of the Medical Staff and/or the MEC, that it should do so. In all such cases, the President of the Medical Staff or his/her designee shall be kept informed of action taken on the matter.
- 8.4** In exercising the authority reserved above, the procedures set forth in these Bylaws will be followed to the extent reasonably possible under the circumstances; but it shall be sufficient that the Board, the CEO, and the other persons involved by appointment of the Board, and any member of the Medical Staff or other person participating or cooperating with such persons during the proceedings, attempt in good faith to comply with such procedures to the extent reasonable and practicable under the circumstances and limitations of the case.

**ARTICLE IX  
OFFICERS**

**SECTION 1. OFFICERS OF THE MEDICAL STAFF.**

**9.1.1** The officers of the Medical Staff shall be a President and a President-Elect.

**SECTION 2. QUALIFICATIONS OF OFFICERS.**

**9.2.1 Each Officer must:**

9.2.1.1 be a member of the Active Medical Staff at the time of nomination and election and must remain a member in good standing during his/her term of office.



9.2.1.2 have been a member of the Active Medical Staff for a minimum of five (5) years, and shall have served at least one (1) term in a Medical Staff leadership role (e.g. Department Chair/Chair-Elect, Committee Chair) and demonstrate executive and administrative ability through experience and participation in staff activities.

9.2.1.3 have demonstrated a high degree of interest in and support of the Medical Staff and the organization.

9.2.1.4 agree to and, if elected, willingly and faithfully discharge the duties and exercise the authority of the office held and work with the other officers and department chairs, committees, the Chief Medical Officer, the Chief Executive Officer and the Board of Trustees.

**9.2.2 Conflict of Interest:** Officers of the Medical Staff shall be subject to the Organization's Conflict of Interest Policy, including the requirement to complete periodic questionnaires.

### **SECTION 3. ELECTION OF OFFICERS.**

**9.3.1** A President-elect shall be elected by majority vote at the annual meeting of the Medical Staff held on the third Monday of September of every even year, and shall be approved by the Board of Trustees at its December meeting. There shall be no voting by proxy. The Presidency passes, at the same time, by succession to the extant President-elect. The President and newly elected President-elect shall assume their duties of office at the regular quarterly Medical Staff meeting in January after the year of election to/assumption of office.

### **SECTION 4. TERM OF OFFICE.**

**9.4.1 Term.** The term of office of each officer shall be two (2) years, beginning on January 1. An officer may hold one (1) office for only two (2) full successive terms. A former officer shall be eligible for reelection to office after an absence of three (3) years from such office.

**9.4.2 Vacancy.** Vacancy in the office of the President-Elect during the term of office shall be filled by special election conducted by the general Medical Staff, with nominations provided by the Nominating Committee. If there is a vacancy in the office of the President, the President-Elect shall become President, and a new President-Elect shall be elected by special election conducted by the general Medical Staff with nominations provided by the Nominating Committee. If for any reason there is a vacancy in both offices, a special election for both positions shall be conducted by the general Medical Staff, with nominations provided by the Nominating Committee, giving particular consideration to nomination of past officers for the position of President, in order to ensure that the newly elected officers have sufficient Medical Staff leadership experience and expertise to ensure the stability of the Medical Staff.

**9.4.3 Resignation.** Any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at the time specified in the resignation.

**9.4.4 Removal from Office.** A Medical Staff officer may be removed from office by three-fourths (3/4) majority vote of the Active Medical Staff or by three fourths (3/4) majority vote of the Board of

Trustees, after reasonable notice and opportunity to be heard. Grounds for removal shall include:

- Failure to comply with applicable policies, Medical Staff Bylaws, Medical Staff Rules and Regulations;
- Failure to perform the duties of the position held;
- Conduct detrimental to the interests of Mary Lanning Healthcare and/or its Medical Staff; or
- An infirmity that renders the individual incapable of fulfilling the duties of the office held.

9.4.4.1 Prior to the initiation of any removal action, the Medical Staff Officer shall be given written notice of the date of any meeting at which such action shall be taken not less than five (5) days before the scheduled date of the meeting. The notice shall be delivered by a means that results in confirmation of delivery either in person or by written documentation. The individual shall be afforded an opportunity to speak to the Medical Staff or the Board of Trustees, as applicable, prior to a removal vote.

## **SECTION 5. DUTIES OF OFFICERS.**

**9.5.1 President.** The President shall:

9.5.1.1 Act in coordination and cooperation with the chief executive officer in all matters of mutual concern within the Hospital;

9.5.1.2 Call, preside, and be responsible for the agenda of all regular and special meetings of the Medical Staff and co-chair (with the incoming Medical Staff President) the January meeting of the Medical Staff after the September meeting at which elections are held;

9.5.1.3 Serve as chairman of the Medical Executive Committee;

9.5.1.4 Serve as ex-officio member of all other Medical Staff committees, without vote;

9.5.1.5 Be responsible, together with the Medical Staff Executive Committee for the enforcement of Medical Staff Bylaws and Rules and Regulations, for implementation of sanctions where they are indicated, and for Medical Staff compliance with procedural safeguards in all instances where corrective action has been requested against a privileged practitioner;

9.5.1.6 Appoint committee members to all Medical Staff committees except where the composition or manner of selection is otherwise specified in these Bylaws, or in Medical Staff Rules and Regulations;

9.5.1.7 Represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the chief executive officer;

9.5.1.8 Receive and interpret the policies of the Board to the Medical Staff;

9.5.1.9 Attend monthly meetings of the Board of Trustees, reporting as an ex-officio member of the Board as regards the affairs of the Medical Staff, including but not limited to the following:

- Proceedings of the Credentials Committee, the Medical Staff Excellence Committee, the Clinical Care Committee, the Regulatory and Compliance Committee, and the various Departments of the Medical Staff;

9.5.1.10 Report annually to the Medical Staff at its September meeting in regard to the status of the Medical Staff;

9.5.1.11 Be the spokesperson for the Medical Staff in its external professional and public relations;

9.5.1.12 Participate in leadership educational processes in an effort to assure effective leadership of the Medical Staff;

9.5.1.13 Promote formal leadership development among members of the Medical Staff;

9.5.1.14 Attend at least one (1) leadership educational seminar during the tenure of presidency.

**9.5.2 President-Elect.** The President-Elect shall:

9.5.2.1 In the absence of the President, assume all the duties and have the authority of the President;

9.5.2.2 In the event of vacancy of the presidency, assume the position of Medical Staff President;

9.5.2.3 Serve as a member of the Executive Committee and the Medical Staff Excellence Committee (functioning as Chair of the latter), and serve as ex-officio member of all other Medical Staff committees without vote;

9.5.2.4 Participate in organized leadership educational processes annually during his/her term as President-Elect so as to assure effective leadership of the Medical Staff;

9.5.2.4.1 At least one educational process shall focus on the peer review process;

9.5.2.5 Promote formal leadership development among members of the Medical Staff;

9.5.2.6 Attend monthly meetings of the Board of Trustees as an ex-officio member/observer without vote, for the primary purpose of learning about the larger structure and function of the organization;

9.5.2.7 Meet at least quarterly with the President and the Chief Medical Officer so as to participate in the development and maintenance of Medical Staff focus and direction.

**ARTICLE X**  
**CLINICAL DEPARTMENTS**  
**(Reference Medical Staff Rules and Regulations, Section 2, Part A)**

**SECTION 1. MEDICAL STAFF DEPARTMENTALIZATION**

The Medical Staff of Mary Lanning Healthcare is a departmentalized organization. Departments of the Medical Staff are:

**10.1.1 Department of Medicine.** Membership in the Department of Medicine shall include medical staff members appropriately privileged in the following disciplines: Internal Medicine, Infectious Disease, Hematology/Oncology, Hospital Medicine, Diagnostic Radiology, Emergency Medicine, Neurology, Nephrology, Psychiatry, Physiatry, Pulmonology, Gastroenterology, Rheumatology, and Cardiology.

**10.1.1.1 Emergency Department.** The Emergency Department at Mary Lanning Healthcare shall be under the oversight of a Medical Director. The Emergency Department Medical Director shall have the following qualifications:

- Membership as an appropriately privileged practitioner on the Medical Staff
- Board Certification/Board Eligibility in Emergency Medicine
- Minimum two (2) years' experience in Emergency Medicine preferred

All policies and procedures governing medical care in the Emergency Department are established by the Medical Staff, revised as needed by the Medical Staff, and care processes are monitored by the Medical Staff on an on-going basis. **(c.f. CMS Conditions of Participation § 482.55, May 2014)**

**10.1.2 Department of Surgery.** Membership in the Department of Surgery shall include medical staff members appropriately privileged in the following disciplines: General Surgery; Cardiovascular Surgery; Neurosurgery; Thoracic Surgery; Interventional Radiology; Pathology; Plastic Surgery; Cosmetic, Wound, and Reconstructive Surgery; Urology; Gynecology; Orthopedics; Ophthalmology; Otorhinolaryngology; Anesthesiology; Dental Specialties; and Podiatry.

**10.1.3 Department of Women and Children.** Membership in the Department of Women and Children shall include medical staff members appropriately privileged in the following disciplines: Obstetrics, Pediatrics and Family Practice.

**10.1.4 Department of Family Practice.** Membership in the Department of Family Practice shall include medical staff members appropriately privileged in the discipline of Family Practice.

**SECTION 2. FORMATION/DISSOLUTION.**

**10.2.1** A department may be formed only when there are a minimum of five (5) qualified members representing at least two (2) separate medical practices or practice entities, and it shall be dissolved and its privileged practitioners incorporated into another department if the number of practitioners or groups fall below such numbers. Provided that the foregoing conditions are

met, a department may be formed or dissolved by action of the Medical Executive Committee and approval of the Board of Trustees.

### **SECTION 3. PRACTITIONERS.**

**10.3.1** All privileged practitioners shall be assigned to the appropriate department or departments at the time clinical privileges are granted or renewed.

### **SECTION 4. DEPARTMENT OFFICERS.**

**10.4.1** Each department shall have a chair and a chair-elect. These individuals are responsible to the Medical Executive Committee for the conduct of affairs within each department.

10.4.1.1 **Qualifications.** The department chair and chair-elect must be appropriately privileged members of the Active Staff.

10.4.2.1 **Term.** The department chair and chair-elect shall serve terms of one (1) year each.

10.4.3.1 **Appointment and Removal.**

10.4.3.1.1 The Chair-elect is elected annually by majority vote of the members of each department who are present and voting at the last departmental meeting of the calendar year, subject to ratification by the Executive Committee.

10.4.3.1.2 The Chair-elect assumes the department chair after serving a one-year term as the chair-elect.

10.4.3.1.3 A departmental chair or chair-elect may be removed by two-thirds (2/3) majority vote of the department members; or by a 2/3 majority vote of the Medical Executive Committee; or by majority vote of the Board of Trustees, after reasonable notice and opportunity to be heard. Grounds for removal shall include:

- Failure to comply with applicable policies, Medical Staff Bylaws, Medical Staff Rules and Regulations;
- Failure to perform the duties of the position held;
- Conduct detrimental to the interests of Mary Lanning Healthcare and/or its Medical Staff; or
- An infirmity that renders the individual incapable of fulfilling the duties of the office held.

10.4.3.1.4 Prior to the initiation of any removal action, the department chair or chair-elect shall be given written notice of the date of any meeting at which such action shall be taken not less than five (5) days before the scheduled date of the meeting. The notice shall be delivered by a means that results in confirmation of delivery either in person or written documentation. The individual shall be afforded an opportunity to speak to the department, the Medical Executive Committee, or the Board of Trustees, as applicable, prior to a removal vote.

**10.4.2 Vacancy.** In the event of a vacancy in a department office, the President may appoint a replacement to serve until the members of the department meet to elect a successor and the Executive Committee approves the same.

**10.4.3 Functions of the Department Chair.** The chair’s responsibilities include:

**10.4.3.1 Governance/Leadership**

10.4.3.1.1 Serve as chair of all department meetings;

10.4.3.1.2 Represent department at all Medical Executive Committee meetings;

10.4.3.1.3 Work collaboratively with the President of the Medical Staff in the general medical staff governance process;

10.4.3.1.4 Complete at least one formal medical staff leadership educational process during the tenure of office;

**10.4.3.2 Credentialing**

10.4.3.2.1 Critically review all applications/reapplications to the medical staff for content and completeness

10.4.3.2.2 Have familiarity with the FPPE and OPPE processes and their importance in credentialing;

10.4.3.2.3 Participate in FPPE and OPPE processes as necessitated by occurrence;

10.4.3.2.4 Communicate with Medical Staff Services Coordinator regarding perceived deficiencies or questions regarding the completeness of any application/reapplication;

10.4.3.2.5 Provide signature of approval to all applications/reapplications deemed appropriate for advancement to the Credentials Committee;

10.4.3.2.6 As much as possible, have all departmental medical staff applications reviewed monthly, at least one (1) week prior to the scheduled Credentials Committee meeting in order that all applications may be submitted to the Committee in a timely manner for their review prior to each meeting;

**10.4.3.3 Administrative/compliance**

10.4.3.3.1 Have familiarity with Medical Staff Bylaws, Rules and Regulations, and Policies in general and in particular as they apply to departmental function;

10.4.3.3.2 Review departmental privilege set(s) during the tenure in office;

10.4.3.3.3 Collaborate when necessary with Medical Staff President in assigning medical staff coverage of patients by department staff when an individual medical staff member, for whatever reason, becomes unable to provide coverage (**c.f. Medical Staff Rules and Regulations, Section 3.4**);

10.4.3.3.4 Collaborate when necessary with Medical Staff President in resolving conflict of opinion between attending and consulting physicians regarding any patient care matter (**c.f. Medical Staff Rules and Regulations, Section 3.7-4**);

10.4.3.3.5 Participate in review/processing of reported practitioner health issues as they impact the quality of patient care and patient safety in the organization (**c.f. Medical Staff Policy Regarding Practitioner Health Issues**);

10.4.3.3.6 Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization

10.4.3.3.7 Integration of the department or service into the primary functions of the organization

10.4.3.3.8 Coordination and integration of interdepartmental and intradepartmental services

10.4.3.3.9 Recommending space and other resources needed by the department or service

#### **10.4.3.4 Clinical**

10.4.3.4.1 Participate as opportunity arises in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services

10.4.3.4.2 Assist with orientation of all new members of the department;

10.4.3.4.3 Discharge of such additional responsibilities as may be imposed by the Medical Staff President or President-Elect, from time to time;

10.4.3.4.4 Conduct surveillance of the professional performance of all appropriately privileged individuals in the department;

10.4.3.4.5 Review and distribute practitioner quality data/performance profiles in a timely manner.

#### **10.4.4 Functions of the Department Chair-Elect.** The chair-elect's responsibilities include:

##### **10.4.4.1 Governance/Leadership**

10.4.6.1.1 In the absence of the Department Chair, serve as chair of all department meetings;

10.4.4.1.2 Represent department at all Medical Executive Committee meetings;

10.4.4.1.3 Work collaboratively with the President of the Medical Staff in the general medical staff governance process;

10.4.4.1.4 Complete at least one formal medical staff leadership educational process during the tenure of office.

#### **10.4.4.2 Administrative/compliance**

10.4.4.2.1 Have familiarity with Medical Staff Bylaws, Rules and Regulations, and Policies in general and in particular as they apply to departmental function;

10.4.4.2.2 With the Department Chair, review departmental privilege set(s) during the tenure in office.

#### **10.4.4.3 Clinical**

10.4.4.3.1 Participate as the opportunity arises in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

### **SECTION 5. FUNCTIONS OF DEPARTMENTS.**

Each department shall, consistent with these Bylaws and the Rules and Regulations of the Medical Staff:

**10.5.1** Support organizational goals including the on-going development of a culture of patient safety and the maintenance of appropriate quality care to patients who are served by the organization.

10.5.1.1 Develop, subject to the approval of the Executive Committee, policies and protocols grounded in evidenced based, best practice medicine, to assure appropriate quality care of patients served by the department.

**10.5.2** By periodic review and approval of departmental privileging criteria (“privilege sets”), assure the integrity of the Medical Staff application/credentialing/privileging processes at Mary Lanning Healthcare.

**10.5.3** Participate in the development and delivery of medical educational programs for the continuing education of members.

**10.5.4** Support continuous organizational and medical staff quality improvement through participation in FPPE, OPPE, and other organizational quality initiatives as necessitated by occurrence.



**SECTION 6. MEETING MANAGEMENT.**

Department meeting schedules are established in Section 2 of the Medical Staff Rules and Regulations. The following stipulations apply to the nature of Medical Staff departmental meetings.

- 10.6.1 Clerical Staff.** Clerical staff representing the Medical Staff Services office are to be present at all department meetings, so as to relate information and reports, maintain records, compile minutes, and carry out responsibilities assigned by the department. Clerical staff attends at the will of the Department Chair.
- 10.6.2 Nonmember Privileged Practitioners.** Nonmember privileged practitioners assigned to the department may attend department meetings in an ex-officio role, with no vote in departmental proceedings. Nonmember privileged practitioners attend at the will of the Department Chair.
- 10.6.3 Minutes.** Departmental meeting minutes will be maintained by the Medical Staff Services Office. Summary reports of departmental meetings will be presented to the Medical Executive Committee by the Department Chair.
- 10.6.4 Quorum.** A quorum is necessary to conduct the business of Medical Staff department meetings, and consists of a simple majority of department members present and voting.

**ARTICLE XI  
COMMITTEES**

**(Reference Medical Staff Rules and Regulations, Section 2, Part B)**

**SECTION 1. EXECUTIVE COMMITTEE.**

**11.1.1 Establishment.** The Medical Executive Committee is established and stands as the governing body of the Medical Staff.<sup>1</sup>

**11.1.2 Composition.** The Medical Executive Committee shall consist of the following members:

11.1.2.1 The Medical Staff President

11.1.2.2 The immediate past president of the Medical Staff

11.1.2.3 The Medical Staff President-elect

11.1.2.4 The Chair of the Credentials Committee

11.1.2.5 The Chairs of the Medical Staff Departments

11.1.2.6 The Chair-elects of the Medical Staff Departments

11.1.2.7 One physician representative from one of the following disciplines: Radiology, Pathology, or Anesthesia (appointed annually by the Medical Staff President)

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<sup>1</sup> Standard MS.01.01.01, The Joint Commission, 3/31/2011.

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*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*

11.1.2.8 The Medical Director of the Emergency Department

11.1.2.9 The CEO, one representative of the Board of Trustees selected by the Chair of the Board of Trustees, the Chief Medical Officer, and the Vice President of Patient Strategies/Chief Nursing Officer shall be *ex officio* members of the Medical Executive Committee, without vote in committee proceedings.

**11.1.3 Committee Member Removal.** A member of the Medical Executive Committee may be removed from the Medical Executive Committee by 2/3 majority vote of the Committee or by the Board of Trustees, or in the case of department chairs and chair-elects, as may occur when the individual is removed from office as outlined in section 10.4.3 of these Bylaws. Grounds for removal shall include:

- Failure to comply with applicable policies, Medical Staff Bylaws, Medical Staff Rules and Regulations;
- Failure to perform the duties of the position held;
- Conduct detrimental to the interests of Mary Lanning Healthcare and/or its Medical Staff; or
- An infirmity that renders the individual incapable of fulfilling the duties of the office held.

11.1.3.1 The procedure for notification of a member of the Medical Executive Committee as regards a motion for the member's removal from the Medical Executive Committee is similar that outlined in Section 10.4.3.4 above for similar action in the removal of a department chair or chair-elect.

**11.1.4 Meeting Schedule.** The Medical Executive Committee shall meet monthly at a time consistent with the meeting calendar established in the Medical Staff Rules and Regulations.

**11.1.5 Functions.** The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by privileged members of the Medical Staff. The Medical Executive Committee shall:

11.1.5.1 Act with authority on behalf of the Medical Staff between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

11.1.5.2 Coordinate the activities and general policies of the various services;

11.1.5.3 Receive and act upon committee reports;

11.1.5.4 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, shall provisionally adopt (and the Board of Trustees may provisionally approve) an urgent amendment without prior notification of the medical staff. In such cases the medical staff will immediately be notified by the Medical Executive Committee. The medical staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive

Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee shall be implemented, and if necessary, a revised amendment shall then be submitted to the Board of Trustees for action.<sup>2</sup>

11.1.5.5 Recommend to the Board of Trustees as regards the following:

11.1.5.5.1 the structure of the Medical Staff;

11.1.5.5.2 the mechanisms of review of credentials processes and the delineation of privileges;

11.1.5.5.3 applicants for privileging/appointment to the Medical Staff;

11.1.5.5.4 participation of the Medical Staff in organizational performance improvement activities and the quality of professional services being provided by members of the Medical Staff;

11.1.5.5.5 the mechanism by which Medical Staff appointment may be terminated;

11.1.5.5.6 hearing procedures;

11.1.5.5.7 other appropriate reports and recommendations that the Medical Executive Committee has received from Medical Staff committees, departments and other groups.

11.1.5.6 Recommend to the CEO and/or administration as regards the following:

11.1.5.6.1 matters of a medical administrative nature;

11.1.5.6.2 matters relating to organizational performance as they affect Medical Staff performance in relation to its ability to deliver safe, quality care to patients;

11.1.5.6.3 matters of the Medical Staff relating to organizational accreditation

11.1.5.7 review periodically, all information available regarding the performance and clinical competence of Staff members and other privileged practitioners and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges (FPPE and OPPE processes);

11.1.5.8 take all reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including initiation of and/or participation in Medical Staff corrective or review measures when warranted;

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<sup>2</sup> MS.01.01.01, EP 11. The Joint Commission Standards.

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11.1.5.9 periodically review these Bylaws, the Medical Staff Rules and Regulations, Medical Staff Policies, and associated documents of the Medical Staff incorporating necessary and/or desirable changes as identified by the Medical Staff Compliance and Regulatory Committee.

11.1.5.10 act according to defined procedures upon all referral from the Medical Staff Excellence Committee.

## **SECTION 2: OTHER COMMITTEES**

**11.2.1** The structure and function of all other Medical Staff committees are detailed in and governed by Medical Staff Rules and Regulations, Section 2, Part B.

## **ARTICLE XII MEDICAL STAFF MEMBER MEETINGS**

### **SECTION 1. REGULAR MEETINGS.**

**12.1.1** Regular meetings of the members of the Medical Staff shall be held at the Hospital three times per year on the third Monday of the designated month, according to the Medical Staff meeting calendar. (Reference Medical Staff Rules and Regulations, Section 2, Part B).

### **SECTION 2. ANNUAL MEETING.**

**12.2.1** The annual meeting shall be held on the third Monday in September of each year. The annual report on Medical Staff activity for the previous year shall be given by the President.

**12.2.2** The agenda for the annual meeting shall include, when applicable, the election of officers to take office on January 1 of the following year.

### **SECTION 3. SPECIAL MEETINGS.**

**12.3.1** The President, the Executive Committee, or any five (5) members of the Active Staff, may at any time file a written request with the President that within ten (10) days of the filing of such a request, a special meeting of the Medical Staff be called. The Medical Executive Committee shall designate the time and place of any special meeting.

**12.3.2** Written or printed notice stating the place, day, hour, and purpose of any special meeting of the Medical Staff shall be delivered, either personally, or by U.S. mail, to each member of the Medical Staff not less than five (5) days nor more than ten (10) days before the date of such meeting by or at the direction of the President (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the U.S. mail, addressed to each Staff member at his/her office address. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

**12.3.3** The agenda at a special meeting shall be:

- 12.3.3.1 Reading of the notice calling the meeting:
- 12.3.3.2 Transaction of the business for which the meeting was called; and
- 12.3.3.3 Adjournment.

**12.3.4** No business shall be transacted at any special meeting, except that stated in the notice calling the meeting.

**SECTION 4. ATTENDANCE.**

**12.4.1** Requirement for meeting attendance is addressed in Article III, Section 3.1.2 of these Bylaws.

12.4.1.1 Active Medical Staff members assigned to the Department of Family Practice may elect attendance at meetings of either the Department of Medicine or the Department of Surgery for a given Medical Staff year. Such an election shall not preclude the member's attendance of meetings of the other Department.

**12.4.2** Courtesy Medical Staff Members, Allied Health Staff, Honorary Staff, and non-Member Privileged Practitioners may attend Medical Staff meetings in *ex officio* capacity as desired, without vote.

**SECTION 5. QUORUM.**

**12.5.1** A quorum for all medical staff membership meetings consists of the presence of a majority (50% + 1) of Active Staff members. In the absence of a quorum, discussions may be held but no business may be transacted.

**ARTICLE XIII  
FUNDING OF MEDICAL STAFF BUSINESS**

**SECTION 1.**

**13.1.1** Funds necessary for carrying out the business of the Medical Staff will be accumulated, in part, by collection of application and re-application processing fees, as governed by the policy for **Medical Staff Application/Reapplication Fees**. Other funds may be appropriated by Mary Lanning Healthcare according to need.

**ARTICLE XIV  
PEER REVIEW PRIVILEGE AND IMMUNITY**

**SECTION 1. INTERPRETATION.**

**14.1.1** It is the intention of these Bylaws to define the term "Peer Review" broadly, and to secure to those who engage in any aspect of Peer Review in, at, for, or on behalf of the Hospital and its Medical Staff, the broadest possible privilege and immunity from liability. This Article and these

Bylaws will be interpreted to effectuate this objective. The privileges and immunities set forth in this Article shall be cumulative of other protections provided by law.

## **SECTION 2. AUTHORIZATION AND RELEASE.**

**14.2.1** The following shall be express conditions on the application for, or the holding or exercise of, membership and privileges at the Hospital. Each applicant and each member hereby expressly:

14.2.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, obtain, review, and act upon information bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct;

14.2.1.2 Authorizes any other individual and organization to provide information to representatives of the Hospital and the Medical Staff bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct, and agrees to execute authorizations and releases to facilitate obtaining such information from third parties at the request of the Hospital;

14.2.1.3 Authorizes other members and representatives of the Medical Staff and representatives and employees of the Hospital to provide information bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct;

14.2.1.4 Consents to inspection of records and documents that may be material to an evaluation of his or her professional ability, qualifications, and conduct, authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying, and agrees to execute authorizations and releases to facilitate obtaining or reviewing such records and documents at the request of the Hospital;

14.2.1.5 Agrees to provide accurate, current, and complete information in connection with the appointment, reappointment, privileging, quality improvement, and corrective action processes at the Hospital, or in response to specific inquiries from the Medical Executive Committee or the Board of Trustees of the Hospital, or as a continuing obligation under these Bylaws;

14.2.1.6 Agrees to immediately inform the CEO of any material changes or developments affecting or changing the information provided in or with his or her application;

14.2.1.7 Agrees to cooperate with the Medical Staff leadership and committees in the conduct of Peer Review activities involving him or her, which includes appearing at interviews, answering questions, and working within the Peer Review structure described in these Bylaws;

14.2.1.8 Releases from liability, to the fullest extent permitted by law, all officers, members and representatives of the Medical Staff and all officers, trustees, employees, and representatives of the Hospital, for their acts performed in connection with conducting peer review activity or furnishing information in connection with peer review activity on behalf of the Medical Staff and the Hospital;

14.2.1.9 Agrees not to commence a legal action against the Medical Staff or Hospital or against any officer, member, or representative of the Medical Staff or any officer, trustee, employee, or

representative of the Hospital, for any investigation or peer review activity taken in accordance with the provisions of these Bylaws;

14.2.1.10 Authorizes representatives of the Medical Staff and the Hospital to disclose to other hospitals, medical associations, licensing boards, and similar organizations, as permitted by law, information regarding his or her professional abilities, qualifications, and conduct, including information about current and past membership and privileges and results of Peer Review activities at the Hospital, in connection with such other party's peer review activities, and releases the Medical Staff and its officers, members and representatives and Hospital and its officers, trustees, employees and representatives for so doing to the fullest extent permitted by law;

14.2.1.11 Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and the exercise of clinical privileges or practice authority at the Hospital.

As used in this section, the term "Hospital and its authorized representatives" includes Mary Lanning Healthcare, the members of the Board and its appointed representatives, the CEO and his or her designee(s), any Hearing Officer, Presiding Officer, the members of any Hearing Committee, consultants, Hospital's legal counsel and their staff and partners, and all members of the Medical Staff. The term also includes allied health practitioners and Hospital employees who have responsibility for obtaining, giving, evaluating, or acting upon information in the Peer Review context or who otherwise participate or provide information to a Peer Review Committee.

### **SECTION 3. SCOPE OF PEER REVIEW.**

**14.3.1** The scope of Peer Review shall include all activities and functions set out in the definition of Peer Review, Peer Review Committee and Peer Review Record in these Bylaws. Further, each officer and committee of the Medical Staff, and each individual member of the Medical Staff who is assigned Peer Review responsibility within the Hospital, is designated a Peer Review agent on behalf of the Medical Executive Committee. Each such officer and committee and their agents (including the CEO and his or her designees) are authorized to engage in peer review activity and to investigate and make recommendations to the Medical Executive Committee concerning applicants or members of the Medical Staff on all matters coming to their attention and within their areas of primary or delegated responsibility, reflecting on qualifications for membership and privileges or on the quality of patient care at the Hospital. In addition, any committee appointed directly by the Board or pursuant to Bylaws, rules, regulations, policies or procedures approved by the Board, whether standing or *ad hoc*, shall be within the scope of the Peer Review privilege when conducting Peer Review or functioning as a Peer Review Committee as defined by law or these Bylaws.

### **SECTION 4. INFORMATION PRIVILEGED.**

**14.4.1** All statements, disclosures, reports, recommendations, and other communications and records made or held in connection with Peer Review activities of Hospital shall, to the fullest extent permitted by law, be confidential and privileged from further disclosure, except as otherwise provided in these Bylaws.

## **ARTICLE XV ALLIED HEALTH PROFESSIONALS**

*MLH Medical Staff Bylaws*

*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*

## **SECTION 1. DEFINITION.**

**15.1.1** Allied health professionals (AHPs) are individuals who may or may not hold clinical privileges, depending upon education and training, and collectively provide direct patient care services at the Hospital as dependent/independent practitioners either under the supervision of appropriately privileged practitioners or as employees of Mary Lanning Healthcare in Human Resource relationships defined by state law. Examples include nurses, physical therapists, respiratory therapists, surgical scrub personnel, dental technicians, LMHPs, CRNAs, Nurse Midwives, APRNs, Physician Assistants, and master level psychologists.

## **SECTION 2. GOVERNANCE OF ALLIED HEALTH PROFESSIONALS**

**15.2.1** Allied health professionals employed by the Hospital who are dependent practitioners and who are not in a professional practice/collaborative agreement with a privileged practitioner and do not provide medical level care are not subject to these bylaws, and are governed by organization Human Resources policies, bylaws, and rules and regulations.

**15.2.2** Allied health professionals who provide medical level care, who are either dependent practitioners in a professional practice agreement with a privileged practitioner or who are licensed independent practitioners in a collaborative agreement with a privileged practitioner, (e.g. Physician Assistants, Advanced Practice Registered Nurses, Nurse Midwives, and Certified Registered Nurse Anesthetists) are identified as non-member privileged practitioners and as such, are subject to these Medical Staff Bylaws, all Medical Staff Rules and Regulations and all Medical Staff Policies, including the peer review process.

### **ARTICLE XVI**

#### **PRACTITIONER HEALTH ISSUES**

##### **Reference Medical Staff Rules and Regulations, Section 3 Medical Staff Policy 3.1, Regarding Practitioner Health Issues**

## **SECTION 1. PURPOSE**

**16.1.1** The purpose of this Article is to establish:

16.1.1.1 the Medical Staff Policy **3.1 Regarding Practitioner Health Issues** as the source of reference and the procedural guide in the identification and management of the impaired health care practitioner;

16.1.1.2 the duty of all practitioners and all organizational employees to report any concern as regards the impairment of a practitioner, as directed in the referenced policy, according to the reporting mechanism established by the referenced policy.

## **SECTION 2. DEFINITION**

**16.2.1** An impaired health care provider is one who is unable to deliver health care with skill, safety, and appropriate professional conduct to patients because of physical or mental illness, including but not limited to temporary and permanent loss of motor skills or cognitive abilities, behavioral impairment, and substance abuse, including abuse of prescription drugs, “recreational” drugs or



alcohol. (Definition consistent with Medical Staff Policy 3.1, Regarding Practitioner Health Issues.)

## **ARTICLE XVII RULES AND REGULATIONS**

### **SECTION 1. NECESSITY AND ADOPTION.**

**17.1.1** The Medical Staff may adopt such Rules and Regulations as may be necessary for the proper conduct of its work. Such Rules and Regulations may be adopted with fourteen (14) days previous notice by majority vote of those members of the Active Medical Staff present and voting, at any regular meeting or at a special meeting called for such purpose at which a quorum is present. Further, amendments to the Rules and Regulations necessitated by actions of regulatory agencies including, but not limited to, the Joint Commission and the Centers for Medicare and Medicaid Services may be provisionally adopted by the Medical Executive Committee, and provisionally approved by the Board of Trustees, without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee.

**17.1.** The medical staff, in the general staff meeting following any provisional amendment(s) to Rules and Regulations, has the opportunity for retrospective review of, and comment on the provisional amendment(s). If there is no disagreement between the organized medical staff and the Medical Executive Committee, the provisional amendment(s) stand(s). If there is conflict over the provisional amendment, the matter may be referred for conflict resolution, as outlined in Article XIX of these Bylaws. If necessary, a revised amendment is then submitted to the Medical Executive Committee for action. **(The Joint Commission Standards, MS 01.01.01, EP 11)**

### **SECTION 2. SUBORDINATION TO BYLAWS.**

**17.2.1** The Rules and Regulations will be construed in a manner consistent with these Bylaws, and in the event of any irreconcilable inconsistency, these Bylaws will control.

## **ARTICLE XVIII AMENDMENTS**

### **SECTION 1. AUTHORITY TO AMEND.**

**18.1.1** These Medical Staff Bylaws may be amended only upon approval of both the Medical Staff and the Board of Trustees.

### **SECTION 2. PROCESS OF AMENDMENT.**

**18.2.1** Medical Staff action may be taken at any regular or special meeting of the Active Staff of which written notice of such amendments has been given to each member of the Active Staff at least two (2) weeks prior to the meeting.

**18.2.2** Amendment requires receipt of two-thirds vote of those members of the Active Medical Staff members present and voting.

18.2.2.1 Amendments to the proposed amendments may be entertained and acted upon at any such meeting without prior notice.

**18.2.3** Amendments to the Medical Staff Bylaws shall become effective upon approval by the Board.

**18.2.4** The Medical Executive Committee may adopt and incorporate amendments to these Bylaws which are in the nature of a technical or typographical correction without further approval or vote.

## **ARTICLE XIX CONFLICT RESOLUTION**

### **SECTION 1. CONFLICT**

**19.1.1** Conflict between the Medical Executive Committee (MEC) and the Medical Staff may arise in the course of conducting business of the Medical Staff. Conflict may also arise between the Medical Executive Committee and the Board of Trustees, and the between the Medical Staff as a whole and the Board of Trustees. When conflict occurs, all parties will strive to resolve all conflicts in the best interests of 1) patient care; 2) the community served by the hospital; 3) the hospital; and 4) the Medical Staff.

### **SECTION 2. MANAGEMENT PROCESS FOR CONFLICT BETWEEN THE BOARD OF TRUSTEES/ADMINISTRATION AND THE MEDICAL EXECUTIVE COMMITTEE (MEC) OR THE MEDICAL STAFF AS A WHOLE**

**19.2.1** Effort shall be made to informally discuss conflict directly (face to face) in one or more meetings between the leaderships of the Medical Staff, and the administration and/or the Board of Trustees.

19.2.1.1 If the conflict can be resolved, the resolution is forwarded to the Board of Trustees and the MEC (or the full medical staff in the case of a dispute between the Board of Trustees and the Medical Staff as a whole) for final approval, where necessary.

19.2.1.2 If the Board of Trustees and the MEC (or the full medical staff, in the case of a dispute between the Board of Trustees and the Medical Staff as a whole) fail to endorse an informal resolution, the conflict management process shall continue as outlined in Section 19.2.2 of these Bylaws.

19.2.1.3 If informal discussion does not resolve the conflict, the conflict management process shall continue as outlined in Section 19.2.2 of these Bylaws.

**19.2.2** In the case of failure of informal discussions in conflict resolution, the matter shall be referred to a joint conference committee.

19.2.2.1 A joint conference committee shall consist of an equal number of members from the Board of Trustees and the medical staff, and shall be a committee of the Medical Staff.

19.2.2.2 Obtaining assistance of an internal or external third party facilitator or mediator may be a next step if joint conference committee participants are unable to resolve the conflict directly with each other. Any facilitator or mediator should be mutually agreed upon by all committee participants and should have skills in facilitating difficult conversations. The cost of the facilitator or mediator shall be shared equally by the Medical Staff and the Hospital.

19.2.2.3 If the joint conference committee is able to resolve the conflict, the resolution shall be sent to the Board of Trustees and the MEC (or the full Medical Staff in the case of a dispute between the Board of Trustees and the Medical Staff as a whole) for approval, as necessary.

19.2.2.4 If the Board of Trustees and the MEC (or the full Medical Staff in the case of a dispute between the Board of Trustees and the Medical Staff as a whole) are not able to approve the resolution achieved by the joint conference committee, the conflict management process will continue as outlined in Section 19.2.3 of these Bylaws.

19.2.2.5 If the joint conference committee is unable to reach a resolution to the conflict, the conflict management process will continue as outlined in Section 19.2.3 of these Bylaws.

**19.2.3** If efforts at conflict resolution, as described above, between the Board of Trustees and the MEC (or the full Medical Staff in the case of a dispute between the Board of Trustees and the Medical Staff as a whole) fail to resolve the conflict, the conflict shall be submitted to binding arbitration.

19.2.3.1 The parties may agree upon either a single arbitrator or a panel of arbitrators (e.g. one arbitrator selected by each party, and a third “neutral” arbitrator selected by the other two arbitrators). The cost of the arbitrator(s) shall be shared equally by the parties.

19.2.3.2 The arbitrator(s) must select the proposal of the party which he/she/they believe(s) most accurately represents the correct finding(s) of fact, and the evidence presented in such proceeding, and the arbitrator(s) may not effect a compromise.

19.2.3.3 The determination of the arbitrator(s) shall be final and binding on the Board of Trustees and the MEC (or the full Medical Staff in the case of a dispute between the Board of Trustees and the Medical Staff as a whole).

### **SECTION 3. MANAGEMENT PROCESS FOR CONFLICT BETWEEN THE MEDICAL EXECUTIVE COMMITTEE AND THE MEDICAL STAFF AS A WHOLE**

**19.3.1** The MEC and the Medical Staff as a whole will strive to resolve all conflicts in the best interests of 1) patient care; 2) the community served by the hospital; 3) the hospital; and 4) the Medical Staff.

*MLH Medical Staff Bylaws*

*Approved by General Medical Staff 09/16/2013*

*Revised by General Medical Staff 05/19/14; 9/15/14; 5/16/2016; 9/19/2016; 9/28/2017*

19.3.1.1 A petition of fifteen percent (15%) of the members of the Medical Staff eligible to vote is required to initiate this conflict management process. The petition to initiate the process must specify the issue or issues that constitute the conflict.

19.3.1.2 The petition to initiate the conflict management process shall identify the individuals who will serve as the representatives of the general Medical Staff in the resolution process, and those individuals are authorized by the petition to engage in conflict resolution with representatives of the MEC.

19.3.1.3 Obtaining the assistance of an internal or external third party facilitator or mediator may be the next step if the participants in the conflict resolution discussions find that the conflict is difficult to resolve directly with each other. The facilitator should be mutually agreed upon by all participants and should have skills in facilitating difficult conversations. The cost of the facilitator or mediator shall be shared equally between the parties.

19.3.1.4 If a compromise can be reached, the Medical Staff shall vote on the compromise. If a compromise cannot be reached, the petition shall trigger a vote of all medical staff members eligible to vote, on each separate issue identified in the petition. A majority vote of those voting shall prevail.

Attest:

\_\_\_\_\_  
Chair, Medical Executive Committee

\_\_\_\_\_  
Date

\_\_\_\_\_  
President, Board of Trustees

\_\_\_\_\_  
Date