REHOBOTH MCKINLEY CHRISTIAN HEALTHCARE SERVICES

BYLAWS

OF THE

MEDICAL STAFF

GALLUP, NEW MEXICO

Rehoboth McKinley
Christian Health Care Services

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RMCHCS MEDICAL STAFF BYLAWS
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DEFINITIONS

1. "Active Staff" shall be those Physicians (D.O.s and M.D.s) licensed in the state of New Mexico that are both clinically privileged to admit and treat patients, and are Members of the Medical Staff who may hold office and vote in Medical Staff elections.
2. "Allied Health Professional" or "AHP" means an individual, who is qualified to render direct or indirect medical or surgical care under the supervision of a Physician who has been afforded privileges to provide such care in the Hospital.
3. "Board" means the Board of Directors of Rehoboth McKinley Christian Health Care Services (RMCHCS).
4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other appropriate specialty boards.
5. "Chief Executive Officer" or "CEO" means the individual appointed by the Board to provide for the overall management of the Hospital; and may also refer to an individual appointed by the CEO to fulfill the responsibilities of his/her position in his/her absence.
6. "Chief of Staff" means the Member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital.
7. "Clinical Privileges" means the Board's recognition of the Practitioners' or AHPs' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
8. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.
9. "Dentist" means an individual who has received the degree of doctor of dental surgery (DDS) or doctor of dental medicine (DMD).
10. "Designee" means one selected by the CEO, Chief of Staff or other Medical Staff officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.
11. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.
12. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a Practitioner's Clinical Privileges are adversely affected by a determination based on the Practitioner's professional conduct or competence.
13. "Focused Professional Practice Evaluation (FPPE)" means a time limited evaluation of practitioner competence in performing a specific privilege implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safety, high-quality patient care.
14. "Hospital" means the hospital that is part of Rehoboth McKinley Christian Health Care Services (RMCHCS).
15. "Information" means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, date and other disclosures whether in written or oral form.
16. "Malice" means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
17. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.
18. "Medical Staff" means the formal organization of Practitioners who are Members of the Medical Staff by virtue of appointment or reappointment to the Medical Staff and who have been granted Clinical Privileges by the Board.
19. "Medical Staff Bylaws" means the Bylaws and the accompanying Rules & Regulations, Fair Hearing Plan, and such other departmental Rules and Regulations as may be adopted by the Medical Staff subject to the approval of the Board.
20. "Medical Staff Year" means January through December.
21. "Member" means a Practitioner and AHP who have been granted Medical Staff membership and Clinical Privileges pursuant to these Bylaws.
22. "Licensed Independent Practitioner" means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.
23. "Ongoing Professional Practice Evaluations (OPPE)" means a documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior; the information gathered during this process is factored into decisions to maintain, revise, or revoke existing privileges(s) prior to or at the end of the two-year reappointment cycle.
24. "Oral & Maxillofacial Surgeon or Oral Surgeon" means an individual with a DDS or DMD degree who has successfully completed a postgraduate program in oral and maxillofacial surgery that is accredited by the Commission on Dental Accreditation.
25. "Peer" means an individual from the same discipline with essentially the same or similar qualifications.
26. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in New Mexico.
27. "Podiatrist" means an individual who has received the degree of doctor of podiatric medicine (D.P.M.).

28. "Practitioner" means a Physician, Dentist, Podiatrist, and Psychologist who have been granted Clinical Privileges at the Hospital, and may mean an AHP if so indicated in these Bylaws.

29. “Precautionary Suspension” means the imposition of an immediate suspension or restriction of clinical privileges which is based on concerns that the failure to take action may result in imminent danger to the health and/or safety of any individual.

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

31. “Psychologist: means an individual who has received the degree of doctor of philosophy (Ph.D.) and received requisite training in psychiatric counseling.

32. “Representative” means a Board or any director or committee thereof; a Chief Executive Officer, or their designee; a medical staff organization and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering and/or dissemination functions.

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

34. “Telemedicine” means the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

35. “Third Parties” means both individuals and organization providing information to any representative.

PREAMBLE

WHEREAS, Rehoboth McKinley Christian Healthcare Services (RMCHCS), hereinafter referred to as "Hospital", is organized under the laws of the State of New Mexico serving as an integrated health care delivery system operating an acute care hospital, outpatient services including clinics and a home health/hospice program.

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

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

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board of Directors; and

WHEREAS, the cooperative efforts of the Medical Staff, Hospital Administration and the Board of Directors are necessary to fulfill these goals,

NOW, THEREFORE, the Practitioners practicing in RMCHCS hereby organize themselves into a Medical Staff conforming to these Bylaws.

ARTICLE I NAME

The name of this organization shall be the Medical Staff of RMCHCS.

ARTICLE II PURPOSES, RESPONSIBILITIES AND AUTHORITY

2.1 PURPOSES

The purposes of the Medical Staff are:

a. To organize the activities of physicians and other clinical practitioners who practice at RMCHCS in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital board. In conformity with this purpose, the medical staff agrees to provide high quality medical care, treatment and services to all patients regardless of race, ethnicity, religion, culture, physical or mental disability, socioeconomic status and ability to pay, sex, sexual orientation, gender identity or expression.

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

c. To foster cooperation with administration and the Board while allowing Medical Staff Members to function with relative freedom in the care and treatment of their patients.

d. To ensure that all patients admitted to or treated in any of the facilities or services of the Hospital receive the same level of quality care, treatment and services, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other quality improvement and patient safety activities in accordance with the Hospital's Performance Improvement and Patient Safety programs;

e. To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Practitioners and AHPs authorized to practice in the Hospital through delineation of Clinical Privileges, on-going review and evaluation of each Practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and Prerogative of AHPs;

f. To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

g. To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;

h. To promulgate, maintain and enforce Bylaws and Rules and Regulations and medical staff policies and procedures for the proper functioning of the Medical Staff;

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

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

k. To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

l. To accomplish its goals through appropriate committees and departments.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

a. Ensuring that Practitioners cooperate with each other in caring for patients in the Hospital.

b. Accounting for the quality, appropriateness and cost effectiveness of patient care, treatment and services rendered by all Practitioners and AHPs authorized to practice in the Hospital, by taking action to:

i. Assist the Board, the CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

ii. Implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of Clinical Privileges and assurance that all individuals with Clinical Privileges provide services within the scope of individual Clinical Privileges granted;

iii. Provide a continuing medical education program addressing issues of quality and patient safety including those related to the types of care, treatment and services offered by the Hospital;

iv. Implement a utilization management program, based on state and federal requirements;

v. Develop an ongoing monitoring procedure for Practitioners and AHPs that provides for the review and evaluation of patient care, treatment and services and resolution of problems identified;

vi. Initiate and pursue corrective action with respect to Practitioners and AHPs, when warranted;

vii. Provide for appropriate supervision of AHPs; and

viii. Develop, administer and enforce these Bylaws, the Rules and Regulations of the Medical Staff and other Hospital and medical staff policies;

ix. Designate licensed independent practitioner members of the organized medical staff to perform and be responsible for oversight activities of the organized medical staff;

x. Ensure patients receive appropriate, care, treatment and services from a licensed independent practitioner who has been credentialed through the medical staff process during the patient's entire length of stay; and

xi. Provide leadership for measuring, assessing and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed through the medical staff processes including:

1) Patient satisfaction;

2) Medical assessment and treatment of patients;

3) Use of information about adverse privileging decision for any practitioner or AHP credentialed through medical staff processes;

4) Use of medications;

5) Use of blood and blood components;

6) Operative and other procedures;

7) Appropriateness of clinical practice patterns and significant departures from established patterns of clinical practice;

8) Use of developed autopsy criteria; and

9) Processes related to sentinel event data and patient safety data.

c. Assisting the Board in maintaining the accreditation status of the Hospital;

d. Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

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

2.3 AUTHORITY

Subject to the authority and approval of the Board, the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities.

ARTICLE III MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

a. Medical Staff membership and Clinical Privilege delineation are separate and distinct privileges extended by the Board.

b. Membership

i. Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff shall be extended only to Practitioners who with sufficient adequacy document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment, physical and mental health status, continuously meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations, and associated policies and procedures of the medical staff and Hospital.

ii. Membership on the Medical Staff shall confer on the Practitioner only those Prerogatives and responsibilities as have been granted by the Board in accordance with these Bylaws such as participation in Medical Staff departmental activities, meetings and Medical Staff elections.

iii. Allied Health Professionals shall be considered members of the member staff with voting right restrictions and other restrictions pursuant to **Article V**.

c. Privileges

i. Granting of Clinical Privileges is also a privilege extended by the Hospital, and is not a right of any person. Practitioners and AHP's granted Clinical Privileges shall continuously meet the qualifications, standards and requirements set forth in these Bylaws, Rules and Regulations, and any applicable policies and procedures.

ii. The Board shall confer on Practitioners and AHP's such Clinical Privileges for treatment of Hospital patients as appropriate, based on qualifications as stated in these Bylaws.

iii. No person shall admit patients to, or provide care, treatment or services to patients in the Hospital, unless such person has had appropriate Clinical Privileges granted.

3.2 GENERAL QUALIFICATIONS/CONDITIONS FOR MEMBERSHIP AND CLINICAL PRIVILEGE DELINEATION

a. **Basic Qualifications**- The only people who shall qualify for membership on the Medical Staff or for Clinical Privilege delineation are those Practitioners or AHPs who:

i. Have a currently valid unrestricted license, issued by the State of New Mexico to practice medicine, oral surgery, dentistry, clinical psychology, podiatry or in the case of AHPs, a valid unrestricted license, certificate or other legal credential as required by the State of New Mexico.

ii. Possess a current, valid, unrestricted drug administration number and NM controlled substance license, if applicable;

iii. Have appropriate written and verbal communication skills, including ability to speak and understand English;

iv. Document their professional experience, background, education, training, demonstrated ability, current competence, judgment, knowledge, character and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

v. Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of Medical Staff responsibilities;

vi. Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;

vii. Have a record that is free from current Medicare/Medicaid sanctions and not be on the Office of Inspector General's (OIG) list of excluded individuals/entities;

viii. Have record free of felony convictions within the last five (5) years, or occurrences that would raise questions of undesirable conduct that would injure the reputation of the medical staff or Hospital.

ix. Have professional liability insurance that meets the requirements of **Section 16.1;**

x. Are graduates of an approved college and/or professional school holding appropriate degrees for their Medical Staff membership or Clinical Privilege delineation;

xi. Have successfully completed approved graduate medical education and internship program as applicable to the Practitioner or AHP.

xii. Continuously demonstrate the ability to work with and relate to visitors, patients and the community in general other Members of the Medical Staff, other health disciplines, management, the Board and the Hospital in a cooperative, professional manner that is essential for maintaining an environment that is appropriate to quality and efficient patient care and safety.

xiii. Provide patient care and conduct interaction with Physicians, AHPs, staff, patients, and their families and all others in a dignified and courteous manner which shall not discriminate on the basis of race, sex, religion, color, national or ethnic origin, disability, sexual orientation or military service in the provision of patient services. Further, practitioners and AHPs shall not discriminate in the provision of patient services based on the patient's financial or insurance status or source of insurance;

xiv. Comply with all state and federal (e.g., EMTALA) requirements for the emergency treatment of, acceptance and transfer of patients;

xv. Abide by the policies, practices, rules, and regulations of the Medical Staff and Hospital regarding patient confidentiality as defined under state and federal law (including "HIPAA" and state law requirements, 45 C. F. R. § 164.501 et seq) including without limitation those practices set forth in the Hospital's Notice of Privacy Practices, as such notice may be amended from time to time;

xvi. Show evidence every two years of continuing education credits as required by New Mexico. The education should be related to the provision of quality patient care to Hospital patients and to privileges requested;

xvii. Meet one (1) of the following requirements:

1) Board certification; or

2) Adequate progress toward Board certification. The determination of adequacy shall be recommended by the MEC and must be approved by the Board; or

3) Demonstration to the satisfaction of the MEC and the Board, competency and training equal or equivalent to that required for Board certification.

The above requirements shall not apply to any Practitioner already a Member of the Medical Staff as of ***August 3, 2011.***

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

xix. Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other Practitioners within the Hospital;

xx. Observe ethical and professional standards, including abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities;

xxi. Provide evidence of physical and mental health that does not impair fulfillment of his/her Medical Staff responsibilities and specific clinical privileges requested by and granted to the applicant;

xxii. Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff and Hospital, in addition, if employed by the Hospital abide by personnel policies of the Hospital

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

c. **Non-Discrimination** - No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin, disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care, treatment or services in the Hospital, to professional ability and judgment, or to community need.

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

e. **Failure** - Failure to meet the qualifications as enumerated and otherwise described in these Bylaws shall be grounds for corrective action, including, but not limited to, termination of Medical Staff membership.

3.3 RESPONSIBILITIES OF INDIVIDUAL PRACTITIONERS AND AHPS

a. **Responsibilities** – In addition to requirements pursuant to **Section 3.2**, each Practitioner/Medical Staff Member and AHP shall:

i. Provide his/her patients with a uniform level of care and continuous care at the generally recognized professional level of quality and national standards of care;

ii. Consistent with generally recognized quality standards, deliver patient care, treatment and services in an efficient, safe and financially prudent manner, and adhere to local medical review policies with regard to utilization;

iii. Practice only within their scope of privileges as determined by the Medical Executive Committee and approved by the Board.

iv. Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff and the Hospital;

v. Agree to serve on medical staff committees if asked and to perform in such a manner as to reflect favorably upon the medical staff.

vi. Discharge the Medical Staff, department, committee and Hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, and election or otherwise;

vii. Adequately prepare and complete in a timely and legible fashion all medical and other required records for all patients he/she admits or, in any way provides care, treatment and services to the extent authorized

viii. At all times observe and promote the confidentiality of patient-identifiable information;

ix. Use Hospital resources appropriately;

x. Provide an email address that will be consistently maintained and utilized by the provider as one of the primary communication tools within the Organization;

xi. Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws;

xii. If, at any time, the Hospital does not have arrangements for the provision of Emergency Services (dedicated Emergency Medicine Physicians), any physician on the Active or Associate Staff clinically treating patients will take emergency call on a rotating basis with the other Active and Associate Staff Members;

xiii. Participate in a health screening prior to initial exercise of privileges, and participate in the Hospital drug testing program;

xiv. Abide by the ethical principles of the Hospital and his/her profession and specialty;

xv. Refuse to engage in improper inducements for patient referral;

xvi. Immediately report any action taken affecting any licensure, certification, registration, or DEA registration to the medical staff office, including but not limited to probation, restriction, suspension, termination, and voluntary or involuntary relinquishment of licensure, certification, registration or privileges, and if:

1) His/her professional liability insurance is modified or terminated;

2) He/she is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence; or

3) He/she ceases to meet any of the standards or requirements set forth herein for continued enjoyment of Clinical Privileges

xvii. Abide by the rules governing fee splitting as outlined by the AMA

xviii. Maintain a current DEA certificate, if applicable to their practice requirements.

xix. Attend continuing medical education conferences and courses as required by New Mexico State medical licensure.

xx. Read and understand the English language, and to communicate in writing and verbally in the English

language in a fluent and intelligent manner

xxi. Arrange for appropriate and timely medical coverage for patients for whom he/she is responsible.

xxii. Read and respond in a timely manner to all communications from the Medical Staff Office, MEC, Board, and/or Administration.

xxiii. Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community.

xxiv. Maintain malpractice and liability insurance coverage at a minimum as required by the New Mexico Malpractice Act and **Section 16.1** of these Bylaws.

b. **Failure** - Failure to carry out the responsibilities as enumerated and otherwise described in these Bylaws shall be grounds for corrective action, including, but not limited to, termination of Medical Staff membership.

3.4 DURATION OF APPOINTMENT

a. **Duration of Initial Appointments**

i. Initial appointments to the Medical Staff and granting Clinical Privileges shall be for a period of not more than two (2) years. Practitioners applying for Active and Associate Staff membership shall be on provisional status for the initial appointment. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff and/or Clinical Privilege delineation shall confer to the appointee only such privileges as may hereinafter be provided.

b. **Declaration of Moratorium** - The Board may from time to time declare moratoriums in the granting of Medical Staff membership and/or Clinical Privilege determination when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof.

c. **Duration of Reappointments** - Reappointment to the Medical Staff and re-granting of Clinical Privileges shall be for a period of not more than **two (2) years**.

d. **Durations if Modifications in Staff Category and Clinical Privileges** - The MEC may recommend to the Board that a change in Medical Staff category of a current Medical Staff Member or the granting of additional privileges to a current Medical Staff Member be made provisional in accordance with the procedures for initial appointment as outlined herein.

e. **Duration of Temporary, Emergency and Disaster Privileges** – See **Sections 7.6, 7.7 and 7.8** of these Bylaws for duration of these types of appointments.

f. **Duration of Appointments/Reappointments for Practitioners Who Provide Contract Services** - The duration of appointment and reappointment cannot not exceed the timeframes defined herein or the length of period of the contract.

3.5 LEAVE OF ABSENCE

a. **Leave Status**

i. A practitioner may obtain a voluntary leave of absence from the Medical Staff by submitting a written request **at least thirty (30) business days** prior to the effective date of the leave if possible to the Medical Staff Office stating the reason for the leave and the time period of the leave, which may not exceed **six (6) months**, renewable under appropriate conditions.

ii. Any practitioner who shall be away from the hospital for sixty days or longer must apply for an official leave of absence.

iii. A practitioner who is absent from practice at the Hospital by virtue of having been granted a leave of absence for reasons such as health, study, military duty, or other valid reasons, may be placed in a leave of

absence (from the Medical Staff) status for a total period of no longer than **two (2) years** in duration, or until the end of the practitioners' appointment, on the recommendation of the applicable Department Chairperson when there is probability of return to Medical Staff activity

iv. During the leave of absence, unless otherwise agreed in writing by the Department Chairperson, the Physician and the President of the Medical Staff, the clinical privileges and staff duties of the member shall be in abeyance.

b. **Termination of Leave**

i. Upon the member's return from a leave of absence, he/she shall make written request to the applicable Department Chairperson for reinstatement of Medical Staff membership and clinical privileges and shall provide documentation to support his/her request as required by the Department Chairperson, the Chief Executive Officer, or the Medical Executive Committee. The Department Chairperson shall than make a recommendation for review and approval by the Credentials Committee and the Medical Executive Committee regarding reinstating the returning practitioner.

ii. In the event that the practitioner's Medical Staff appointment (two years) will end while the staff member is on a leave of absence, reappointment of that staff member should occur prior to the scheduled leave of absence or membership will be terminated.

iii. The MEC shall make a recommendation to the Board concerning the reinstatement of the Member's Medical Staff membership and Clinical Privileges after the MEC has satisfied itself as to the continuing competency of the returning practitioner.

iv. Termination of Medical Staff membership, privileges and Prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for Medical Staff membership subsequently received from an individual so terminated shall be submitted and processed in the manner specified for application for initial appointments.

v. If a Member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning practitioner. Any new privileges requested will be acted upon and monitored in similar fashion as if the practitioner were a new applicant and may include provisional status.

vi. Reinstatement will ordinarily be automatic if a leave of absence is an armed services commitment. However, if such a leave of absence occurs with no medical activity for **twelve (12) or more months**, the reinstatement may only occur after the MEC is satisfied as to the continuing competency of the returning practitioner. Any new privileges requested will be acted upon and monitored in similar fashion as if the practitioner were a new applicant and may include provisional status. The MEC may also require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

vii. If a Member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC and/or the Board may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

viii. Practitioners not receiving privileges and appointment as outlined above shall not be entitled to procedural rights as provided for in the Bylaws.

ix. Failure to request reinstatement within the timeframes as outlined above will result in automatic termination of Medical Staff membership and Clinical Privileges and Prerogatives without right of hearing or appellate review.

ARTICLE IV CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES OF MEDICAL STAFF MEMBERSHIP

The Medical Staff shall include Active, Associate, Consulting, Honorary ~~and~~ Affiliate and Telemedicine categories.

4.2 PROVISIONAL STATUS

a. **Nature of Provisional Status**

i. Initial appointments to the Active and Associate categories of the Medical Staff shall be provisional. Each newly appointed Member shall be assigned to a department where his/her performance and competence shall be observed by the Chairperson. Conditions of appointment, such as proctorship requirements, may be imposed as deemed appropriate by the MEC and in accordance with the *Focused Professional Practice Evaluation Policy.*

ii. At a reasonable time before the end of the first **twelve (12) month**s of the initial appointment, the Member will be evaluated by the Chairperson of the Department or Service Chief who shall make a report to the Credentials Committee for the removal or extension of the provisional status. Information and findings from the Hospital's Performance Improvement and Patient Safety programs, including *Focused Professional Practice Evaluation*, shall be considered as part of the evaluation process.

iii. Before the end of any provisional period, the Chairperson of the Department shall recommend extending or removal of the provisional status to the Credentials Committee. The Credentials Committee and MEC shall consider the recommendation of the department, and shall make a recommendation to the Board. The decision of the MEC shall be based on the Practitioner's demonstrated competence, appropriate utilization, meeting attendance and Bylaws compliance, as well as all factors considered in a reappointment process as outlined in these Bylaws.

4.3 ACTIVE STAFF

a. **Qualifications** - The Active Staff shall consist of Practitioners who:

i. Meet the basic qualifications for Medical Staff membership and Clinical Privileges set forth in these Bylaws;

ii. Are professionally based in the community served by the Hospital, close enough to provide timely and continuous care to their patients in the hospital and to fulfill their staff responsibilities;

iii. Regularly admit to, or are otherwise regularly be involved in the care of at least **twenty-five (25) patient/patient encounters** in the Hospital in a calendar year. Regularly involved is defined as an inpatient admission, consultation, emergency department encounter or inpatient or outpatient surgical procedure at the Hospital (excluding Clinics).

iv. In the event that members of the active category do not meet the qualifications for reappointment to the active category, and if the members are otherwise abiding by all Bylaws, Rules and Regulations, and policies of the medical staff and Hospital, the members may be appointed to another medical staff category if they meet the eligibility requirements for such category.

b. **Prerogatives** - The Prerogatives of an Active Staff Member shall be:

i. To admit patients without limitation in accordance with privileges granted, unless otherwise provided in the Medical Staff Bylaws, Rules & Regulations and privileges granted;

ii. To exercise such Clinical Privileges as are granted to him/her pursuant to **Article VII;**

iii. To vote on all matters presented at general and special meetings of the Medical Staff;

iv. To vote and hold office in the Medical Staff organization and departments and on committees to which he/she is appointed;

v. To vote in all Medical Staff elections;

vi. To issues not pertaining to

- Individual peer review,
- formal investigations of professional performance or conduct,
- denial of requests for appointment or clinical privileges, or
- any other matter relating to individual membership or privileges.

1) To meet with the MEC on matters relevant to the responsibilities of the MEC; In the event the practitioner is unable to resolve a matter of concern after working with his or her department chair or other appropriate medical staff leader(s), that practitioner may, on written notice to the Chief of Staff two weeks in advance of a regular meeting, meet with the MEC to discuss the issue;

2) To initiate a recall election of a medical staff officer by following the procedure outlined in **Section 12.1 (g)** of these Bylaws, regarding removal and resignation from office;

3) To call a general staff meeting of the medical staff to discuss a matter relevant to the medical staff; on presentation of a petition signed by 25% of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted;

4) To challenge any rule or policy established by the MEC; In the event that a rule, regulation, or policy is thought to be inappropriate, any active staff member may submit a petition signed by 25% of the members of the active category. On presentation of such a petition, the adoption procedure outlined in **Article XVII** will be followed; and

5) To call for a department meeting by presenting a petition signed by 25% of the members of the department. On presentation of such a petition, the department chair will schedule a department meeting.

c. **Responsibilities** - Each Member of the Active Staff shall:

i. Meet the basic responsibilities set forth in **Section 3.3;**

ii. Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing care, treatment or services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within **twenty-four (24) hours** of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than **four (4) hours** after admission or sooner if warranted by the patient's condition.

iii. Actively participate in:

1) The Performance Improvement and Patient Safety program(s) and other patient care evaluation and monitoring activities required of the Medical Staff;

2) Supervision of provisional appointees where appropriate;

3) Supervision of AHPs for which/he she is identified as the supervising practitioner;

4) The emergency on-call rotation, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

5) Promoting effective utilization of resources consistent with delivery of quality patient care; and

6) Discharging such other Medical Staff functions as may be required from time-to-time;

iv. Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

v. Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the department and committees of which he/she is a Member.

vi. Abide the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff and Hospital, and if employed by the Hospital abide by personnel policies of the Hospital

vii. Shall pay any applicable application fees, dues, and assessments.

4.4 ASSOCIATE STAFF

a. **Qualifications** - The Associate Staff category is reserved for medical staff members who do not meet the eligibility requirements for active category, including low-volume providers, RMCHCS Clinic providers not meeting active staff category qualification, or practitioners choosing not to pursue active status. Associate Staff shall consist of Practitioners, who:

i. Provide care, treatment and services to: (a) emergency department patients; (b) non-emergency department patients only on an occasional basis, not admitting or regularly participating in the care, treatment or services of more than one hundred twenty-five (125) patient encounters in a calendar year; (Encounter defined as involved in inpatient, admission, consultation, emergency department services or inpatient or outpatient surgical procedure at the Hospital of less than 125 patients encounters at the Hospital

ii. Meet the basic qualifications set forth in **Section 3.2(a);**

iii. Are professionally based in the community served by the Hospital, close enough to provide timely and continuous care to their patients in the hospital and to fulfill their staff responsibilities;

iv. Are Members of the Active Staff of another hospital where he/she actively participates in the Performance Improvement and Patient Safety programs.

b. **Prerogatives** - Associate Staff Members shall not hold elective office or serve on the MEC, Credentials Committee or Peer Review Committee. Associate Staff members shall not be Department Chairpersons. Prerogatives of the Associate Staff shall be to:

i. Vote at medical staff meetings;

ii. To admit patients without limitation in accordance with privileges granted, unless otherwise provided in the Medical Staff Bylaws, Rules & Regulations and privileges granted;

iii. To exercise such Clinical Privileges as are granted to him/her pursuant to **Article VII**;

iv. Attend any Medical Staff or Hospital education programs, although attendance is not required; and

v. If requested, may agree to serve on a committee and in such an instance may vote on the committee to which he/she is appointed. If he/she agrees to accept a committee assignment, he/she must carry out such an assignment in the same manner as required by Active staff members, including attendance requirements.

c. **Responsibilities** - Each Member of the Associate Staff shall:

i. Discharge the basic responsibilities specified in **Section 3.3**;

ii. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing care, treatment or service;

iii. Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member;

iv. Support the organization's quality and patient safety programs; and

v. Shall pay any applicable application fees, dues, and assessments.

4.5 CONSULTING STAFF

a. Qualifications - Acceptance to the consulting staff category shall be based on a recurring need for such specialized services in the hospital and the availability of the applicant to provide such services. The need for such services shall be determined by the Board based upon the recommendation of the Medical Staff. The Consultant Staff shall consist of those physicians who:

i. Meet the qualifications for membership and appointment as set forth in **Section 3.2a**;

ii. Have an Active Staff appointment at another hospital, unless an exception is made in unusual circumstances by the Credentials and Medical Executive Committees and approved by the Board;

iii. Act as consultants only and are ineligible to admit or assume responsibility for the continuous care of hospitalized patients; and

iv. With initial application and each application for reappointment, provide evidence of clinical performance at their primary hospital in such form as may be requested. In addition, especially for those Consultant Staff appointees who do not maintain a primary appointment at another hospital, they shall provide other information as may be required in order to perform an appropriate evaluation of qualifications (including, but not limited to, information from the individual's office practice, information from managed care organizations in which the applicant participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

b. **Prerogatives –** Consultant staff may not vote (except when serving on a committee), or hold office. Prerogative of Consultant Staff shall be:

i. To exercise such Clinical Privileges as are granted to him/her pursuant to **Article VII**;

ii. Attend any Medical Staff or Hospital education programs, although attendance is not required;

iii. If requested, may agree to serve on a committee and in such an instance may vote on the committee to which he/she is appointed. If he/she agrees to accept a committee assignment, he/she must carry out such an assignment in the same manner as required by Active staff members, including attendance requirements; and

iv. Is encouraged, but is not required, to attend Medical Staff or department meetings (except as may be required to address a question or concern with the Consultant Staff member's practice at the hospital).

c. **Responsibilities** –Each member of the Consulting Staff shall:

i. Discharge the basic responsibilities specified in **Section 3.3**.

ii. Cooperate with the performance improvement, patient safety, monitoring, and peer review activities at the Hospital, including responding fully and timely to any inquiries regarding the care of patients at the Hospital; and

iii. Shall pay all applicable application fees, dues, and assessments.

4.6 HONORARY STAFF

a. **Qualifications** – Honorary category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. The Honorary Staff shall consist of practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be individuals who:

i. Have retired from active Hospital services, but continue to demonstrate a genuine concern for the Hospital;

ii. Are of outstanding reputation in a particular specialty, whether or not a resident in the community; or

iii. Have provided distinguished service to the Hospital;

iv. Honorary Staff Members shall not be required to meet the qualifications set forth in **Section 3.2** of these Bylaws.

b. **Prerogatives** - Prerogatives of an Honorary Staff Member shall be:

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

ii. Honorary Staff Members shall not in any circumstances admit patients to the Hospital or exercise clinical privileges.

iii. Honorary Staff Members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.7 AFFILIATE STAFF

a. Qualifications - Practitioners who order outpatient tests and/or procedures and wish to follow the course of patients who are admitted at the Hospital and do not fall within another Medical Staff category shall be considered Affiliate Staff Members. In order to qualify for appointment for the Affiliate Staff of the Medical Staff, a Practitioner shall:

i. Maintain a license in good standing to practice medicine or osteopathy in the state of New Mexico; and

ii. Provide the information required by Responsibilities of Affiliate Staff defined below with regard to any test or procedure ordered.

b. Prerogatives - The Prerogatives of a Affiliate Staff appointee shall:

i. Order outpatient laboratory tests, diagnostic tests and receive results of such tests;

ii. Order outpatient procedures to be performed by Practitioners with appropriate privileges at the Hospital and receive the results of such procedures;

iii. Not be eligible for clinical privileges, not manage patient care in the Hospital and not order tests on inpatients at the Hospital; and

iv. Not be eligible to vote, or to hold office; and

v. Attend general medical staff meetings and to serve on committees,

c. Responsibilities

i. Each Affiliate Staff Member shall provide the following information when referring a patient for a diagnostic test or study:

1) Practitioner's name, New Mexico license number, office address and telephone number; and

2) Written order from the Practitioner's office.

ii. Affiliate Staff shall comply with all applicable medical staff and Hospital policies and procedures.

iii. Each Affiliate Staff Member shall be responsible for reviewing all results of tests ordered and for providing such further medical care or for referring the patient to another Practitioner for such care as the patient's condition may indicate. For those Affiliate Staff not employed by the Hospital or working in a Clinic or other location owned by the Hospital and within the scope of the Hospital's accreditation, since such patient care shall occur outside the Hospital, neither the Medical Staff nor the Hospital shall be responsible for reviewing such care through the Hospital's and Medical Staff's Performance Improvement Program or otherwise.

iv. Any Affiliate Staff appointee who desires to transfer to another staff category and to request clinical privileges must meet the qualifications, standards, and requirements for appointment and clinical privileges as set forth in these Bylaws.

4.8 TELEMEDICINE STAFF

The Telemedicine Staff Category shall consist of Practitioners who are recognized by the Medical Staff for their ability to provide specialized services for patients of the Hospital through telemetry and other telemedicine/teleradiology technology.
Telemedicine Practitioners must meet the basic qualifications for membership and appointment set forth in the

Medical Staff Bylaws, Article 3, Section 3.2.
Telemedicine privileges will be granted pursuant to the process outlined in the Medical Staff Bylaws, Article 7, Section 7.9.
Telemedicine Practitioners may not vote or hold office in the Medical Staff organization.

ARTICLE V ALLIED HEALTH PROFESSIONALS (AHPs)

5.1 GENERAL PROVISIONS

a. Allied Health Professionals (AHPs) shall not be employed, granted authority to exercise privileges, or given a credentialing application unless and until the Board has authorized and approved provision of such services.

b. Where appropriate, the Medical Executive Committee may establish particular qualifications required of practitioners of a specific category of AHP provided that such qualifications are not founded on arbitrary or discriminatory basis and are in conformance with applicable law and approved by the Board.

c. AHPs are voting members of the Medical Staff.

d. All patients treated by AHPs shall receive the same basic medical evaluation as patients admitted to other medical or surgical services. Members of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or may arise during hospitalization and shall independently determine the risk and effect of any proposed surgical or medical procedure on the total health status of the patient.

5.2 CATEGORIES

a. AHP categories approved by the Board include:

i. **Independent** - Independent AHPs are those practitioners permitted to practice independently without direct physician supervision and within the state of New Mexico scope of practice. Independent AHPs at RMCHCS are:

1. Dentist
2. Podiatrists
3. Psychologists

ii. **Dependent** - Dependent AHPs must be under the direction (and where required, supervision) of a sponsoring Medical Staff member. Dependent AHPs at RMCHCS are:

1. Licensed Independent Social Workers
2. Physician Assistants
3. Advance Practice Registered Nurses:

a) Nurse Midwives

i) *Special Provisions*: Must be sponsored by an OBGYN appropriately credentialed and privileged at RMCHCS; must work in collaboration with the sponsoring physician in accordance with approved medical staff protocols; on-call OBGYN must be immediately available as defined in approved medical staff protocols.

b) Nurse Practitioners

i) *Special Provisions:* Must be sponsored by an appropriately credentialed and privileged Medical Staff member at RMCHCS; must work in collaboration with the sponsoring physician in accordance with approved medical staff protocols; the sponsoring physician does not need to be immediately available on site if the Nurse Practitioner is functioning within approved medical staff protocols.

c) Nurse Anesthetists

ii) *Special Provisions*: Must be sponsored by an anesthesiologist appropriately

credentialed and privileged Medical Staff member at RMCHCS; must work in collaboration with the sponsoring physician in accordance with approved medical staff protocols; the sponsoring physician does not need to be immediately available on site if the Nurse Anesthesia is functioning within approved medical staff protocols.

5.3 QUALIFICATIONS - Only AHPs holding a license, certificate or other legal credential as provided under New Mexico State law, shall be eligible to provide specified services in the Hospital as recommended by the MEC and approved by the Board. AHPs must:

a. Meet the general qualification/conditions for membership and clinic privilege delineation described in **Section 3.2**;

b. Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care, treatment and services at the generally recognized professional level of quality and efficiency and that they are qualified to provide needed services within the Hospital;

c. Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective professions, work cooperatively with others and are willing to participate in the discharge of AHP staff responsibilities;

d. Have acceptable professional claims history and continuous professional liability insurance in the prescribed amounts:

i. AHPs who are employed by the hospital are covered for professional liability for services provided as employees under insurance policies of the applicable organization(s).

ii. AHPs who are employed, contracted or sponsored by members of the Medical Staff must be covered by the practitioner employer and specifically named in the professional liability policy and must meet the Hospital requirements for coverage.

iii. AHPs must demonstrate professional liability insurance in the amount required by the Board.

e. Provide a needed service within the Hospital and be eligible to provide specified services;

f. Must demonstrate ongoing competence as developed by assigned department; and

g. Unless permitted by law and by the Hospital to practice independently, must provide written signature of the sponsoring Medical Staff appointee who has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.4 PREROGATIVES - Upon establishing experience, training and current competence, AHPs shall have the following Prerogatives.

a. Independent AHP Prerogatives:

i. To exercise judgment within the AHP's area of competence;

ii. Participate directly, including writing orders to the extent permitted by law, the privileges granted and within the scope of the AHP's license, certification or other applicable legal credential.

iii. To participate as appropriate in patient care evaluation and other performance improvement and patient safety activities required of the Medical Staff and the Hospital;

iv. To support and participate as appropriate in the organization's Performance Improvement and Patient Safety programs.

v. To vote.

vi. Exercise such other prerogatives as shall, by resolution or written policy duly adopted by the medical staff or by any of its departments or committee and approved by the Medical Executive Committee and the Board, be accorded to AHPs as a group or to any specific category of AHP.

b. Dependent AHP Prerogatives:

i. To exercise judgment within the AHP's area of competence, and manage and coordinate patient care, treatment and services under the supervision or direction of a physician practitioner of the Medical Staff (except as otherwise expressly provided by resolution of the department, approved by the Medical Executive Committee and the Board) and consistent with the limitations stated in **Sections 7.3 and 7.4**, and law and regulation;

ii. To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a supervising physician or dentist to the extent established by the MEC, but not beyond the scope of the AHP license, certificate or other legal credential;

iii. To participate as appropriate in patient care evaluation and other performance improvement and patient safety activities required of the Medical Staff and the Hospital;

iv. To support and participate as appropriate in the organization's Performance Improvement and Patient Safety programs.

v. To vote.

vi. Exercise such other prerogatives as shall, by resolution or written policy duly adopted by the medical staff or by any of its departments or committee and approved by the Medical Executive Committee and the Board, be accorded to AHPs as a group or to any specific category of AHP.

5.5 RESPONSIBILITIES - Each AHP shall:

a. Meet the basic responsibilities as required by **Section 3.3** for medical staff members.

b. Retain appropriate responsibility within his area for professional competence for the care, treatment and services of each patient for whom he/she is providing services, or arrange a suitable alternative for such care.

c. If the AHP holds admitting privileges, attend meetings per **Section 14.8**

d. Provide his/her patients with continuous care at the AHP's generally recognized professional level of quality and efficiency in the community to the extent authorized by his or her license, certification or other legal credentials;

e. Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff and Hospital, and if employed by the Hospital, abide by personnel policies of the Hospital;

f. Discharge any committee functions for which he/she is responsible;

g. Cooperate with Members of the Medical Staff, administration, the Board and employees of the Hospital;

h. Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible and to the extent authorized;

i. Write orders only as permitted by privileges granted and his/her licensure or certification;

j. Participate in performance improvement and patient safety activities of the Hospital

k. Participate in continuing professional education;

l. Seek consultation, supervision, and direction whenever appropriate or necessary; and

m. Abide by the ethical principles of his/her profession and specialty.

5.6 DEPENDENT AHP SPONSOR/SUPERVISION REQUIREMENTS

a. Dependent AHPs must be assigned to a Medical Staff member who serves as a supervisor/collaborator/sponsor and is deemed acceptable by the medical staff. The supervisor/collaborator/sponsor must be a member of the active medical staff in good standing. The supervisor/collaborator/sponsor must sign the privileges of the AHP he or she supervises. In doing so, he or she accepts responsibility for the AHP appropriate supervision of the services provided by each AHP under his or her supervision and agrees that the AHP will not exceed the scope of practice defined by law and within the AHP's licensing/supervising/collaborating agreement and/or privileges granted.

b. The supervisor/collaborator/sponsor must agree to participate as requested in the evaluation of competency (i.e., during and at the conclusion of the initial focused professional practice evaluations [FPPE], at the time of reappointment of the AHP, and at intervals between reappointment, as defined by the ongoing professional practice evaluation [OPPE] of the AHP(s) who he or she supervises. A copy of the supervising/collaborating/sponsoring agreement will be submitted, and the AHP's application will be signed by both parties.

5.7 PROCEDURES FOR EVALUATING PERFORMANCE OF AHPs

a. The performance of all AHPs will be evaluated as part of the medical staff's routine performance improvement processes. AHPs' performance shall be consistent with the medical staff policies and procedures regarding FPPE and OPPE.

b. Any concerns regarding the quality or appropriateness of care, treatment or services provided by an AHP identified during such review processes shall be brought to the attention of the appropriate medical staff review committee.

c. Any concerns regarding the supervision of an AHP by a physician shall be referred to the appropriate medical staff department or review committee.

d. In addition, the quality of care provided by dependent AHPs employed by the hospital will also be reviewed on an ongoing basis through the hospital's employment performance evaluation process.

e. In the event that there is unsatisfactory performance, the sponsoring physician will be notified in writing and corrective action will be taken.

5.8 CONDITIONS FOR GRANTING AHP CLINICAL PRIVILEGES AND GRIEVANCE PROCEDURE

a. Credentialing and Privileging

i. AHPs shall be credentialed in the same manner as outlined in **Article VI** of the Medical Staff Bylaws for credentialing of Practitioners. Each AHP shall be assigned to one (1) of the clinical departments and shall be granted Clinical Privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

ii. Clinical Privilege delineation of AHP's must be approved by the Board and may be terminated at will by the Board or the CEO.

b. Grievance Procedure and Corrective Action

i. Applicability of the Fair Hearing Plan - AHP privileges and their reduction, suspension, restriction, revocation, or termination ("Adverse Decisions") shall not be covered by the provisions of the Fair Hearing Plan.

ii. Special Considerations for Employed AHPs: If the AHP is an employee of the Hospital and the activities or

professional conduct are related to:

1) Behavioral issues, applicable Human Resources (HR) policies will be followed;

2) Quality of care and privileges, the matter will be resolved pursuant to **Section 5.8b iii,** AHP Grievance Procedure.

If it is unclear if the concern identified should follow processes 1) or 2) above, an investigation and recommendation for manner of course will be determined by the Chief Human Resources Officer, Chief Quality Officer, Chief Medical Officer and chairperson of the medical department. The investigation and recommendation for manner of action should be completed within **five (5) business days** of the issue being identified, reported and/or occurring. The investigation may involve an interview with the AHP involved and his or her supervising/collaborating/sponsoring medical staff member and an interview with other individuals or groups.

iii. AHP Grievance Procedure - If the AHP is not an employee of the Hospital or the AHP is employed by the Hospital and pursuant to **Section 5.8b ii**, with the exception of automatic termination of privileges as described **Section 5.8c**, the affected AHP shall have the right to notice of the reasons for the Adverse Decision and shall be allowed an appearance before the Credentials Committee. The Credentials Committee shall make a recommendation to the Medical Executive Committee. The MEC may take actions pursuant to **Section 9.1e** of the corrective action process. Should the MEC recommend an Adverse Decision to the Board, the AHP shall then be permitted to submit a written statement of appeal to the MEC for consideration prior to an Adverse Decision becoming permanent. The Board's decision is final with no right to appeal.

c. **Automatic Termination of Privileges** – AHP privileges shall automatically terminate if any of the following conditions exist/occur:

i. Revocation of the privileges of the AHP's supervising Practitioner unless another qualified Practitioner indicates his/her willingness to sponsor, collaborate and/or supervise the AHP and complies with all requirements hereunder for undertaking such supervision. For employed AHPs, the Hospital will make every effort to identify another qualified Practitioner prior to revoking the AHPs privileges. Such effort may include, but not be limited to, identification of a qualified locum tenens to provide oversight and supervision until such time as another qualified Practitioner may be identified. In the event that an AHP's sponsoring and collaborating and/or supervising Practitioner's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan or as applicable, Human Resources grievance procedure(s). In the case of CRNAs who are sponsored by an anesthesiologist, the CRNA's privileges shall be unaffected by the termination of a given anesthesiologists privileges so long as another anesthesiologist remains willing to collaborate with the CRNA for purposes of their cases;

ii. Employment with the Hospital being terminated for any reason;

iii. License or other legal credential expiring or being revoked;

iv. AHP being listed on the Medicare/Medicaid OIG Exclusion List; or

v. AHP failing to meet or maintain the eligibility criteria for AHPs.

d. Indemnification - If the sponsoring/supervising Practitioner employs or directly contracts with the AHP for services, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure of such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or Clinical Privileges.

5.9 NON-EMPLOYEES BROUGHT INTO THE HOSPITAL BY PRACTITIONERS

Technicians or other individuals who are not employees of RMCHCS and do not fall within the AHP categories defined in **Section 5.2** and who are brought into the hospital by members of the medical staff, dentists or podiatrists to perform selected skills or assist with specified procedures, must be approved to perform special services under the direct supervision of a medical staff member who is fully privileged. Such individuals are subject to the requirements outlined in Medical Staff *Non-Employees Brought Into the Hospital by Practitioners Policy*.

ARTICLE VI PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT AND CLINICAL PRIVILEGE DELINEATION

6.1 GENERAL PROCEDURE

a. The Medical Staff through its designated departments, committees, and officers shall investigate And consider each application for appointment or reappointment to the medical staff and each request for modifications of Medical Staff membership status and/or Clinical Privileges and shall adopt and transmit recommendations to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff members and Clinical Privileges. The Medical Staff shall perform these same investigations, evaluation and recommendation functions in connection with any AHP whether or not such individual is eligible for Medical Staff membership.

b. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or Clinical Privileges.

c. Each application for appointment or reappointment to the Medical Staff and each application for delineation of Clinical Privileges shall be in writing, submitted to the Medical Staff Coordinator or designee on the prescribed form approved by the Board, and signed by the applicant.

d. When a practitioner requests an application form, the Medical Staff Coordinator shall give the applicant a copy of, or access to a copy of, these Bylaws, the Rules and Regulations and the Fair Hearing Plan and a summary of other medical staff governance policies.

e. An application will be considered only after completion of the entire application and receipt of all requested information. Applicants shall supply the Hospital with all information requested on the application.

f. Applicants for privileges need not be members of the medical staff.

g. In its discretion, the Board may delegate authority for Medical Staff appointments, reappointments and Clinical Privilege delineation to a committee of the Board consisting of at least two Board members, (the "Expedited Process") as described in **Section 7.5**. The Expedited Process is not the same as "temporary" privileges as described in **Section 7.6**.

h. An application fee may be assessed.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT/ CLINICAL PRIVILEGES

The application form for both Medical Staff and AHPs shall include, at a minimum, the following:

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

   i. To be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges; and
   ii. To be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether he/she is granted membership and/or Clinical Privileges.

b. Administrative Remedies: A statement indicating that the applicant agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action at his/her own expense, should an adverse ruling be made with respect to his/her Medical Staff membership, Medical Staff status, and/or Clinical Privileges;

c. Felony Charges: Any current criminal charges pending against the applicant and any past convictions or pleas. The applicant shall notify the CEO and the Chief of Staff within **seven (7) business days** of receiving notice of the initiation of any felony charges;

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

e. Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Medical Staff membership and exercising the privileges requested;

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

g. Education: Detailed information concerning the applicant's education and training;

h. Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each applicant must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

i. Medicare Penalty Statement - A signed Medicare penalty statement

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

k. Professional Sanctions: Information as to whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily or involuntarily relinquished:

   i. Membership/fellowship in local, state or national professional organizations;

   ii. Specialty board certifications/eligibility; date of certification or eligibility;

   iii. License to practice any profession in any state or jurisdiction;

   iv. Drug Enforcement Agency (DEA) number/controlled substance license/registration;

   v. Liability insurance coverage;

   vi. Voluntary or involuntary termination of Medical Staff membership;

   vii. Voluntary or involuntary limitation, reduction or loss of Clinical Privileges at any hospital or health care institution;

   viii. The Practitioner's or AHP's management of patients which may have given rise to investigation by the state medical board or state professional board; or

   ix. Participation in any private, federal or state health insurance program, including Medicare or Medicaid.

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

l. Qualifications & Current Competency: Detailed information concerning the applicant's experience and

qualifications for the requested Medical Staff category and Clinical Privileges requested, including:

i. Information in satisfaction of the basic qualifications specified in **Section 3.2a**, any additional qualification specified by these Bylaws and any and all of the applicant's current professional license(s) and federal and state drug registration numbers;

ii. Relevant practitioner-specific data as compared to aggregate, when available; and

iii. Morbidity and mortality data, when available

m. Peer References: The names of at least three (3) Practitioners, (excluding partners, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, experience and clinical ability, ethical character, current health status impact on ability to perform privileges requested, and ability to work with others. Peer References will include the following information:

i. Medical/clinical and technical knowledge and skills;

ii. Clinical judgment;

iii. Interpersonal skills;

iv. Communication skills;

v. Professionalism;

vi. Relevant training and experience;

vii. Current Competence; and

viii. Any effects of health status on the privileges requested.

n. Request: Specific requests stating the category and specific Clinical Privileges for which the applicant wishes to be considered;

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

p. Photograph Identification: Current government issued photo identification;

q. Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years.

r. For Dependent AHP's Only; Designation of supervising physician(s).

6.3 PROCESSING THE APPLICATION

a. **Request for Application** - A Practitioner or AHP wishing to be considered for Medical Staff appointment or reappointment and/or Clinical Privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

b. **Applicant's Burden** - The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and physical and mental health status, and resolving any doubts about these or any of the other basic qualifications specified in **Section 3.2a.** By submitting the application, the applicant:

i. Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff membership and Clinical Privileges;

ii. Authorizes Hospital representatives to consult with others who have been associated with him/her and/or

who may have information bearing on his/her current competence and qualifications;

iii. Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current professional qualifications and competence, health status and ability to carry out the Clinical Privileges he/she requests as well as of his/her professional ethical qualifications for Medical Staff membership;

iv. Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, agrees to notify the Hospital of any change in any of the information furnished in the application, and acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application;

v. Pledges to provide continuous care for his/her patients who are treated in the Hospital;

vi. Authorizes hospital representatives to query Medicare exclusion list.

vii. Authorizes the Hospital to conduct a criminal background check.

viii. Agrees to release and immunity from liability throughout the term of appointment and thereafter as to inquiries received about the applicant as follows or as otherwise indicated by specific statements on the application form:

1) Immunity: To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities.

2) Authorization to Obtain Information from Third Parties: The applicant authorizes the Hospital, medical staff leaders, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

3) Authorization to Release Information to Third Parties: The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

4) Hearing and Appeal Procedures: The applicant agrees that the hearing and appeal procedures set forth in these Bylaws will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

5) Legal Actions: If, notwithstanding the provisions in this section, an applicant institutes legal action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

c. **Submission of Application & Verification of Information**

i. Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the Medical Staff Office. The application shall be returned to the Practitioner or AHP and shall not be processed further if one (1) or more of the following applies:

1) Not Licensed. The Practitioner or AHP is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff or Clinical Privilege delineation; or

2) Membership or Clinical Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the Practitioner or AHP has had his/her application for Medical Staff appointment and/ or Clinical Privilege delineation at this Hospital denied, has resigned his/her Medical Staff appointment and/ or Clinical Privileges at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment or Clinical Privilege delineation, or has had his/her appointment or Clinical Privileges revoked or terminated at this Hospital; or

3) Exclusive Contract or Moratorium. The Practitioner or AHP practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board within the Practitioner's or AHP's specialty; or

4) Inadequate Insurance. The Practitioner or AHP does not meet the liability insurance coverage requirements of these Bylaws; or

5) Ineligible for Medicare Provider Status. The Practitioner or AHP if applicable, is not a participating provider in the Medicare and Medicaid programs and is currently ineligible to be a participating provider; or

6) No DEA number. The Practitioner's (or AHP's if applicable) DEA number/controlled substance license has been revoked or voluntarily relinquished (this shall not apply to pathologists); or

7) Continuous Care Requirement. For applicants who will be seeking advancement to a category requiring timely and continuous care to their patients, failure to maintain a professional base in the community, close enough to provide timely and continuous care to her/her patients; or

8) Application Incomplete. The Practitioner or AHP has failed to provide any information required by these Bylaws or requested on the application, or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application; or;

9) Verification of Applicant Identity– If the hospital is unable to confirm the applicant requesting approval is the same individual identified in the credentialing documents

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

iii. In the event that none of the above applies to the application, the Medical Staff Coordinator or approved Credentials Verification Organization (CVO) in accordance with CVO contract shall promptly seek to collect or verify the references, licensure and other evidence submitted.

iv. The CEO or his/her designee shall promptly notify the applicant, via Special Notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification.

v. Verification shall be obtained from primary sources whenever feasible, which may include verification via the MEC approved Internet sites of at least the following information: the licensure, education, relevant training and current competence. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if the Medical Staff Office/CVO has documented its attempts to contact the primary source.

vi. In addition, the Medical Staff Office/CVO will collect additional relevant information including, Data Bank query, information on all prior and current liability insurance carriers concerning claims, suits, and settlements and judgments (if any), AMA or AOA Physician Profile, Federation of State Medical Board, OIG list and Fraud and Abuse Control Information System.

vii. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the applicable department.

viii. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including:

1) Licensure is also verified at the time of expiration of the applicant's licensure regardless of whether the applicant is in the process of applying for medical staff membership or Clinical Privilege delineation, at the time of renewal or revision of clinical privileges, and whenever a new privilege are requested

2) Data Bank is queried during the initial application process, every two years, and at the time the applicant's privileges are renewed or whenever new privileges are requested.

ix. The Medical Staff Coordinator shall transmit the completed application and all supporting materials to the chairperson of each department in which the applicant seeks privileges.

d. **Description of Clinical Privileges** - Medical Staff appointments or reappointments shall not confer any Clinical Privileges or rights to practice in the Hospital. Each Practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those Clinical Privileges specifically granted by the Board. The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information required, including meeting any and all specialty specific criteria for Clinical Privileges. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the Clinical Privileges he/she requests.

e. **Department Chairperson Action** - Upon receipt, the chairperson of each department shall review the application and supporting documentation, and transmit to the Credentials Committee on the prescribed form a written report and recommendations as to staff category, department affiliation, and clinical privileges to be granted, any conditions of supervision and any special conditions to be attached to the appointment. The transmission of such should be in a timeframe to assure the complete processing of the application occurs within a timeframe as described in **Section 6.3m**. A department chairperson may also recommend that the Credentials Committee defer action on the application. The reasons for each recommendation shall be stated and supported by references to the completed application and all of which shall be transmitted with the report. Any minority view shall also be reduced to writing, supported by reasons and references, and transmitted with the chairperson's report.

f. **Credentials Committee Action**

i. After transmission of required information by the Department Chairperson, at next regularly scheduled meeting and within a timeframe assuring the complete processing of the applications occurs within a timeframe as described in **Section 6.3m**, the members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Department Chairperson and such other information available as may be relevant to consideration of the applicant's qualifications for the Medical Staff category and Clinical Privileges requested.

ii. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in final judgments will be evaluated by the Credential Committee before recommending clinical privileges.

iii. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, Clinical Privileges to be granted and any special conditions to be attached to the appointment.

iv. For AHPs the Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to the delineation of Clinical Privileges and any special conditions to be attached to such delineation.

v. The Credentials Committee also may recommend that the MEC defer action on the application.

vi. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee.

vii. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

g. **Medical Executive Committee Action**

i. After transmission of required information by the Credentials Committee, at the next regularly scheduled meeting and within a timeframe assuring the complete processing of the applications occurs within a timeframe as described in **Section 6.3m**, the members of the MEC shall review the application, the supporting documentation, the recommendation of the Department Chairperson, Credentials Committee and such other information available as may be relevant to consideration of the applicant's qualifications for the Medical Staff category and Clinical Privileges requested.

ii. The MEC shall then forward to the Board a written report on the prescribed form concerning Medical Staff recommendations and, if appointment is recommended, denied or deferred for Medical Staff category and Clinical Privileges to be granted and any special conditions to be attached to the appointment.

iii. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report.

iv. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

v. Effect of Medical Executive Committee Action

1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within **thirty (30) business days** with a recommendation for either provisional appointment with specified Clinical Privileges or for rejection for Medical Staff membership. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same. The MEC may also defer action on the application pursuant to **Section 6.3n**.

2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board or if the Department Chairperson, Credentials and MEC each provide favorable recommendations, the applicant may be eligible for the Expedited Privileging process pursuant to all requirements and criteria of **Section 7.5**. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chairperson and Credentials Committee.

3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the Practitioner by Special Notice which shall specify the reason or reasons for the recommendation of denial and the Practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as the recommendation of denial of appointment, or recommendation of denial or restriction of requested Clinical Privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan. When the recommendation of the MEC is adverse to the AHP applicant, provisions of the grievance process as described in **Section 5.8b** shall be followed.

h. **Board Action** – The Board, shall in whole or in part adopt, or reject a favorable recommendation or defer for further consideration as follows:

i. Decision; Deadline. The Board may accept, reject or modify the MEC recommendations. The Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. To assure the complete processing of the applications occurs within a timeframe as described in **Section 6.3m**, the Board shall make every reasonable effort to render its decision within **sixty (60) business days** following receipt of the MEC recommendation.

ii. Favorable Action. In the event that the decision of the board is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been approved and that Medical Staff membership and/or Clinical Privileges are granted. The decision to grant Medical Staff appointment or reappointment, together with all requested Clinical Privileges, shall constitute a favorable action even if the exercise of Clinical Privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of Clinical Privileges, or any similar form of quality improvement that does not materially restrict the applicant's ability to exercise the requested Clinical Privileges.

iii. Adverse Action. In the event that the MEC recommendations are favorable to the applicant, but the Board action is adverse, Practitioners shall be entitled to the procedural rights specified in the Fair Hearing Plan. The CEO or his/her designee shall deliver within **thirty (30) business days** to the applicant by Special Notice a letter enclosing the Board written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan. Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action. AHP's shall not be entitled to the Fair Hearing Plan, but shall be entitled to grievance process as described in the in **Section 5.8b.**

i. **Notice Of Final Decision**

i. Notice of the Board's final decision shall be given, through the Chief Executive Officer, to the applicant. A decision and notice to appoint shall include:

1) The staff category to which the applicant is appointed;

2) The department to which he/she is assigned;

3) The clinical privileges he/she may exercise; and

4) Any special conditions attached to the appointment.

ii. After successful appointment or reappointment to the medical staff, the provider will be required to sign the Provider Code of Conduct

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

k. **Reapplication After Adverse Appointment Decision** - An applicant who has received a final adverse decision regarding appointment and/or initial Clinical Privilege delineation shall not be considered for appointment or initial Clinical Privilege delineation for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

l. **Time Periods for Processing**

i. Applications for Medical Staff appointments or privileges shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The timeframe for processing a completed application including the Service Chief or Department Chairperson, Credentials Committee and MEC, and Board decision should not exceed **one hundred fifty (150) business days.**

ii. Preferably:

1) The Medical Staff Coordinator shall transmit an application to the appropriate department upon completing the information collection and verification tasks, but in any event within **thirty business (30) days** after receiving the completed application.
2) The applicable department chairperson shall act on the application within **thirty business (30) days** after receiving it from the Medical Staff Coordinator and forward his/her recommendations to the Credentials Committee.

3) The Credentials Committee shall act on the application with **thirty business (30) days** after receipt from the Department Chairperson.
4) The Medical Executive Committee shall review the application and make its recommendation to the Board within **thirty business (30) days** after receiving the recommendation from the Credentials Committee.
5) The Board (or the appropriate committee thereof) shall then take final action on the application at its next regular meeting.

iii. The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have his application processed within those periods.

m. **Denial for Hospital's Inability to Accommodate Applicant**

i. A decision by the MEC or Board to deny Medical Staff membership, Medical Staff category assignment, department affiliation or particular Clinical Privileges based on any of the following criteria shall **not** be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan or AHP grievance process:

1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

2) On the basis of inconsistency with the Hospital's current management plan and/or written plan for development including the mix of patient care services to be provided; or

3) On the basis of professional contracts the Hospital has entered into for the rendition of services within various specialties.

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

iii. Within **ninety (90) days** of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in these Bylaws for initial appointment shall apply.

6.4 CONFLICT RESOLUTION RELATED TO DECISIONS ON APPLICANTS

Whenever the Board's proposed decision will be contrary to the Medical Executive Committee recommendations, the Board shall submit the matter to a joint conference of equal numbers of Medical Staff and Board practitioners for review and recommendation before making its final decision and giving notice of final decision as required by **Section 6.3j**.

6.5 REAPPOINTMENT AND REPRIVILEGING PROCESS

a. **General**

i. Reappointment to the Medical Staff and granting of privileges is not a right. The Burden of proof is on each applicant to demonstrate continued qualifications for reappointment and competency for reassignment of clinical privileges.

ii. The Medical Staff Coordinator, at least **six (6) months** before the expiration date of the practitioner's/AHP's current appointment and/or Clinical Privileges, shall provide such practitioner/AHP with a reappointment application form to use in considering his/her reappointment. Within **sixty (60) days** of receipt of the reappointment application, each practitioner who desires reappointment shall return his/her completed reappointment application form along with an updated privilege form and other required documentation to the Medical Staff Office. Failure, without a good cause, to return the form shall be deemed a voluntary resignation and shall result in automatic termination of privileges at the expiration of the practitioner's/AHP's current term.

b. **Content Of Reappointment Application Form-** The reappointment application form shall request data necessary to update the medical staff file. This form shall include, without limitation, information about the following:

i. Education - Continuing training, education, and experience during the preceding appointment period that qualifies the Practitioner or AHP for the privileges sought on reappointment;

ii. License: Current licensure;

iii. Health Status: Current physical and mental health status only to the extent necessary to determine the Practitioner's or AHP's ability to perform the functions of Medical Staff membership or to exercise the privileges requested;

iv. Previous Affiliations: The name and address of any other hospital, health care organization or practice setting where the Practitioner or AHP provided clinical services during the preceding appointment period;

v. Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions, organizations or licensing authority during the preceding appointment period;

vi. Professional Sanctions: Sanctions of any kind imposed or pending by any other healthcare institutions, professional healthcare organizations, or licensing authority as delineated in **Section 6.2k**.

vii. Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

viii. Felony Charges: Any current criminal charges pending against the applicant and any convictions or pleas during the preceding appointment period. The Practitioner or AHP shall notify the CEO and the Chief of Staff within **seven (7) business days** of receiving notice of the initiation of any felony charges;

ix. Fraud: Any allegations of civil or criminal fraud pending against any applicant, and any past allegations resolved during the previous appointment period; as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program;

x. Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past **two (2) years** during the preceding appointment period;

xi. Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each Practitioner or AHP must, at all times, keep the CEO informed of changes in his/her professional liability coverage;

xii. Current Competency and Peer References:

1) Objective evidence of the individual's clinical performance, current competence, and judgment, based on the findings, including Department Chairperson evaluations, Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluations, Objective evidence should include information concerning:
    a) Medical/clinical and technical knowledge and skills
    b) Clinical judgment
    c) Interpersonal Skills
    d) Communication Skills
    e) Professionalism
    f) Information from hospital performance improvement activities
    g) Relevant practitioner specific data compared to aggregate data, when available
    h) Morbidity and mortality data, when available

2) When insufficient practitioner-specific data are available, a total of three (3) peer recommendations are required.

3) Department Chairperson and peer recommendations will include an evaluation of information described in **Section 6.2m**;

xiii. Notification of Release & Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions.

xiv. Information on Ethics/Qualifications: Such other specific information about the Medical Staff Member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital.

xv. For Dependent AHPs Only: Designation of supervising physician; and

xvi. CME - Documentation of CME requirements as requested

c. Verification Of Information - The Medical Staff Coordinator shall in timely fashion, seek to collect or verify the additional information deemed pertinent, including information regarding the practitioner's/AHP's professional activities, performance, conduct in this hospital and his fulfillment of staff membership obligations, data bank query and primary source verification of licensure in accordance with **Section 6.3cv**. The Medical Staff Coordinator shall promptly notify the practitioner of any problems in obtaining the information required. The practitioner shall then have the same burden of producing adequate information and resolving any doubts as provided in **Section 6.3b.** When collection and verifications are accomplished, the Medical Staff Coordinator shall transmit the information form and supporting materials to the chairperson of the appropriate department or departments in which the practitioner has privileges or requests additional privileges. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information in accordance with **Section 6.3c,** including query of the Data Bank, is complete.

d. Basis for Recommendations - Each recommendation concerning the reappointment of a Medical Staff Member and/ or Clinical Privileges to be granted shall be based upon such Member's or AHP's professional performance, ability to perform privileges requested (i.e., Health Status validation), technical skills and clinical judgment in the care and treatment of patients, his/her discharge of Medical Staff obligations, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, medical staff and Hospital policies/procedures, his/her cooperation with other Practitioners, AHP's and with patients. Other information upon which each recommendation will be based includes any matters bearing on his/her ability and willingness to contribute to quality patient care and patient safety in the Hospital and the results of the Hospital monitoring and evaluation process, including OPPE, other performance improvement and patient safety activities. Such OPPE activities shall include relevant applicant specific information that is considered and compared to aggregate information when available, including morbidity and mortality data, when available.

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

6.6 REQUESTS FOR MODIFICATION OF PRACTITIONER'S STATUS OR PRIVILEGES

A Medical Staff Member or AHP may, either in connection with reappointment and/ or reprivileging or at any other time, request modification of his/her Medical Staff category or Clinical Privileges, by submitting a written application to the Medical Staff Office on the prescribed form. Such application shall be processed in substantially the same manner as provided in **Section 6.5** for reappointment and reprivileging. No Medical Staff Member or AHP may seek modification of privileges or Medical Staff category previously denied on initial appointment, reappointment and/ or reprivileging unless supported by documentation of additional training and experience. Modifications of Medical Staff category or Clinical Privileges shall remain in effect until the next regularly scheduled reappointment/ reprivileging period. Information regarding each Medical Staff Member or AHP scope of privileges will be updated when modifications are approved. A request by a Medical Staff Member or AHP for a modification of privileges must be supported by documentation supportive of the request, including at least three (3) peer references

6.7 MISSTATEMENTS OR OMISSIONS

a. Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written

response. The Chief of Staff and CEO will review the response and determine whether the application should be processed further.

b. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished.

c. No action taken pursuant to this section will entitle the applicant or appointee to a hearing or appeal.

6.8 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

a. **Qualifications & Processing** - A Practitioner or AHP who is providing clinical contract services to the Hospital must meet the same qualifications for membership including on-call requirements and medical record keeping; must be processed for appointment, reappointment, and/ or Clinical Privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category or Clinical Privilege delineation as any other applicant or Medical Staff Member.

b. **Requirements for Service** - In recommending approval of any such Practitioners or AHPs, the Medical Staff must require that the services provided meet applicable regulatory requirements including the Joint Commission requirements, are subject to appropriate quality controls and monitoring activities, and are integrated and evaluated as part of the overall Hospital Performance Improvement and Patient Safety program(s).

c. **Termination** - Unless otherwise provided in the contract for services, expiration or termination of any contract for services pursuant to **this Section** shall automatically result in concurrent termination of Medical Staff membership and Clinical Privileges. The Fair Hearing Plan and the AHP grievance process shall not apply in this case.

ARTICLE VII DETERMINATION OF CLINICAL PRIVILEGES

7.1 USE OF CLINICAL PRIVILEGES

Each practitioner or AHP practicing at RMCHCS by virtue of providing clinical care, treatment or services shall, in connection with such practice be entitled to exercise only those Clinical Privileges granted to him/her by the Board.. These privileges must also be within the scope of his/her New Mexico State license and consistent with any restrictions thereon.

7.2 DELINEATION OF PRIVILEGES

a. **Requests** - Each application for appointment and reappointment to the Medical Staff and/ or each application for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Practitioner's or AHP's qualifications to exercise the privileges requested. A request by a Medical Staff Member or AHP for a modification of privileges must be supported by documentation supportive of the request, including at least three (3) peer references.

b. **Basis for Privileges Determination**

i. Granting of Clinical Privileges shall be Hospital specific and shall be based on the Practitioner's or AHP's education, training, clinical and technical skills, current competence, including documented experience, treatment areas or procedures; the results of treatment; references, health status as related to privileges requests; and the conclusions drawn from performance improvement and patient safety activities, when available.

ii. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills.

iii. Clinical Privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions shall be added to and maintained in the Medical Staff file established for a Medical Staff Member or AHP.

iv. The applicant has the burden of establishing his or her qualifications and competency in the clinical privileges requested.

v. Privileges will also be granted based on the organization's resources necessary to support the requested privilege, including, sufficient space, equipment, staffing and financial resources to support the privileges being requested.

c. **Procedure** - All requests for Clinical Privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in **Article VI**. The Data Bank shall be queried each time new privileges are requested.

d. **Limitations on Privileges** - The delineation of an individual's Clinical Privileges includes the limitations, if any, on an individual's Prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

e. **Increasing Or Adding Privileges**

i. A member of the medical Staff desiring increased or additional privileges shall apply in writing to the Medical Staff Services Office. The application shall include documentation of training, education, experience, and submission of any additional requested information, including competency. The request shall be processed in the same manner as applications for initial appointment including NPDB query. Lack of documentation of the appropriate training, education, and competency will result in denial of that privilege. Future requests for that privilege will not be accepted without submission of all requested and required information.

ii. New clinical privilege requests will also be evaluated based on the hospital's ability to accommodate based on space, equipment, staffing and financial resources. Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital, (2) criteria to be eligible to request those clinical privileges have been established and (3) other requirements as required by the organization's *Request for Clinical Privileges/Techniques New to the Organization Policy* have been considered and addressed.

iii. New privileges will be subject to the FPPE process, to be reevaluated within **twelve (12)** months by the Chairman of the Department or Service Chief, Credentials Committee and Medical Executive Committee and advanced to the permanent privilege category if appropriate in accordance with the medical staff FPPE Policy.

7.3 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL PRIVILEGES

Requests to perform specified patient care services from AHPs should be processed in the manner specified in **Article V** and **Article VI**. An AHP may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his professional competence, and may participate directly in the medical management of patients under the collaboration/supervision or direction of a sponsoring physician who has been accorded privileges to provide such care.

7.4 SPECIAL CONDITIONS FOR DENTAL, PODIATRIC AND PSYCHOLOGY PRIVILEGES

a. Requests for Clinical Privileges from dentists, oral surgeons, podiatrists and psychologists shall be processed, evaluated and granted in the manner specified in **Article VI**.

b. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chief of Surgery, however, other dentists and/or oral surgeons, podiatrists, or psychologists as appropriate shall participate in the review of the dentist, oral surgeon, podiatrist, or psychologist through the performance improvement process.

c. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted for other surgical services.

d. A Physician Member of the Medical Staff or appropriately credentialed AHP shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure, if any, on the total health status of the patient.

e. Dentists, oral surgeons, podiatrists and psychologists are responsible for that part of their patients' histories and physicals that relate to their respective discipline.

f. Admission limitations for these practitioners will be as described in the Medical Staff Rules and Regulations or on applicable privilege delineation forms.

g. The dentist applicant shall be a graduate of a dental school recognized by the Council on Dental Education of the American Dental Association and legally licensed to practice dentistry in the State of New Mexico.

h. Podiatrists will have graduated from an accredited Podiatric Medical School and be board certified in the area of podiatric practice in which they are requesting privileges. The application for privileges will list specific conditions they wish to have privileges to treat, and specific surgical procedures they wish to perform. Competency in the surgical privileges requested must be documented with a log of cases done in the last two years including the type and number of each procedure performed. Podiatrists will be licensed by the appropriate State of New Mexico Board, and will be insured by malpractice insurance as required by state law and hospital rules and regulations. Admission limitations are described in the Medical Staff Rules and Regulations or on applicable privilege delineation forms.

i. Oral maxillofacial surgeons must have graduated from an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association- approved residency program. Oral maxillofacial surgeons must also be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery.

j. A psychologist must have earned a doctorate degree (PhD or PsyD, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least one (1) year of clinical experience in an organization healthcare setting, supervised by a licensed psychologist, one year of which must have been post doctorate. A psychologist must have completed an internship endorsed by the APA and be board certified as appropriate to area of clinical practice.

7.5 EXPEDITED PRIVILEGES

a. At its discretion, the Board may delegate authority for initial appointments, reappointments and Clinical Privilege delineation to a committee of the Board consisting of at least two Board members, (the "Expedited Process") when the following criteria are met: ***Note:*** *The Expedited Process is not the same as "temporary" privileges as described in* ***Section 7.6****.*

i. The applicant's application is complete;

ii. The Department Chairperson, Credentials Committee and Medical Executive Committee makes a final recommendation that is in favor of the Applicant and that is without limitation;

iii. There are no current challenges or previously successful challenges to the applicant's licensure or registration;

iv. The applicant has not received an involuntary termination of medical staff membership at another organization;

v. The applicant has not received involuntary limitation, reduction, denial, or loss of Clinical Privileges; and

vi. There have been no final judgments adverse to the applicant in a professional liability action.

b. This subcommittee of the Board, acting on behalf of the Board, shall make the final decision on the application. The full Board of Directors shall be notified of appointments that have been made pursuant to this expedited process at its next regularly scheduled meeting and such notification shall be reflected in the minutes of the Board meeting.

7.6 TEMPORARY PRIVILEGES

a. **Restrictions** - The CEO (or designee) acting on behalf of the Board and based on the recommendation of the president of the medical staff (or designee), may grant temporary privileges provided the medical staff office is able to verify the

practitioner's current licensure and competence. Temporary privileges may be granted only in two circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns with the Department Chairperson and Credentials Committee and is awaiting review and approval of the MEC and the Board.

i. **Important patient care, treatment, or service need:** Temporary privileges may be granted on a case-by-case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time not to exceed **one hundred twenty (120) calendar days**.

1) Prior to granting such privileges, primary source verification of current licensure and current competence must be obtained.

2) Such privileges are intended for isolated instances in which extension of such privileges are shown to be in an individual patient's best interest and no Practitioner, except those who will serve in the capacity of Locum Tenens, shall be granted temporary privileges on more than two (2) occasions in any given year. If the two (2) occasions is exceeded by a given Practitioner, such person shall be required to apply for membership on the Medical Staff and another appropriate category of the medical staff or AHP privileges as appropriate.

3) Prior to any award of temporary privileges pursuant to this Section, the applicant must submit, in addition to the completed application, a government issued photo identification, the consent and release required by these Bylaws, copies of the Practitioner's license to practice medicine and DEA certificate, if applicable. Data Bank query and OIG query must also be obtained.

4) In exercising temporary privileges, the applicant shall act under the supervision of the Chairperson of the applicable department;

ii. **Locum Tenens Practitioners**:

1) Members of the Medical Staff seeking to provide coverage through locum tenens shall, where possible, advise the Hospital at least **sixty (60) business days** in advance of the identity of the locum tenens and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

2) Locum tenens practitioners will be credentialed and privileged pursuant to **Article VI** and **Section 7.6a iii** unless an urgent, important patient care need exists in which case the practitioner/AHP may be credentialed and privileged pursuant to **Section 7.6a i**.

3) The following provisions are applicable to all Locum Tenens regardless of whether or not the practitioner/AHP was privileged the **Article VI** and **Article VII** or granted temporary privileges for an important patient care need:

a) Locum tenens practitioners are not eligible for membership to the Medical Staff;

b) Privileges granted may not exceed **one hundred twenty (120) calendar days**;

c) Locum tenens practitioners must meet the general conditions and qualifications as specified in **Section 3.2** and **Section 3.3** of these Bylaws; and

d) A locum tenens practitioner/AHP is not entitled to the procedural rights afforded in the Fair Hearing Plan or AHP grievance process because his or her request for locum tenens privileges is refused or because his or her privileges are terminated or suspended.

iii. **Clean application awaiting approval:** Temporary privileges may be granted for up to **120 calendar days** when a practitioner applying for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval from the Board. To receive temporary privileges under these circumstances, the applicant must provide a complete application and evidence of the following, which has been verified by the Hospital:

1) Current licensure

2) Relevant education, training and experience
3) Current competence
4) Current Drug Enforcement Agency registration (if applicable)
5) Current professional liability insurance in the amount required
6) Malpractice history
7) Positive peer references
8) Ability to perform the privileges requested
9) Results from a query to the NPDB
10) No current or previous successful challenges to licensure or registration
11) No subjection to involuntary termination of medical staff membership at another organization
12) No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

b. **Special Requirements** - Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's/AHP's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such Practitioner be admitted upon dual admission with a Member of the Active Staff. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations, and policies of the medical staff and hospital in all matters relating to his or her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, Rules and Regulations, and policies control all matters relating to the exercise of clinical privileges.

c. **Termination** - The CEO, acting on behalf of the Board and after consulting with the Chief of Staff and/or Chairperson of the Department, may terminate any or all of a practitioner's privileges based on the discovery of any event of a professionally questionable nature concerning a Practitioner's/AHP's qualifications or ability to exercise any or all of the temporary privileges granted, When a patient's life or wellbeing is endangered, any person entitled to impose summary suspension under **Section 9.3a** may affect the termination. In the event of such a termination, the practitioner's patients will be assigned to another practitioner by the Chief of Staff or by the Chairperson of the Department or his or her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

d. **Rights Of The Practitioner/AHP With Temporary Privileges** - A practitioner/AHP is not entitled to the procedural rights afforded in the Fair Hearing Plan or AHP grievance process because his or her request for temporary privileges is refused or because his or her temporary privileges are terminated or suspended.

e. **Term of Temporary Privileges** - The applicant may be granted temporary privileges for a specific period of time as warranted by the situation but such time shall not exceed **120 calendar days**. Any temporary privileges granted shall expire automatically at the end of the time period for which they were granted.

7.7 EMERGENCY PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his license and regardless of department, staff status or clinical privileges, shall be permitted, and shall be assisted by hospital personnel, to do everything possible to save a patient from serious harm. When the emergency is over, ongoing care of the patient will be provided by the appropriate member of the RMCHCS Medical Staff.

7.8 DISASTER PRIVILEGES

a. **Implementation** - Disaster privileges will only be granted when the following two conditions are present:

i. The Emergency Operation Plan has been activated; **and**

ii. The organization is unable to meet immediate patient needs.

b. **Responsibility for Granting Disaster Privileges**

i. Disaster privileges will be made on a case-by case basis in accordance with the needs of the organization and its patients, and on the qualifications of the individual (practitioner/AHP).

ii. The following individual(s) may grant disaster privileges:

1) CEO or his/her designee;
2) Chief of Staff or his/her designee;
3) CMO or his/her designee; and/or
4) Incident Commander or his/her designee.

c. **Identification of Individuals Granted Disaster Privileges** - Individuals granted disaster privileges will be issued a Disaster Identification Badge when signing into the Command Center in accordance with the organization's Emergency Operations Plan.

d. **Management and Oversight**

i. All individuals granted disaster privileges will be expected to sign-in at the Command Center. A record will be made of name, professional affiliation/specialty, and any current hospital/clinic affiliations. The initial verification process as defined below will also be initiated.

ii. The Incident Commander or Medical Director responsible for coordination of the Command Center or his/her designee, will assign the individual to appropriate areas as needed in accordance with the hospital's Emergency Operations Plan and patient needs.

iii. If possible, the individual will be paired with a current member of the medical staff with similar privileges.

iv. Oversight of the professional performance of individuals granted disaster privileges will be through observation and clinical review by an assigned medical staff member.
Feedback may also be requested from hospital staff working with the individual.

v. Individuals granted disaster privileges will sign a statement attesting that the individual agrees to be bound by all hospital policies and Rules and Regulations.

e. Verification Process

i. Initial Verification Process - In order be eligible for disaster privileges, individuals must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) **and** at least one of the following:

1) A current hospital picture identification card that clearly identifies the professional designation;

2) A current license to practice;

3) Primary source verification of the license;

4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corp (MRC), Emergency System Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organizations or groups;
5) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

6) Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioners' ability to act as a licensed independent practitioner during a disaster.

ii. Primary Source Verification

1) Primary source verification is only required if the individual provides care, treatment or services under the disaster privileges.

2) The Medical Staff Office Coordinator or his/her designee(s) are responsible for obtaining primary source verification. All elements required for temporary privileges will be primary source verified to the extent possible prior to granting disaster privileges.

3) Primary source verification of licensure begins as soon as the immediate situation is under control or within 72 hours from the time the individual presents to the organization and is granted disaster privileges, whichever comes first.

4) In the extraordinary circumstance that primary source verification cannot be completed within 72 hours (e.g., no means of communication or lack of resources), it is expected that primary source verification will be completed as soon as possible. In these extraordinary circumstances, there must be documentation of the following:

   a) Reasons(s) it could not be performed within 72 hours of the individuals arrival;

   b) Evidence of the individual demonstrated ability to continue to provide adequate care, treatment, and services; **and**

   c) Evidence of the organization's attempts to perform primary source verification as soon as possible.

f. Continuation/Suspension/Termination of Disaster Privileges

i. Within 72 hours of the individual being granted disaster privileges, the Chief of Staff or his/her designee will make a determination as to whether the individual disaster privileges should be continued as initially granted.

ii. The Chief of Staff or his/her designee is responsible for making this determination based on information obtained regarding the professional practice of individual from the assigned medical staff member and hospital staff, as appropriate.

iii. All disaster privileges are terminated when the Emergency Operations Plan is no longer activated.

iv. On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning qualifications or ability to exercise any or all of the disaster privileges granted, the Chief of Staff or his/her designee may terminate any or all of the individual's disaster privileges. Where the life or well-being of a patient is endangered by continued treatment by the individual, the termination may be effected by any person entitled to impose summary suspensions as described in the Medical Staff Bylaws. In the event of any such termination, the individual patients shall be assigned to another medical staff member by the Chief of Staff or his/her designee. The wishes of the patient shall be considered, if feasible, in choosing a substitute.

v. Individuals granted disaster privileges shall not be entitled to the procedural rights afforded by Medical Staff Bylaws.

7.9 TELEMEDICINE PRIVILEGES

a. Per the Centers for Medicare and Medicaid Services (CMS), telemedicine is the provision of clinical services provided for patients by physicians and practitioners from a distant-site via electronic communication. The distant-site telemedicine physician or practitioner provides clinical services to the Hospital either simultaneously, as may be the case in real time consultations with patients, or non-simultaneously as may be the case in Teleradiology.

b. The Hospital will have written agreements with distant-site hospitals or telemedicine entities in accordance with CMS requirements.

c. The Board will grant privileges to each telemedicine physician or practitioner providing services at RMCHCS under an agreement with the distant-site hospital or telemedicine entity before they may provide telemedicine services at RMCHCS.

d. The Medical Executive Committee in collaboration with Department Chairpersons will evaluate the organization's ability to safely provide telemedicine services on an ongoing basis, to include recommending to the Board which clinical services are appropriately delivered by physicians or practitioners through this medium, the clinical services offered are consistent with commonly accepted quality standards, and applicable state regulations and scopes of practice are met.

e. Practitioners providing telemedicine services limited to second opinions do not require privileges at this Hospital.

f. Termination of the contract which carries with it termination of a telemedicine practitioner's privileges is not subject to the Fair Hearing Plan. If the distant-site's participation in Medicare is terminated, either voluntarily or involuntarily, at any time during the agreement with the Hospital, then, as of the effective date of the termination, the Hospital may no longer receive telemedicine services under the agreement with the distant site.

g. Telemedicine credentials and privileges may be withdrawn by action of the CEO, the Board, or the Medical Executive Committee at any time and in accordance with defined contracts.

h. Telemedicine privileges will be granted pursuant to the following:

i. The option used for granting telemedicine privileges may be dependent on the scope of care, treatment and services provided. The option identified must be consistent for all requests from the same distant-site providing the same care, treatment and services.

ii. The Credentials Committee will recommend to the Board the option to be utilized for granting telemedicine privileges for the distant-site. The Board will approve the option to be used for the distant site and the written agreement with the distant-site will include the option utilized and required elements concerning credentialing and privileging of telemedicine physicians and practitioners.

iii. The options that may be used are as follows:

1) The practitioner is credentialed and privileged at RMCHCS in accordance with these Bylaws and as defined in **Article VI** of these Bylaws; or

2) When making recommendations to the Board, the medical staff may rely upon the credentialing and privileging decisions made by the distant-site. If this option is utilized all of the following requirements must be met:

a) The distant-site hospital is Joint Commission accredited and is a Medicare participant, or if the distant site is a telemedicine entity (not a hospital), the distant site must be Joint Commission accredited; and

b) The individual distant-site physician or practitioner is privileged at the distant-site hospital or telemedicine entity; and

c) The distant-site providing the telemedicine services provides a current list of the distant-site physician's or practitioner's privileges at the distant-site and pertinent licensure information; and

d) The individual distant-site physician or practitioner holds a license issued or recognized by the state of New Mexico; and

e) With respect to a distant-site physician or practitioner who holds current privileges at RMCHCS, RMCHCS will have evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site 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 RMCHCS's patients (including but not limited to adverse outcomes related to events considered reviewable by the Joint Commission) and all complaints the hospital has received about the distant-site physician or practitioner.

i. If the Board exercises the option to grant privileges based on its medical staff recommendations that rely upon the distant-site telemedicine entity or hospital, the RMCHCS medical staff office may, but is not required to, maintain a separate file on each telemedicine physician and practitioner, but may instead have a file on all telemedicine physicians and practitioners providing services at RMCHCS under each agreement with a distant-site, indicating which telemedicine service privileges RMCHCS has granted to each physician or practitioner on the list.

ARTICLE VIII PROFESSIONAL PRACTICE EVALUATION & COLLEGIAL INTERVENTION

8.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

a. **Application** - FPPE applies to Medical Staff and AHPs privileged through medical staff mechanisms at RMCHCS. Practitioners requesting membership, but not clinical privileges do not require a FPPE process be implemented.

b. **Implementation** - FPPE will be implemented to evaluate privilege-specific competence as follows:
   i. For all initially requested privileges for practitioners/AHPs new to the organization or when a practitioner/AHP with current privileges at the organization requests new privileges;

   ii. When practitioners/AHPs return after an extended leave of absence; and/or

   iii. When performance issues are identified.

c. **Associated Details and Integration**

   i. FPPE will be fully integrated into the medical staff's performance improvement processes.

   ii. The associated details of the FPPE process, including criteria and triggers for evaluation and monitoring will be as defined in the MEC approved *Focused Professional Practice Evaluation Policy*.

8.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

i) **Application** - OPPE applies to Medical Staff and AHPs privileged through medical staff mechanisms at RMCHCS. Practitioners requesting membership, but not clinical privileges do not require an OPPE process be implemented.

ii) **Implementation**

   i. The medical staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to allow practitioners/AHPS to maintain existing privileges, revise existing privileges, or revoke an existing privilege prior to or at the time of reappointment.

   ii. OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of practitioner's/AHP's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process.

iii) **Associated Details and Integration**

   i. OPPE will be fully integrated into the medical staff's performance improvement processes.

   ii. The associated details of the OPPE process will be as defined in the MEC approved *Ongoing Professional Practice Evaluation Policy.*

8.3 COLLEGIAL INTERVENTIONS

a. These Bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional

conduct. The goal of these progressive steps is to help the individual voluntarily respond to and resolve questions that have been raised.

b. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities.

c. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management.

d. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include, but are not limited to, the following:

i. Education and advising colleagues of all applicable policies, included those related to appropriate behavior, ED call obligations, and timely and adequate completion of medical records;

ii. Following up on questions or concerns raised about the clinical practice and/or conduct of privileged individuals and recommending steps, such as proctoring, monitoring, consultation, and letters of guidance;

iii. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

e. Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should recommend to the Board that the practitioner's membership and/or privileges be restricted or revoked. Before issuing such a recommendation, the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation pursuant to **Article IX, Corrective Action.**

ARTICLE IX CORRECTIVE ACTION

9.1 ROUTINE CORRECTIVE ACTION

a. <u>Criteria For Initiation</u>

i. Whenever a practitioner/AHP with clinical privileges shall engage in, make or exhibit acts, omissions, statements, demeanor, professional conduct, or deemed to have provided substandard care, and the same is reasonable likely to be disruptive to hospital operations or detrimental to patient safety and the delivery of quality patient care, corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the chairperson of any department in which he holds membership or has clinical privileges, by the chairperson of any standing committee of the Medical Staff, by the Chief Executive Officer, by the Board, by any officer of the Board, or by appropriate committee of the Board.

ii. Procedural guidelines from this Section of the Bylaws, the Fair Hearing Plan and from the Health Care Quality Improvement Act as applicable shall be followed for all Practitioners and any and all peer review and / or corrective action shall be taken in good faith in the interest of quality patient care. Procedural guidelines from this Section of the Bylaws and the AHPs grievance process as applicable and as described in **Section 5.8b** shall be followed. If professional conduct suggests a Practitioner or AHP is impaired, action will be pursuant to the *Practitioner Health Policy*.

b. <u>Special Considerations for Employed Practitioners and AHPs</u>

i. If an AHP or physician is an employee of the Hospital and corrective action is needed/considered the process followed should be pursuant to **Section 5.8b.**

ii. If the practitioner is an employee of the Hospital and the activities or professional conduct are related to:

6) Behavioral issues, applicable Human Resources (HR) policies will be followed;

7) Quality of care and privileges, the matter may be resolved pursuant this Section (Corrective Action) and the Fair Hearing Plan.

If it is unclear if the concern identified should follow the HR process or the processes as defined in this Section, an investigation and recommendation for manner of course will be determined by the Chief Human Resources Officer, Chief Quality Officer, Chief Medical Officer and the chairperson of the medical department. The investigation and recommendation for manner of action should be completed within five **(5) business days** of the issue being identified, reported and/or occurring. The investigation may involve an interview with the practitioner involved and an interview with other individuals or groups.

c. **Requests And Notices -** All requests for corrective action shall be in writing, submitted to the CEO, CMO, Director of Human Resource and/or Chief of Staff as appropriate and supported by reference to the specified activities or conduct which constitutes the grounds for the request. The Chief Executive Officer will be notified within **three (3) business days** of all requests for corrective action and kept fully informed of all action taken in conjunction therewith.

d. **Investigation -** After deliberation with appropriate individuals, the Chief of Staff or designee may either act on the request or direct that an investigation concerning the grounds for the corrective action request be undertaken within **seven (7) business days** of receipt of the request for corrective action. The Chief of Staff or designee may conduct such investigation himself or may assign this task to an officer, department, or Executive Committee of the Medical Staff, or to an external peer review source when no expertise in a specialty field is locally available. The investigation process shall not be deemed, a "hearing" as that term is used in **Article X**, the Fair Hearing Plan, but may include consultation with the practitioner involved. If the investigation is accomplished by a group or individual other than the Medical Executive Committee, such group or individual shall provide a written report of the investigation to the Medical Executive committee as soon as is practicable after the assignment to investigate has been made. The Medical Executive Committee may at any time within its discretion, and shall at the request of the Board (or appropriate committee thereof) terminate the investigative process and proceed with action as provided in **Section 9.1e**.

e. **Medical Executive Committee Action -** As soon as practicable after the conclusion of the investigative process, but in any event within **30 business days** after receipt of the request for corrective action unless deferred pursuant to **Section 9.**1f, the Medical Executive Committee shall take action upon such request. Such action may include without limitation:

i. Recommending rejection of the request for corrective action;

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

iii. Referral for health assessment and/or treatment;

iv. Recommending the issuing of a warning or a reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

v. Recommending terms of probation, education or required consultation;

vi. Recommending reduction, suspension or revocation of Clinical Privileges;

vii. Recommending reduction of Medical Staff category or limitation of any Medical Staff Prerogatives; or

viii. Recommending suspension or revocation of Medical Staff membership.

f. **Deferral -** If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request, but only upon the written consent of the affected practitioner. A subsequent recommendation for any one or more of the action provided in **Section 9.1e (i-viii)**, above must be made within the time specified in such written consent, and if no such time is specified, then within **thirty (30) business days** of the deferral.

g. **Procedural Rights -** Any action by the MEC pursuant to Section **9.1e (v-vii) or 9.1e (iv)** (where such action materially restricts a Practitioner's/AHP's exercise of privileges) or any combination of such actions, shall entitle the Practitioner to the procedural rights as specified in the provisions of **Article X** and the Fair Hearing Plan or AHP to

defined AHP grievance procedure. Further, participation of Practitioners or AHPs undergoing investigation or peer review shall be governed by the Fair Hearing Plan or the AHP grievance procedure respectively. The Board may be informed of the recommendation, but shall take no action until the Member has either waived his/her right to a hearing and/or appearance or completed the hearing and/or the appearance.

h. Other Action

i. If the Medical Executive Committee's action is to reject the request for corrective action, such action shall conclude the matter and notice of final decision shall be given by certified mail and such recommendation together with all supporting documentation shall be transmitted to the Board. The Fair Hearing Plan or AHP grievance procedure shall not apply to such actions.

ii. If the Medical Executive Committee's action is a warning, admonition or reprimand, and does not meet criteria for Procedural Rights pursuant to **Section 9.1g,** such action shall conclude the matter and notice of final decision shall be given by certified mail and such recommendation together with all supporting documentation shall be transmitted to the Board. The Fair Hearing Plan or AHP grievance procedure shall not apply to such actions.

i. Board Action

i. If, in the Board's determination, the Medical Executive Committee fails to act in a timely fashion in processing and recommending action on the request for corrective action, the Board (or appropriate committee thereof) may, after notifying the Medical Executive Committee, take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Board. If such action is adverse the Chief Executive Officer shall promptly so inform the practitioner by special notice, and he shall be entitled to the procedural rights as provided in the Fair Hearing Plan or AHP grievance procedure as applicable.

ii. When corrective action is initiated by the Board, the functions assigned to the MEC under **this Section** shall be performed by the Board, and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

9.2 PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

a. Grounds for Precautionary Suspension or Restriction

i. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief of Staff, the chief of the relevant clinical department, the Medical Executive Committee, the Chief Medical Officer, the CEO, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; and (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

ii. A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

iii. Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

iv. A precautionary suspension is effective immediately and will be promptly reported to the CEO and the Chief of Staff. A precautionary suspension will remain in effect unless it is modified by the CEO or Medical Executive Committee.

v. Within **three (3) business days** of the imposition of the suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), will be provided to the individual.

b. Medical Executive Committee Procedure

i. Within a reasonable time, not to exceed **thirty (30) business** days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.

ii. As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

iii. At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.

iv. The individual may be accompanied by counsel at this meeting. The role of counsel will be limited to providing advice to the individual subject to the suspension. Counsel may not make a presentation to or question members of the Medical Executive Committee or anyone else attending the meeting. The Medical Executive Committee may also have counsel present subject to the same conditions that counsel may not question the individual. A record of this meeting will be maintained by a stenographic reporter.

v. After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee will also determine whether to begin an investigation.

vi. If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than **thirty (30) business days** must be reported to the National Practitioner Data Bank.

vii. There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

viii. Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

9.3 SUMMARY SUSPENSION

a. Criteria For And Initiation

i. Whenever a practitioner's/AHP's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other persons present in the Hospital and/or behavior of the practitioner/AHP is disruptive/detrimental to the functioning of the Hospital or Hospital processes, either the chairperson of the Medical Executive Committee or of a department, the Chief Executive Officer, (or his designated representative), the Executive Committee of the Medical Staff or the Executive Committee of the Board, or the Board (or an appropriate committee thereof) shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition, and the Chief Executive Officer or chairperson of the Medical Executive Committee shall promptly give special notice of the suspension to the practitioner.

ii. **Disruptive Behavior:** Practitioner/AHP disruptive behavior pursuant to the disruptive behavior policy/ies of the Hospital may be subject to summary suspension. Disruptive behavior by employed practitioners/AHPs will also follow applicable Human Resources policies.

iii. Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a practitioner/AHP with appropriate Clinical Privileges to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the substitute practitioner.

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

b. Medical Executive Committee Action After Summary Suspension - As soon as possible after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. This meeting shall take place not more than 96 hours following the suspension. The Medical Executive Committee may modify, continue, or terminate the terms of the summary suspension. Final recommendation must be made in accordance with **Section 9.1e and Section 9.1f.**

c. Procedural Rights

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

ii. The practitioner shall be notified of the basis of the suspension by certified mail, and given **ten (10) business days** to produce clear and convincing evidence that the facts relied upon by the Hospital in taking summary action are not correct. If the Hospital does not receive such evidence from the member within **ten (10) business days**, the individual's Medical Staff membership and clinical privileges shall automatically terminate, and the individual shall not be entitled to a hearing as set forth elsewhere in these Bylaws.

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

iv. Unless otherwise stated in these Bylaws, upon ratification of the summary suspension or modification which materially restricts the Practitioner's Clinical Privileges, the Practitioner shall be entitled to the procedural rights provided in the Fair Hearing Plan and/or AHP grievance procedure as appropriate. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

9.4 AUTOMATIC SUSPENSION

a. **Criteria For and Initiation**

i. Whenever a Practitioner/AHP violates Hospital policies, rules or regulations, or acts in a manner disruptive to Hospital operations, or in such a manner as to endanger the assets of the Hospital because of financially imprudent actions not justified by patient care considerations, automatic suspension may be initiated by the Hospital CEO, by the Chairman of the Board, or by the Board.

ii. In the following instances, the practitioner's/AHP's privileges and/or membership will be considered relinquished or limited as described, and the action shall be final without a right to hearing or grievance procedure. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable. The Chief of the medical staff may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present within **60 business days** of the relinquishment. After **60 business days**, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

1) Licensure:

a) Revocation and Suspension: Whenever a practitioner's/AHP's license or other legal credential authorizing practice in this or another state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b) Restriction: Whenever a practitioner's/AHP's license or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or

certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c) Probation: Whenever a practitioner/AHP is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d) Expiration: Failure to maintain a current active medical license will result in suspension of privileges until license is renewed and in good standing.

2) **Medicare, Medicaid, Tricare (a managed care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs**: Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of Inspector General's list of excluded individuals/entities will be considered to have automatically relinquished his or her privileges.

3) **Controlled Substances**:

b) Revocation, Limitation, Suspension: Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

c) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

4) **Medical Record Completion Requirements:** A practitioner/AHP will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever he or she fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. Notice of automatic suspension for medical records completion requirements shall be from the Medical Staff Office in collaboration with the HIM department. The relinquished privileges will be automatically restored when the medical records are completed in compliance with medical records policies. MEC deliberation pursuant to **Section 9.4b** is not required for automatic suspension due to medical record completion requirements.

5) **Professional Liability Insurance:** Failure of a practitioner/AHP to maintain professional liability insurance in the amount required by state regulations and medical staff and board policies, and sufficient to cover the clinical privileges granted, shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If within **60 business days** of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

6) **Medical Staff Dues and Special Assessments:** Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. A practitioner who does not remit such payments within **60 business days** of receiving written warning of the delinquency shall be considered to have voluntarily resigned membership on the medical staff.

7) **Felony/Misdemeanor Indictment or Conviction:** A practitioner/AHP who has been indicted, convicted of, or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately on such indictment, conviction, or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the board or through corrective action, if necessary.

8) **Failure to Satisfy the Special Appearance Requirement:** A practitioner/AHP who fails without good cause to appear at a meeting where a special appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within **30 business days** will be considered a voluntary resignation from the medical staff.

9) **Failure to participate in an Evaluation:** A practitioner/AHP who fails to participate in an evaluation of his or her qualifications for medical staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within **30 business days** will be considered a voluntary resignation from the medical staff.

10) **Failure to Execute Release and/or Provide Documents:** A practitioner/AHP who fails to execute a general or specific release and/or provide documents when requested by the president of the medical staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within **30 business days** of notice of the automatic relinquishment, the practitioner/AHP may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

b. **Medical Executive Committee Deliberation** As soon as practicable, but no later than ninety **four (4) business days** following automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which such action was taken. The Medical Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation, including limitation of prerogatives. Thereafter, when the matter involves a practitioner, then a procedure to be followed shall be provided in **Section 9.1g and 9.1i,** as applicable.

c. **Automatic Suspension - Fair Hearing Plan Not Applicable -** No practitioner/AHP, whose privileges are automatically suspended under this Section, shall have the right of hearing or appeal as provided under these Bylaws or AHP grievance procedure. The Chief of Staff shall designate a physician to provide continued medical care for any suspended Practitioner's patients.

d. **Chief of Staff -** It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Chief of Staff informed of the names of Medical Staff Members who have been suspended or expelled.

9.5 CONFIDENTIALITY

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

9.6 SUMMARY SUPERVISION

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

9.7 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in the peer review activities described in these Bylaws.

9.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to **Section 9.1 or 9.3** shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

ARTICLE X FAIR HEARING and APPELLATE REVIEW PLAN

10.1 PURPOSE, RIGHT TO AND REQUEST FOR FAIR HEARING

a. **Purposes:** This Fair Hearing and Appellate Review Plan sets forth procedures to be followed in connection with all hearings to be provided to members of the RMCMCS Medical Staff and applicants for Medical Staff membership and/or clinical privileges (referred to as "practitioners"), in accordance with the Bylaws of the Medical Staff. This Fair Hearing and Appellate Review Plan shall not apply to Allied Healthcare Practitioners.

b. **Right to Hearing:** No practitioner shall be entitled to any hearing except as expressly provided in the Medical Staff Bylaws or this Fair Hearing and Appellate Review Plan.

i. When a Medical Staff member is entitled to a hearing after a materially adverse recommendation by the Medical Executive Committee or adverse action by the Board, such hearing shall be held before a panel of members of the Medical Staff in accordance with **Section 10.2** of this Fair Hearing and Appellate Review Plan, unless the provisions within these Bylaws provide otherwise. A recommendation shall be considered to be materially adverse if the recommendation would have a significant adverse effect on the practitioner's Medical Staff membership or clinical privileges, including a recommendation to materially reduce, suspend clinical privileges for more than **thirty (30) business days** (other than precautionary suspension), restrict, modify, revoke, terminate, refuse to renew, or impose conditions a practitioner's the clinical privileges including mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance), or Medical Staff membership.

ii. An applicant for initial Medical Staff appointment and privileges, members of the Provisional Staff and shall be entitled only to a Modified Hearing after a materially adverse recommendation by the Medical Executive Committee or adverse action by the Board. Such Modified Hearing shall be held before the Medical Staff Credentials Committee in accordance with in **Section 10.3** of this Fair Hearing and Appellate Review Plan.

iii. The following recommendations by the Medical Executive Committee, or actions by the Board, shall not be considered to be material adverse recommendations or actions and in the event of such recommendation or action, the practitioner shall only be entitled to a Modified Hearing in accordance with **Section 10.3** of this Fair Hearing and Appellate Review Plan.

a) Denial of a request for change in staff category;

b) Denial of requested departmental, division, service, or other clinical unit affiliation;

c) Denial of appointment, reappointment, or clinical privileges due to failure to admit or treat sufficient number of patients in the Hospital;

d) Placement on medical leave; or

e) Refusal to terminate medical leave;

iv. Except as otherwise specifically provided in the Medical Staff Bylaws or this Fair Hearing and Appellate Review Plan, no practitioner shall be entitled to a hearing if the practitioner's Medical Staff membership or clinical privileges, or ability to treat certain patients in the Hospital, are limited, terminated, or reduced for reasons which in no way relate to the practitioner's professional qualifications, competence, or conduct, and which are not reportable to the National Practitioner Data Bank or to the State of New Mexico.

v. No practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which does not restrict or place conditions on the individual's clinical privileges or ability to admit or treat patients in the Hospital including, but not limited to, the following:

1) Letters of warning, reprimand, or admonition;

2) Imposition of monitoring, proctoring, review, second opinion, or consultation requirements;

3) Requiring provision of information or documents, such as office records, or notice of events or actions;

4) Imposition of educational or training requirements;

5) Placement on probationary or other conditional status;

6) Appointment or reappointment for less than two (2) years; or

7) Refusal to place a practitioner on any on-call or interpretation roster, removal of any practitioner from any such roster, or a requirement that a practitioner serve on an on-call roster.

vi. In the event any practitioner fails to (i) maintain appropriate malpractice insurance, (ii) maintain a current, active, appropriate state license, or (iii) is excluded from participation in Medicare or Medicaid, the practitioner shall be automatically suspended. The practitioner shall be notified of the basis of the suspension by certified mail, and given **ten (10) business days** to produce clear and convincing evidence that there is no basis for automatic suspension.

vii. If the practitioner disputes the suspension and provides evidence that there is no basis for the suspension, the practitioner shall be entitled to a Modified Hearing pursuant to **Section 10.3** if the Hospital Chief Executive Officer does not rescind the suspension.

viii. If the Hospital does not receive such evidence from the member within **ten (10) business days**, the individual's Medical Staff membership and clinical privileges shall automatically terminate, and the individual shall not be entitled to a hearing as set forth in the Bylaws or elsewhere in this Fair Hearing and Appellate Review Plan.

ix. No individual shall be entitled to a hearing or any other procedural rights as a result of a refusal by the Hospital to provide an application form to such individual.

x. No applicant or medical staff member shall be entitled as a matter of right to more than one hearing or appellate review on any single matter that may be the subject of an appeal. In the event that the Board ultimately denies medical staff appointment or reappointment to an applicant, or revokes or terminates the medical staff appointment and/or clinical privileges of a current member, that individual may not apply within five years for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

c. **Request for Hearing:** Any request for a hearing shall be made in such manner and at such times as are set forth in these Bylaws.

10.2 FULL PANEL HEARING PROCEDURES

a. **Appointment of Panel Members and Composition of Hearing Committee**

i. Upon receipt of a request for a hearing under circumstances which entitle the person requesting the hearing to a hearing before a panel of Medical Staff members, the Chief of Staff in consultation with the Chief Executive Officer, or designee, shall appoint three (3) members of the Medical Staff, who are impartial peers, to serve on a hearing panel. There also may be appointed one or more alternate members of the hearing panel. As an

alternative to appointing a hearing panel, the Chief of Staff, with the agreement of the Chief Executive Officer, may elect to have the hearing held before (i) a single arbitrator mutually acceptable to the practitioner and the Hospital, or (ii) a hearing officer who is not in direct economic competition with the physician to conduct the hearing. The term "hearing panel" as used in this Fair Hearing and Appellate Review Plan shall include a hearing panel, arbitrator, or hearing officer.

ii. Any member of the hearing panel, including any alternate, who participates in the entire hearing, may be permitted to participate in the deliberations and to vote on the recommendations of the hearing panel.

iii. No person shall be a member of any hearing panel if that person has had any prior involvement in the specific cases or issues to be considered by the panel or is in direct economic competition with the practitioner involved.

b. **Notice to Practitioner of Hearing Date and Summary of Hearing Rights -** At least **thirty (30) business days** prior to the date scheduled for the hearing, a notice shall be sent to the practitioner advising the practitioner of the following:

i. The date, time and place of the hearing,

ii. A summary of the practitioner's rights in connection with the hearing, and

iii. The identity of prospective members of the hearing panel.

c. **Objection to Prospective Panel Members:** If the practitioner has any objection to any proposed panel member, the practitioner shall, within **ten (10) business** days of receipt of notification of the members of the hearing panel, notify the Chief Executive Office in writing of the objection and the reasons for the objection. The Chief of Staff and the Chief Executive Officer shall, after considering such objections, decide in their discretion whether to replace any person objected to and the practitioner shall be notified of the final members of the hearing panel.

d. **Notification of Reasons for Proposed Action, Witnesses and Documents:**

i. At least **fifteen (15) business days** prior to the hearing, the practitioner involved shall be sent by certified and regular mail a statement;

a) Setting forth the reasons for the proposed action;

b) Identifying any witnesses expected to testify before the panel in support of the recommendation under consideration;

c) Identifying all medical records or documents expected to be submitted to the panel for consideration; and

d) The identity of any hearing officer.

ii. If expert witnesses are to be called in support of the recommendations of the Medical Staff at the hearing, the practitioner, at least **fifteen (15) business days** before the hearing, shall be (a) told the identity of the expert(s) to be called; (b) provided a copy of each expert's curriculum vitae; (c) provided a copy of any written report setting forth each expert's opinions or a written description of the substance of each expert's testimony; and, (d) provided copies of all documents or materials provided by the Hospital for review by the expert(s).

iii. At least seven **(7) business days** prior to the hearing the practitioner shall provide to the Medical Staff a list of any witnesses the practitioner will call to testify, a summary of the subject matter of the witnesses' testimony and a copy of all documents the practitioner intends to introduce at the hearing. If the practitioner intends to call expert witnesses at the hearing, the member shall (a) identify the expert(s) to be called; (b) provide a copy of each witness's curriculum vitae; (c) provide copies of any reports from the expert(s) or a written description of the substance of each expert's testimony; and, (d) copies of all documents or materials provided by the practitioner for review by the expert(s). No witness may be called on behalf of the practitioner, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the panel, which have not been disclosed in accordance with this section.

e. **Hearing Officer:** If the hearing is held before a panel of physicians, the Chief of Staff and the Chief Executive Officer shall select a hearing officer to preside at the hearing. The hearing officer shall be an attorney or other individual familiar with procedures relating to peer review hearings.

i. The hearing officer shall rule on all procedural matters at the hearing, rule on any objections to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the hearing panel for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

ii. The hearing officer shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, and to limit the number of witnesses to be called by the Medical Staff or practitioner.

f. **Burden of Proof:** Whenever a hearing relates to the denial of a practitioner's request for reappointment or modification of privileges or Medical Staff status, the practitioner shall be advised of the nature and source of the information upon which the adverse recommendation is based. In all cases the practitioner shall have the burden of proving by clear and convincing evidence that the adverse recommendation or action lacks any factual basis or is arbitrary, unreasonable, or capricious. It shall not be a defense to any action proposed by the Medical Executive Committee or the Board that different action has been taken in the past with regard to any other staff member.

g. **Report and Recommendations of Hearing Panel:** Within **fifteen (15) business days** after final adjournment of the hearing, including receipt of all written submissions, the hearing panel shall deliver a written report to the Medical Executive Committee stating in full its findings, the reasons and evidence upon which it based its findings, and its recommendations. The time for submitting the report and recommendations may be extended by the hearing panel if additional time is needed. A copy of the report and recommendations shall be delivered to the practitioner. Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the MEC and/or Board unless it finds that the individual who requested the hearing has proved, by (clear and convincing/a preponderance of the) evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

h. **Practitioner Response to Report and Recommendations:** Within **fifteen (15) business days** after the report and recommendations of the hearing panel are delivered to the Medical Executive Committee, the practitioner may submit a written statement to the Medical Executive Committee specifying the findings of fact, conclusions and procedural matters with which the practitioner disagrees and the reasons for such disagreement. The practitioner may not submit new information, nor evidence not previously considered by the hearing panel, except as may be requested by the Medical Executive Committee.

i. **Appearance before Medical Executive Committee:** The Chief of Staff may, in his/her sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Executive Committee to present oral argument or respond to inquiries.

j. **Medical Executive Committee Action:** The Medical Executive Committee shall consider the entire case and, if additional information is needed, the Committee may remand the case to the hearing panel for any further proceedings the Medical Executive Committee deems appropriate. After receipt of the report of the hearing panel and any additional information requested, the Medical Executive Committee shall consider the entire case and vote on its recommendations to the Board. Any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of the report and recommendations of the Medical Executive Committee shall be sent to the practitioner involved.

k. **Board of Directors Action:** Final action by the Board shall be taken in accordance with the provisions of the Medical Staff Bylaws and **Section 10.4** of this Fair Hearing and Appellate Review Plan.

10.3 MODIFIED HEARING

a. **Scheduling of Hearing**: Upon receipt of a request for a hearing under circumstances which entitles a practitioner to a modified hearing, the Chief of the Credentials Committee shall be notified and shall schedule a date for the hearing. A majority of the members of the Credentials Committee shall constitute a quorum for purposes of conducting a hearing.

b. **Notice to Practitioner of Hearing Date, Membership of Credentials Committee, and Summary of Hearing Rights:** At least **thirty (30) business days** prior to the date scheduled for the hearing, a notice shall be sent to the practitioner advising the practitioner of the following:

i. The date, time and place of the hearing,

ii. The names of the members of the Credentials Committee, and

iii. A summary of the practitioner's rights in connection with the hearing.

c. **Objection to Members of Credentials Committee:** If the practitioner has any objection to any member of the Credentials Committee participating in the hearing, the practitioner shall notify the Chief of the Credentials Committee in writing of any objection at least **ten (10) business days** before the hearing and shall state the reasons for such objection. The Chief of the Credentials Committee shall, after reviewing the objections, decide whether to excuse the member objected to from the hearing. If the practitioner objects to the participation of the Chief of the Credentials Committee, the Chief Executive Officer shall decide whether to excuse the Chief from the hearing. No member of the Credentials Committee shall participate in any hearing involving an individual with whom the member of the Committee is in direct economic competition.

d. Notification of Reasons for Proposed Action, Witnesses and Documents:

i. At least **fifteen (15) business days** prior to the hearing, the practitioner involved shall be sent by certified and regular mail a statement

a) Setting forth the reasons for the proposed action,

b) Identifying any witnesses expected to testify before the Credentials Committee in support of the recommendation under consideration,

c) Identifying all medical records or documents expected to be submitted to the Credentials Committee for consideration, and

d) The identity of any hearing officer to be used at the hearing.

ii. If expert witnesses are to be called in support of the recommendations of the Medical Staff at the hearing, the practitioner, at least **fifteen (15) business days** before the hearing, shall be (a) told the identity of the expert(s) to be called; (b) provided a copy of each expert's curriculum vitae; (c) provided a copy of any written report setting forth each expert's opinions or a written description of the substance of each expert's testimony; and, (d) provided copies of all documents or materials provided by the Hospital for review by the expert(s).

iii. At least **seven (7) business days** prior to the hearing the practitioner shall provide to the Medical Staff a list of any witnesses the practitioner will call to testify, a summary of the subject matter of the witnesses' testimony and a copy of all documents the practitioner intends to introduce at the hearing. If the practitioner intends to call expert witnesses at the hearing, the member shall provide the Chief of the Credentials Committee (a) a copy of each witness's curriculum vitae; (b) copies of any reports from the expert(s) or a written description of the substance of each expert's testimony; and, (c) copies of all documents or materials provided by the practitioner for review by the expert(s). No witness may be called on behalf of the practitioner, no testimony or opinions may be elicited from any expert, nor any documents submitted for consideration by the Credentials Committee, which have not been disclosed in accordance with this section.

e. **Hearing Officer:** The Chief of the Credentials Committee and the Chief Executive Officer of the Hospital may, in their sole discretion, select a hearing officer to preside at the hearing. The hearing officer shall be an attorney or other individual familiar with procedures relating to peer review hearings.

i. If a hearing officer is utilized, the hearing officer shall rule on all procedural matters at the hearing, rule on any objects to testimony or evidence that is offered at the hearing, decide whether evidence has sufficient relevance and reliability to be submitted to the Credentials Committee for consideration, rule on requests for postponements or extensions of time, and shall generally be responsible for regulating the proceedings.

ii. The hearing officer shall have the authority to resolve all issues regarding scheduling of hearings, and shall have the authority to recess and reconvene the hearing, to impose time limits for examination and cross-examination of witnesses, to limit the number of witnesses to be called by the Medical Staff or member, and to advise the members of the Credentials Committee concerning legal and procedural matters.

iii. In lieu of a hearing officer the Credentials Committee may be advised by and have the assistance of legal counsel to advise the Committee members and assist them with the preparation of their report.

f. **Conduct of Hearing:** If a hearing officer is not utilized, the Chief of the Credentials Committee shall have the same authority as a hearing officer as set forth in **Section 10.3e** above to resolve all issues regarding the conduct of the of hearings and the introduction of evidence and testimony, except that the Chief of the Credentials Committee also shall be entitled to vote on any recommendations.

g. **Burden of Proof:** At the hearing the practitioner shall be advised of the nature and source of the information upon which the adverse recommendation is based. The practitioner shall have the burden of proving by clear and convincing evidence that the adverse recommendation or action lacks any factual basis or is arbitrary, unreasonable, or capricious. It shall not be a defense to any action proposed by the Medical Executive Committee or the Board that different action has been taken in the past with regard to any other staff member.

h. **Report and Recommendations:** After final adjournment of the hearing, the Credentials Committee shall consider the matter and make a written report to the Medical Executive Committee setting forth the action the Credentials Committee recommends and the reasons therefore. There shall be attached to the report any written materials or statements submitted by the practitioner. A copy of the report shall be sent to the practitioner. Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the MEC and/or Board unless it finds that the individual who requested the hearing has proved, by (clear and convincing/a preponderance of the) evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

i. **Practitioner Response to Report and Recommendations:** Within **fifteen (15) business days** after the report and recommendations of the Credentials Committee are delivered to the Medical Executive Committee, the practitioner may submit a written statement to the Medical Executive Committee specifying the findings of fact, conclusions and procedural matters with which the practitioner disagrees and the reasons for such disagreement. The practitioner may not submit new information or evidence not previously considered by the Credentials Committee except as may be requested by the Medical Executive Committee.

j. **Appearance before Medical Executive Committee:** The Chief of Staff may, in his/her sole discretion, permit or require the practitioner or his/her representative to appear before the Medical Executive Committee to present oral argument or respond to inquiries.

k. **Medical Executive Committee Action:** The Medical Executive Committee shall consider the entire case and, if additional information is needed, the Committee may remand the case to the Credentials Committee for any further proceedings the Medical Executive Committee deems appropriate. After receipt of the report of the Credentials Committee and any additional information requested, the Medical Executive Committee shall consider the entire case and vote on its recommendations to the Board. Any minority views may be reduced to writing, supported by reasons and references, and transmitted with the majority report. A copy of the report and recommendations of the Medical Executive Committee shall be sent to the applicant involved.

l. **Board Action:** Final action by the Board shall be taken in accordance with the provisions of the Medical Staff Bylaws and **Section 10.4** of this Fair Hearing and Appellate Review Plan.

10.4 APPELLATE REVIEW

a. **Request for Appellate Review**: If after considering the report and recommendations of the hearing panel or Credentials Committee, the recommendations of the Medical Executive Committee continue to be adverse to the practitioner, the practitioner may, within **ten (10) business days** after the practitioner is notified of the adverse recommendations of the Medical Executive Committee, request appellate review by the Board of Directors, or any Committee of the Board designated by the Board (collectively referred to as the "Board"), which also may include a request to appear before the Board to present oral argument. Such a request must be submitted in writing to the Chief Executive Officer.

b. **Standard of Appellate Review:** Appellate review by the Board shall be limited to determining whether the practitioner has established by clear and convincing evidence that:

i. There has been a substantial failure to comply with the Medical Staff Bylaws during the course of the proceedings,

ii. The recommendation of the Medical Executive Committee is arbitrary, capricious, or unreasonable, or

iii. The recommendation of the Medical Executive Committee is not supported by reliable evidence.

c. Written Statement of Practitioner:

i. If the practitioner requests appellate review by the Board, the practitioner shall be required to submit a written statement to the Board setting forth specifically any findings of fact, conclusions, recommendations and procedural matters with which the practitioner disagrees and the reasons therefore. Any written statement must be delivered to the Chief Executive Officer of the Hospital within **ten (10) business days** after the practitioner receives the report and recommendations of the Medical Executive Committee. Failure to submit such a statement shall be deemed a waiver or withdrawal of any request for appellate review by the Board.

ii. The practitioner shall provide a copy of the practitioner's written statement to the Medical Executive Committee which may submit a response to the Board of Directors, with a copy to the practitioner, within **fifteen (15) business days** after receipt.

d. **Notice of Appearance before Board**: The Board may, in its sole discretion, permit or require the parties or their representatives to appear before the Board and present oral argument in support of their positions. The practitioner shall be notified of the date, time and place the practitioner is to appear before the Board at least **seven (7) business days** in advance. The failure of the practitioner to appear shall be considered a withdrawal of any request for appellate review by the Board.

e. **Oral Argument before Board**: Any presentation before the Board shall be limited to oral argument, and the practitioner shall not be permitted to introduce any new facts or evidence which was not introduced at any hearing. No witnesses shall be permitted to present testimony before the Board unless the Board consents to such testimony. The practitioner may be accompanied by an attorney who may advise and speak on behalf of the practitioner; however, the members of the Board shall be permitted to direct questions to the practitioner who shall be required to respond personally. The amount of time available for the practitioner's presentation may be limited by the Board or subject to such conditions as the Board determines to be appropriate.

f. **Action by Board**: Within **sixty (60) business days** after the practitioner's appearance before the Board, or **sixty (60) business days** after date of the report of the Medical Executive Committee if the practitioner does not appear before the Board, the Board shall act to accept, reject, or accept with modification, the recommendations of the Medical Executive Committee, or refer the matter back to the Medical Executive Committee for further consideration or investigation. If the Board refers the matter back to the Medical Executive Committee for further consideration, the Board shall state the reasons for such referral.

g. **Reconsideration by Medical Executive Committee**: In the event the decision of the Board differs substantially from the recommendations of the Medical Executive Committee, further action shall be held in abeyance for a period not to exceed sixty **(60) business days**. The Medical Executive Committee shall be advised of the intended action by the Board and the reasons for such action. The Medical Executive Committee shall review the proposed action of the Board of Directors, conduct any further investigation and make such additional comments or recommendations as the Medical Executive Committee deems appropriate. The Chief of Staff shall prepare a further report to the Board setting forth any additional findings or recommendations of the Medical Executive Committee and the reasons for the recommendations. The practitioner shall be notified of any further findings or recommendations of the Medical Executive Committee and provided a copy of any report. The practitioner may, within **seven (7) business days** of receiving any such report, submit to the Chief Executive Officer for the Board any written comments the practitioner wishes to make concerning the report of the Medical Executive Committee.

h. **Final Action by the Board:** After receiving any further comments or recommendations from the Medical Executive Committee, the Board shall take final action. In the event no comments or recommendations are received from the Medical Executive Committee within **sixty (60) business days** of the original decision of the Board of Directors, that

decision of the Board shall become final unless the Board extends the time for the Medical Executive Committee to submit a report or comments.

i. **Notification of Board Action:** The Hospital Chief Executive Officer shall notify the applicant, the Medical Executive Committee, the Credentials Committee, and Chief of the appropriate Department of the final action taken by the Board.

j. **Written Statement from Board**: If the final decision of the Board is materially adverse to the practitioner; the practitioner shall be provided a statement from the Board setting forth the reasons for the action taken.

k. **Effect of Board Action:** The final action of the Board shall be effective at such time as the Board designates and such action shall not be stayed by any judicial review proceedings without the consent of the Board.

10.5 GENERAL PROVISIONS

a. Timely Objections to Actions: In the event any practitioner has any objection to any action taken or procedures followed by the Hospital, the Medical Staff, or any individual, hearing panel, or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the body before whom the matter is pending to address the objection and take any corrective action deemed appropriate. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

b. Attorney Representation: The practitioner and Hospital may be represented by an attorney at any hearing before the Medical Executive Committee or Board. If the practitioner will be represented by counsel at any hearing or appearance, the practitioner shall notify the Chief Executive Officer of the name of the attorney or other representative at least **ten (10) business days** prior to the hearing or appearance.

c. Medical Staff Representative: The individual, committee, or body whose recommendations are challenged may designate a member of the Medical Staff to represent the position of the individual, committee, or body before the hearing panel, Credentials Committee, Medical Executive Committee or the Board. The Chief Executive Officer may designate a Hospital representative to represent the position of the Hospital or Medical Staff committee or department. In addition, the Hospital, including the Medical Executive Committee, may be represented by an attorney before any hearing panel, the Credentials Committee, the Medical Executive Committee, or the Board. In the event of a modified hearing before the Credentials Committee, the Credentials Committee may have counsel present to advise the Committee. The Chief Executive Officer or designee may appear and testify concerning any matters and present evidence to the hearing panel, Credentials Committee, Medical Executive Committee or the Board.

d. Presence of Practitioner: The practitioner shall be personally present at all hearings, except for good cause shown, and the failure of the practitioner to appear personally shall be a waiver of the right to a hearing.

e. Examination and Cross Examination of Witnesses: The practitioner, any attorney or other person representing the practitioner, any designated representative of the committee or body whose recommendations are challenged, the Chief Executive Officer or designee, and the Hospital counsel shall have the right to call, examine, cross-examine, and impeach witnesses, to introduce any exhibits, and to rebut any evidence.

f. Testimony of Practitioner: If the practitioner involved does not testify in his or her own behalf, the practitioner may be called and examined as if under cross-examination at any hearing or before any appellate review body.

g. Evidence and Testimony Requested by Hearing Panel or Credentials Committee: The hearing panel or Credentials Committee may call and examine witnesses and receive and examine such exhibits as it deems appropriate on its own initiative, provided all parties involved shall be given reasonable notice of all witnesses or exhibits to be examined by the hearing panel or Credentials Committee and adequate opportunity to challenge or rebut such evidence.

h. Discovery: Except as specifically provided in this Fair Hearing and Appellate Review Plan, there shall be no right to conduct discovery in connection with any hearing and no practitioner shall be permitted access to any peer review records, minutes or other documents relating to any other member of the Medical Staff. The individual requesting a hearing shall, however, be entitled to receive a copy of any documents relied on by the Medical Executive Committee or Board, any documents to be introduced at the hearing, and any medical records relied on or to be introduced at the

hearing, so long as the individual agrees in writing to keep all such documents and information confidential. The production of such documents shall not constitute a waiver of any peer review protection for those documents or any other documents.

i. Rules of Evidence: The hearing need not be conducted according to technical rules of evidence relating to the admissibility or presentation of evidence and all evidence determined to be relevant and reliable by the Chief of the hearing panel or Credentials Committee or the hearing officer shall be considered. All testimony shall be presented under oath or affirmation.

j. Court Reporter: Unless all parties agree otherwise, the hearing shall be recorded by a court reporter. The record of the hearing need not be transcribed unless specifically requested and the person or body requesting the transcript shall be responsible for the cost of transcription.

k. Recess of Hearing: The hearing panel or Credentials Committee may recess any hearing to obtain further information.

l. Written Statement by Practitioner: The practitioner shall have the right to submit a written statement at the close of the hearing. Such statement shall be submitted within a reasonable time as established by the hearing officer, hearing panel, or Credentials Committee.

m. Failure to Make Request or Appearance: If any practitioner fails to make a required request or appearance within the time specified herein or otherwise fails to comply with procedures for hearing and review set forth herein, the practitioner shall be deemed to have waived all further rights hereunder and shall be deemed to have consented to the recommendations then under consideration.

n. Modification of Time Requirements: All time periods may be modified for good cause by the hearing officer or chief of the committee or body before which the case is currently pending.

o. Confidentiality and Privilege: All information received, notes, records, minutes, documents, or materials of any kind which are obtained, reviewed, or considered in connection with any matters considered or action or investigation taken pursuant to the Medical Staff Bylaws or this Fair Hearing and Appellate Review Plan relating to Medical Staff membership or clinical privileges shall be confidential and privileged, shall not be admissible or discoverable in any legal proceedings, and shall be subject to all other protection afforded to such documents or proceedings by law.

p. Immunity: All practitioners and all those participating in or providing information to any department, section, committee, hearing panel or officer of the Medical Staff shall, to the fullest extent permitted by law, not be liable for any actions taken or information provided in connection with the review, grant, or denial of Medical Staff membership or clinical privileges, or any other action taken pursuant to the Bylaws of the Medical Staff or this Fair Hearing and Appellate Review Plan.

ARTICLE XI CLINICAL DEPARTMENTS AND SERVICES

11.1 ORGANIZATION OF DEPARTMENTS

a. **Structure –** The Medical Staff shall be organized into Departments and Services.

b. **Department Chairperson–** Each department shall have a chairperson who is selected and has the qualifications, authority, duties, and responsibilities as specified in **Section 11.5.**

11.2 DESIGNATION

a. **Current Departments**

i. The current departments are:

1) **Medicine,** including:

a) Internal Medicine and all subspecialties thereof, including Cardiology, Nephrology, Endocrinology, Pulmonology and Sleep Medicine.

b) Family Medicine

c) Hospitalists

d) Pediatrics

e) Emergency Medicine

f) Radiology

g) Psychology

h) All subspecialties thereof including those provided by outpatient and Clinic physicians/AHPs within these specialties.

2) **Surgery,** including:

a) General Surgery and all subspecialties thereof, including Orthopedics, ENT and Ophthalmology

b) OB/GYN

c) Pathology

d) Anesthesia

e) All subspecialties thereof, including those provided by outpatient and Clinic physicians/AHPs within these specialties.

b. **Review of Departments** - The Medical Staff shall review its department organization at the annual meeting, recommending possible changes.

c. **Future Departments** - When deemed appropriate and consistent with the provisions of **Section 11.6** the Medical Executive Committee and the Board, by their joint action, may create a new department, or eliminate, sub-divide, further subdivide or combine departments.

11.3 ASSIGNMENT TO DEPARTMENTS

After considering the chairperson of the appropriate department's recommendations, the MEC will recommend department assignments for all practitioners/AHPs in accordance with his/her qualifications. Each practitioner shall be assigned membership in at least one primary department, but may be granted clinical privileges or specified services in one or more of the other departments. The exercise of clinical privilege or the performance of specified services within any department shall be subject to the rules and regulations of that department, the medical staff rules/regulations and the authority of the department chairperson.

11.4 RESPONSIBILITIES OF DEPARTMENTS

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

a. Meet at least four (4) times per year for the purpose of receiving and considering patient care evaluation findings and the results of the department's other review, evaluation and monitoring activities and of performing or receiving reports on other department and staff functions;

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

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

d. Monitor on an ongoing basis the compliance of its department Members with these Bylaws, and the Rules and Regulations, policies, procedures and other standards of the Hospital;

e. Monitor on an ongoing basis the compliance of its department Members with applicable professional standards;

f. Coordinate the patient care provided by the department's Members with nursing, administrative, and other non-Medical Staff services;

g. Foster an atmosphere of professional decorum within the department;

h. Submit written minutes of department meetings to the Medical Executive Committee concerning;

   i. Findings of the department's review, evaluation and monitoring activities, action taken thereon, and the results of such review;

   ii. Recommendations for maintaining and improving the quality of care provided in the department of the Hospital; and

   iii. Such other matters as may be requested from time to time by the Medical Executive Committee.

i. Recommend to the MEC, CEO and Board those clinical services to be provided by Telemedicine, if any, within the department;

j. Provide leadership and oversight for patient safety initiatives within the department; and

k. Analyze and improve patient satisfaction.

11.5 DEPARTMENT CHAIRPERSON

a. **Selection** – Each department shall have a Chairperson, who shall be recommended by the current Chief of Staff and approved by the MEC.

b. **Removal –** Removal of a department chairperson from office may be upon the recommendation of the Medical Executive Committee or by a simple majority vote of the department members eligible to vote on departmental matters. Removal from office will be considered if:

   i. The chair ceases to be a member in good standing on them medical staff;

   ii. The chair suffers an involuntary loss or significant limitation of practice privileges;

   iii. The chair fails to maintain any of the qualifications described in **11.5d**; or

   iv. The MEC determines that the Chair has failed to effectively fail to carry out the responsibilities of the position to the satisfaction of the MEC and the Board.

   If the department chair is removed, a new election will be held.

c. **Term of Office** – A department chairperson shall serve a **two (2) year term** commencing on the first day of the month after the annual meeting. He shall serve until his successor is chosen, unless he shall sooner resign or be removed from office. A department chairperson shall be eligible to succeed himself only if elected by his department.

d. **Qualifications** – Each chairperson shall:

   i. Be a member of the Active Staff;

ii. Have current certification by an appropriate specialty board or comparable competence affirmatively establish through the credentialing process; and

iii. Be willing and able to faithfully discharge the functions of his/her office.

e. **Roles and Responsibilities –** Each chairperson shall be responsible for:

i. Clinically related activities of the department;

ii. Administratively related activities of the department, unless otherwise provided by the Hospital;

iii. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

iv. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;

v. Recommending clinical privileges for each member of the department;

vi. 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;

vii. Integration of the department or service into the primary functions of the organization;

viii. Coordination and integration of interdepartmental and intradepartmental services;

ix. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

x. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

xi. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

xii. Continuous assessment and improvement of the quality of care, treatment, and services;

xiii. Maintenance of quality control programs, as appropriate;

xiv. Orientation and continuing education of all persons in the department or service; and

xv. Assisting in development of budgets and recommending space and other resources needed by the department or service

11.6 MODIFICATIONS IN CLINICAL ORGANIZATIONAL UNITS

In creating, eliminating, subdividing, or combining departments, sections, or any other clinical organizational units that may exist or be contemplated, the following guidelines shall be followed:

a. **Creation Of Subdivision**: A sufficient number of practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational components to enable accomplishment of the functions generally assigned to such components in these Bylaws and Rules and Regulations, and the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions.

b. **Eliminations**: The number of practitioners available is no longer adequate and will not be so in the near future to accomplish assigned functions, or the patient or service activity associate with the component to be dissolved is no longer sufficient to warrant imposition of the responsibility to accomplish those assigned functions.

c. **Combination:** Two or more organizational components may be combined if this will result in more effective and efficient accomplishment of assigned functions. In all instances of modification, the Hospital's written plan of development as constraints or mandates imposed by external planning authorities must also be considered.

11.7 CLINICAL SERVICES

a. **Structure**

i. In addition to the departments of the Medical Staff, there shall be services within the Medical Staff as follows:

1) Anesthesia

2) Emergency Medicine

3) OB/GYN

4) Surgery

5) Hospitalists

6) Pediatrics

7) Pathology

8) Radiology

ii. Such services shall not constitute departments as that term is used herein without the express designation by the MEC and the Board. Each service shall be headed by a Chief selected in the manner and having the authority and responsibilities set forth in these Bylaws. The purpose of the services shall be to provide specialized care within the Hospital and to monitor and evaluate the quality of care rendered in the service and to be accountable to the department to which such service is assigned for the discharge of these functions.

b. **Qualifications of Service Chiefs** – Service Chiefs must meet the qualification requirements described in **Section 11.5d** and any applicable State and/or federal law(s). Additional qualifications are as required by applicable contract.

c. **Selection of Service Chiefs** – Service Chiefs shall be selected by the Chief of Staff.

~~d.~~ **Terms of Service Chiefs -** The Service Chief shall serve a **two (2) year term.**

e. **Removal of Service Chiefs** – Removal may be based upon failure to perform, either unable or unwillingly, the duties and responsibilities set forth in these Bylaws and/or as otherwise provided in written contract.

f. **Duties and Responsibilities of Service Chiefs**- The Chief of each service shall have the following duties with respect to his/her service:

i. Account to the appropriate Department Chairperson and to the MEC for all professional activities within the service;

ii. Develop and implement service programs, policies and procedures in cooperation with the Department Chairperson;

iii. Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointees having Clinical Privileges in the service and report regularly thereon to the Department Chairperson;

iv. Implement within his/her service any actions or programs designated by the Department Chairperson or MEC;

v. Participate in every phase of administration of his/her service in cooperation with the Department Chairperson, the nursing service, other departments, administration and the Board;

vi. Assist in the preparation of such annual reports regarding the service as may be required by the Department Chairperson, MEC, the CEO or the Board;

vii. As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory;

viii. Perform such other duties as may reasonably be requested by the Department Chairperson, Chief of Staff, the MEC, the department Chairperson or the Board;

ix. Maintain quality control programs, as appropriate and applicable to the service; and

x. Other responsibilities as defined in any service contract.

ARTICLE XII OFFICERS AND OTHER OFFICIALS OF THE MEDICAL STAFF

12.1 OFFICERS OF THE STAFF

a. Identification of Medical Staff Officers - The officers of the staff shall be the:

i. Chief of Staff;

ii. Chief of Staff Elect;

iii. Past Chief of Staff.

b. Office Sequence - The officers shall serve each office in sequence, beginning with Chief of Staff Elect, then Chief of Staff, and then Past Chief of Staff.

c. Qualifications of Officers

i. Officers must be members of the Active Staff at the time of nomination and election, actively involved in patient care at the Hospital in good standing, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers must be practitioners with demonstrated qualifications based on training, experience, and ability to direct the medico administrative aspects of hospital and staff activities.

ii. They must have previously served in a significant leadership position on a medical staff (e.g., department or section chair, committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. The medical staff leadership and succession committee will have discretion to determine whether a staff member wishing to run for office meets the qualifying criteria.

iii. Officers may not simultaneously hold a leadership position on another Hospital's medical staff or in a facility that directly competes with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain the position is in the best interest of the Hospital. The Board shall have discretion to determine what constitutes a leadership position at another hospital.

d. Nominations

i. BY MEC: At least **30 days** before the annual meeting, the Medical Executive Committee shall submit to the staff one or more qualified nominees for each office (with the exception of the office of the Immediate Past Chief of Staff). The Nominating Committee shall consist of the current members of the MEC.

ii. BY PETITION: Nominations may also be made by petition signed by at least 35% of the members of the Active Staff and filed with the staff officers at least **7 days** before the annual meeting. The Nominating Committee must determine if candidates meet the qualifications to become officers before they can be placed on the ballot. As soon thereafter as reasonably possible, the names of these additional nominees shall be reported to the staff.

iii. BY OTHER MEANS: If, before the election, all or any of the individuals nominated for an office pursuant to the nominating committee or by petition as indicated above shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Medical Executive committee shall submit one or more substitute nominees at the annual meeting. Nominations shall be accepted from the floor.

e. Election of Officers - New officers shall be elected at the annual meeting of the staff each year and at least one month prior to expiration of current term. Only members of the Active Staff category shall be eligible to vote. Voting shall be by secret ballot provided there is more than one candidate for the particular office. If only one candidate for office is nominated, the elections shall be effected by voice vote. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

f. Term Of Office - Each officer shall serve a one year term with an option to serve successive terms, commencing on the first day of the month following the annual meeting. Each officer shall serve until the end of his term and until a successor is elected, unless he shall sooner resign or be removed from office. An individual may be re-elected for successive terms.

g. Removal Of Elected Officers - Except as otherwise provided, removal of an officer may be initiated by a majority vote of the practitioners eligible to vote for staff officers. Removal may be based only upon failure to perform, either unable or unwillingly, the duties of the position held as described in these bylaws, complaints regarding the performance of staff officers must be directed to the Medical Executive committee with the approval of a majority of the members of the staff.

h. Vacancies In Elected Office - Vacancy in the office of Chief of Staff Elect shall be filled by a special election conducted as reasonably soon as possible after the vacancy occurs following the general mechanism outlined in **this Section.** The Chief of Staff Elect shall fill the incomplete term of the vacancy in the office of the Chief of Staff. Vacancy in the office of Past Chief of Staff shall be filled by the Medical Executive Committee by appointing the most recent Past Chief of Staff if available and willing to serve.

12.2 DUTIES OF OFFICERS AND OTHER OFFICIALS OF THE MEDICAL STAFF

a. Chief Of Staff - The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff in all matters. As the chief elected official of the staff, the Chief of Staff shall:

i. Appoint multi-disciplinary Medical Staff committees;

ii. Aid in coordinating the activities of the Hospital administration and of the nursing and other non-physician patient care services with those of the Medical Staff;

iii. Be responsible to the Board, in conjunction with the MEC, for the quality, safety and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff;

iv. Work with the Board in implementation of the Board's quality, safety, performance, efficiency and other standards;

v. In concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges;

vi. Along with the continuing medical education programs, utilization review/ management, monitoring functions and patient care evaluation studies;

vii. Participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Hospital management committees;

viii. Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the Chief Executive Officer and other officials;

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

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

xi. Serve as a member of the MEC and as an ex-officio member of all other Medical Staff committees or functions;

xii. Assist in coordinating the educational activities of the Medical Staff;

xiii. Serve as liaison for the Medical Staff in its external professional and public relations;

xiv. Be responsible to the Board for administration of a program to assure high quality medical care in the Hospital;

xv. Receive and interpret the policies of the Board to the Medical Staff, and report and interpret to the Board the performance and maintenance of the Medical Staff's responsibility for providing quality medical care; and

xvi. Collaborate with the Hospitals Medical Staff Office to ensure:

1) Proper notice of all Medical Staff meetings on order of the appropriate authority;

2) Preparation of accurate and complete minutes for MEC and Medical Staff meetings;

3) Answer is rendered to all official Medical Staff correspondence; and

4) Preparation of financial statements and report status of Medical Staff funds, if any.

b. **Chief Of Staff Elect -** The Chief of Staff Elect shall assume, in the absence of the Chief of Staff, all of his authority and duties. He shall perform such duties and supervision as may be assigned to him by the Chief of the Medical Staff, MEC or the Board. He is responsible for keeping accurate and complete minutes of all Medical Executive Committee and general staff meetings. He will call meetings on the order of the Chief of Staff. He shall serve as member of the Medical Executive Committee.

c. **Past Chief Of Staff -** The Past Chief of Staff shall be a member of the Medical Executive Committee and shall perform such duties as assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

d. **Department Chairpersons** – Selection, removal, qualifications, duties and responsibilities of department chairperson will be pursuant to **Section 11.5.**

e. **Service Chiefs -** These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty. Selection, removal, qualifications, duties and responsibilities of Service Chief will be pursuant to **Section 11.7**.

ARTICLE XIII COMMITTEES AND FUNCTIONS

13.1 GENERAL PROVISIONS

a. The Standing Committees and the functions of the Medical Staff are set forth below and elsewhere in these Bylaws. These committees will be responsible to the MEC.

b. The MEC may, by resolution and upon approval of the Board, establish a medical staff committee to perform one or more of the required medical staff committee functions.

c. In the absence of a medical staff committee, then the Medical Executive Committee itself can:

i. Perform the function;

ii. Receive such reports or recommendations;

iii. Assign the function to a new or existing medical staff committee; and/or

iv. Assign the function to the medical staff as a whole

d. Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

e. All information pertaining to activities performed by the Medical Staff, its committees and departments shall be privileged and confidential to the full extent provided by law.

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

13.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

a. <u>Composition</u>

i. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the MEC. The majority of the voting members of the MEC must be fully licensed doctors of medicine or osteopathy actively practicing in the Hospital. Other practitioners and individuals may be eligible for MEC membership if approved by the Medical Staff in accordance with these Bylaws

ii. The Medical Executive Committee shall consist of at least 5 members.

iii. The members of the committee shall be as follows:

1) Chief of Staff, serving as chairperson of committee

2) Chief of Staff Elect

3) Past Chief of Staff

4) Medicine Department Chairperson

5) Surgery Department Chairperson

6) Clinical Service Chiefs

7) Hospitalist Service Chief or Designee

8) CEO, serving as ex-officio member without vote

9) Chief Medical Officer, serving as ex-officio member without vote

b. <u>Authority/Functions Delegated to the MEC by the Medical Staff</u> – The committee shall be responsible for governance of the Medical Staff and shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board. The duties of the Medical Executive Committee as delegated by the Medical Staff shall include at least the following:

i. Serve as final decision-making body of the medical staff in accordance with these Bylaws and provide oversight of all medical staff functions;

ii. Coordinate the implementation of policies, procedures and plans adopted by the Board;

iii. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department/clinical section assignments, clinical privileges and corrective action;

iv. Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provision;

v. Initiating an investigation of any incident, course of conduct, or allegation indicating that an appointee to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for appointees to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff membership or Clinical Privileges without limitation, further training, or other safeguards;

vi. Adoption of associated details which supplement the medical staff Bylaws as described in **Section 17.4.**

vii. Report to the Board and to the medical staff the overall quality, safety and efficiency of professional patient care services provided by individuals with clinical privileges, and coordinate the participation of the medical staff in the Hospital's performance improvement and patient safety activities;

viii. Developing and implementing programs for continuing medical education for the Medical Staff;

ix. Assuring and participating in an annual evaluation of the effectiveness of the Hospital's performance improvement and patient safety programs;

x. Taking reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members and AHPs, including initiating collegial and educational efforts and investigations and corrective action, when warranted;

xi. Recommending actions to the CEO on matters of a medico-administrative nature and making recommendations to the Board on medical, administration and Hospital matters;

xii. Keeping the medical staff up to date concerning the licensure and accreditation status of the Hospital;

xiii. Participating in identifying community health needs and setting Hospital goals and implementing programs to meet those needs;

xiv. Reviewing and acting on reports from medical staff committees, departments, and other assigned activity groups;

xv. Formulating and recommending medical staff rules, regulations, policies and procedures to the Board;

xvi. Requesting evaluations of practitioners privileged through medical staff process when there is question about the applicant's or member's ability to perform privileges requested or currently granted;

xvii. Making recommendation to the Board concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

xviii. Consulting with Hospital administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;

xix. Overseeing the portion of the Corporate Compliance Plan that pertains to the medical staff;

xx. Holding medical staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities;

xxi. Making recommendations to the medical staff for changes or amendments to the Bylaws; and

xxii. Acting on behalf of the organized medical staff between regular meetings of the medical staff on those issues identified within the list of MEC responsibilities and elsewhere in the Bylaws;

c. **How the Medical Staff Delegates Authority to the MEC** - The medical staff delegates its authority to the MEC through approving the Bylaws which describes the responsibilities delegated to the MEC as defined in **Section 13.2 b** and elsewhere in these Bylaws. The medical staff may delegate additional responsibilities by a majority vote of members eligible to vote.

d. **How the Medical Staff May Remove Authority Delegated to the MEC** – The medical staff may remove the authorities and responsibilities delegated to the MEC by recommending amending the MEC responsibilities described in **Section 13.2b** and elsewhere in these Bylaws pursuant to **Section 4.3b (vi)** and **Section 17.1**.

e. **Meetings** - The Medical Executive Committee shall meet at least ten times per year and shall maintain a permanent record of its proceedings and actions.

f. **Special Meetings of the Medical Executive Committee** - The Chief of the Medical Staff or the Chief's designee may call a special meeting of the MEC, when a majority of the MEC can be convened.

13.3 **CREDENTIALS COMMITTEE**

a. **Composition** - The Credentials Committee shall consist of four (4) to six (6) active staff physician members selected by the Chief of Staff. The Chairperson of the Committee will be selected by the Chief of Staff.

b. **Functions** - The functions of the Credentials Committee shall be to:

i. Establish criteria for the granting of Clinical Privileges within the medical staff departments and submit the recommendations to the Department Chairpersons and MEC for review and approval;

ii. Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for Medical Staff membership and delineation of Clinical Privileges;

iii. Make a report to the MEC on each applicant for Medical Staff membership and Clinical Privileges;

iv. Review, on a periodic basis, applications for reappointment including information regarding the competence of Medical Staff Members and AHPs; and as a result of such reviews make recommendations for the granting of privileges and reappointments; and

v. Investigate any breach of ethics that is reported to it.

c. **Meetings** - This committee shall meet at least ten times per year and as required to perform its functions.

13.4 **BYLAWS COMMITTEE**

a. **Composition** - The Bylaws Committee shall consist of:

i. Chief of Staff Elect, who will serve as the Chairperson;

ii. One Active Staff member selected by the Chief of Staff;

iii. Chief Medical Officer (CMO); and

iv. Chief Quality Officer

b. **Functions** - The functions of the Bylaws Committee shall be to review and evaluate the Bylaws and Rules and Regulations and any proposed revisions for compliance with applicable regulatory requirements and current standards of practice and make recommendations for revisions to Medical Staff, MEC and Board pursuant to **Article XVII.**

c. **Meetings** - This committee shall meet at least every three (3) years or more frequently as necessary to perform its functions.

13.5 MEDICAL STAFF FUNCTIONS

a. **Composition of Committees and Appointment**

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

ii. Medical staff committees performing medical staff functions required by these Bylaws or Hospital policy may include representatives of any appropriate hospital department.

iii. Unless otherwise specifically provided, the Chief of Staff appoints medical staff committee members. Each committee selects its chair unless the committee chair is provided for in these Bylaws.

iv. The Chief of Staff and the Chief Executive Officer, or the respective designee, serves as non-voting, ex-officio committee members unless the voting privilege is expressly given.

b. **Functions** - The functions of the Medical Staff are to:

i. Monitor, evaluate and improve care provided in and develop clinical policy for special care areas, such as intensive care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

ii. Conduct or coordinate quality, appropriateness and improvement activities, including:

1) Medical assessment and treatment of patients;
2) Use of information about adverse privileging decisions for any practitioner/AHP privileges through medical staff processes;
3) Use of medications;
4) Use of blood and blood components;
5) Operative and other procedures;
6) Patient satisfaction
7) Appropriateness of clinical practice patterns and significant departures from established patterns of clinical practice;
8) use of developed autopsy criteria;
9) Sentinel event review and patient safety;
10) Patient/family education
11) Coordination of care, treatment and services
12) Accurate , timely and legible completion of medical records

iii. Conduct or coordinate utilization review/ management activities;

iv. Provide continuing education opportunities responsive to the performance improvement and patient safety programs of the Hospital, new state-of-the-art developments, and other perceived needs and supervise Hospital's professional library services;

v. Prevent, investigate and control infections and monitor the Hospital's infection control program;

vi. Plan for response to fire and other disasters (natural or otherwise);

vii. Plan for response to Hospital growth and development and for the provision of services required to meet the needs of the community;

viii. Direct Medical Staff organizational activities, including Medical Staff Bylaws, review and recommendations for revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

ix. Coordinate the care provided by Members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services; and

x. Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff.

c. **Meetings** - These functions shall be performed as required by any applicable state, federal and regulatory requirements, accrediting bodies, and as deemed appropriate by the MEC and the Board. A medical staff committee established to perform one or more of the staff functions required by these Bylaws or Hospital policy shall meet as often as is necessary to discharge its assigned duties and in accordance with any applicable state, federal or other regulatory requirements.

13.6 TERM AND REMOVAL - Unless otherwise specifically provided, medical staff committee members serve until either a successor is elected or appointed, or he resigns or is removed from the committee. A medical staff committee member, except an ex-officio member, can be removed by the Chief of Staff or a majority vote of the Medical Executive Committee. An administrative staff committee member serves for a term equivalent to that of a medical staff member unless either, a successor is elected or appointed or he resigns or is removed from the committee. The Chief Executive Officer can remove an administrative staff committee member.

13.7 VACANCIES - Unless specifically otherwise provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.

ARTICLE XIV MEETINGS

14.1 ANNUAL STAFF MEETING

a. **Meeting Time** - A regular annual meeting of the active medical staff shall be held in the month of January at a date, time and place determined by the MEC.

b. **Order of Business & Agenda -** The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

i. Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

ii. Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Department Chairperson(s);

iii. The election of officers and other officials of the Medical Staff when required by these Bylaws;

iv. Recommendations for maintenance and improvement of patient care and patient safety; and

v. Other old or new business.

14.2 REGULAR MEDICAL STAFF MEETINGS

a. **Meeting Frequency & Time** - The Medical Staff shall meet at least four (4) times per year, with the January meeting each year to be designated as the Annual Staff Meeting. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular Medical Staff meeting must be changed for any reason, the notice procedure in **Section 14.4** shall be followed.

b. **Order of Business & Agenda** - The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda includes, at least the following:

i. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

ii. Report from the Medical Executive Committee

iii. Old business

iv. New business

c. **Special Meetings** - Special meetings of the Medical Staff may be called at any time by the Board of Trustees, Chief of Staff, the Medical Executive Committee or not less than thirty-three percent (33%) of the membership of the active staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

14.3 MEDICAL STAFF FUNCTION COMMITTEES AND DEPARTMENT MEETINGS

Committees and departments of the active medical staff determine the time of regular meetings by resolution. The frequency of meetings conforms to these bylaws. The chairperson of any committee or department of the active medical staff, the Board, the Chief of Staff or one third (1/3) of a committee or departments current members can call a special meeting. The meeting notices state the only business that will be considered at a special meeting.

14.4 NOTICE OF MEETINGS

If a general medical staff meeting, special medical staff meeting, regular committee or department meeting of the medical staff was not called by a resolution, then a notice of the place, day and time of the meeting must be given to all persons entitled to attend the meeting at least **five (5) days** before the meeting. Attendance at a meeting constitutes waiver of notice of the meeting.

14.5 QUORUM

a. **MEC, Credentials Committee and Peer Review Committee –** A quorum is defined as 50% of the voting members.

b. **Annual, Regular, Special Staff Meetings and other Medical Staff Committees -** A quorum is defined as members present and eligible to vote.

14.6 MANNER OF ACTION

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

14.7 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Medical Executive Committee, and made available to the staff. A department file of the minutes of each meeting shall be maintained.

14.8 ATTENDANCE REQUIREMENTS

a. **Regular Attendance** – The recommended, but not required, attendance for active Medical Staff and admitting AHPs is fifty percent (50%) of all regular business meetings, all meetings of each department of which he/she is a member and committees to which he/she has been assigned. If stricter requirements for meeting attendance are defined elsewhere in these Bylaws the stricter requirement applies.

b. **MEC, Credentials Committee, Peer Review Committee** – Fifty percent (50%) meeting attendance is required for MEC, Credentials Committee and Peer Review Committee members.

c. **Absence from Meetings**

i. Any Member who is compelled to be absent from any Medical Staff, departmental or committee meeting where attendance is required shall promptly provide, in writing to the regular presiding officer thereof, the reason for such absence. Unless excused for a good cause, failure to meet the attendance requirements of these Bylaws shall be grounds for corrective action.

ii. Reinstatement of a Medical Staff Member whose membership has been revoked because of absence from meetings shall be made only on application, and such application shall be processed in the same manner as an application for initial appointment

d. Special Appearance

i. When an apparent or suspected deviation from standard treatment of a patient is to be discussed at a regular department or committee meeting of the active medical staff then the practitioner:
   1) Will be given special notice, at least **five (5) days** prior to the meeting, by registered mail of the time and place of the meeting, and;
   2) Will be given a statement of the issue(s) involved, and;
   3) Will be advised that the practitioner's appearance is mandatory.

ii. If the practitioner does not appear at any meeting for which he was given special notice, then there will be automatic suspension of all or such portion of the practitioner's clinical privileges, pursuant to **Section 9.4a(ii)(8)** Such suspension shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

iii. The Medical Executive Committee, upon a showing of good cause, can excuse the failure of the mandatory appearance.

ARTICLE XV CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

15.1 AUTHORIZATION AND CONDITIONS

By applying for, or exercising, clinical privileges or providing specified patient care services within the Hospital, a practitioner:

a. authorizes representatives of the hospital and medical staff to solicit, provide and act upon information bearing on his professional ability and qualification;

b. agrees to be bound by the provisions of **this Article** and to waive all legal claims against a representative who acts in accordance with the provisions of **this Article**;

c. Acknowledges that the provisions of **this Article** are express conditions to his application for staff membership, continuation of such membership, and to his exercise of clinical privileges.

15.2 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner, including applicants, Medical Staff Members or AHPS, submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential, shall not be disseminated, and not be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

15.3 LIMIT ON LIABILITY FOR PERSONS WHO PARTICIPATE IN REVIEW ORGANIZATION FUNCTION

New Mexico statutes as well as Federal statutes and regulations provide certain protections for persons who participate in peer review and/or privileges actions. The primary statute is called the Review Organization Immunity Act, NMSA section 41.9-4. It establishes limitation on liability for persons performing duties, functions, or services as a member or review organization. The Review Organization Immunity Act includes duly appointed hospital committees assigned to evaluate quality of health care services and professional standards reviews. Federal regulations under HIPAA provide rules for disseminating patient information to hospital committees performing hospital operations, as well as provide limits on liability for persons involved therein.

15.4 ACTIVITIES AND INFORMATION COVERED

a. **Activities** - The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:

i. Application for appointment, clinical privileges, or specified services;

ii. Periodic reappraisals for reappointment, clinical privileges, or specified services;

iii. Corrective action;

iv. Hearings and appellate reviews;

v. Patient care evaluation;

vi. Utilization reviews; and

vii. Other Hospital, department, committee, or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

b. Information - The acts, communications, reports, recommendations, disclosures or other information referred to in **this Article**, may relate to a practitioner's/AHPs qualifications, clinical ability, judgment, character, physical and mental health emotional stability related to privileges requested/granted, professional ethics, or any other matter that might directly or indirectly affect patient care.

15.5 RELEASES

a. Each practitioner/AHP, upon request of the Hospital, shall execute general and specific releases in accordance with this Article, subject to such malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

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

15.6 ACTION IN GOOD FAITH

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

15.7 CUMULATIVE EFFECT

Provisions of these Bylaws and application forms relating to authorization, confidentiality or information and immunities from liability shall be in addition to other protection provided by law and not in limitations thereof, and in the event of conflict, the applicable law shall be controlling.

ARTICLE XVI GENERAL PROVISIONS

16.1 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner granted Clinical Privileges in the Hospital shall maintain in force professional liability insurance coverage through an insurance carrier authorized by the State of New Mexico. Such professional liability amounts shall be at a minimum: (1) if participating in the New Mexico Patient's Compensation Fund in an amount not less than $200,000 per occurrence and $600,000 in the aggregate or (2) if not participating in the New Mexico Patient's Compensation Fund, in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate with a carrier reasonably acceptable to the Hospital. All AHPs shall be required to carry malpractice coverage in an amount not less than $200,000 per occurrence and $600,000 in the aggregate with a carrier reasonably acceptable to the Hospital. He/she also shall be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

16.2 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointment, reappointment, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the Medical Executive Committee. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

16.3 CONSTRUCTION OF TERMS AND HEADINGS

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

16.4 TRANSMITTAL OF REPORTS

Unless otherwise specified, reports and other information that these Bylaws require to be transmitted to the Board shall be deemed so transmitted when delivered by the Chief of Staff, CEO or his/her designee.

16.5 BOARD ACTION

Unless otherwise specified in these Bylaws, whenever these Bylaws require or authorize action by the governing board, the action must be taken at a Board meeting. An expedited governing board approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met, pursuant to **Section 7.5** in these bylaws. A committee of the Board, consisting of at least two (2) voting members, to whom the Board has delegated the responsibility and authority to act, may take such action on Clinical Privileges.

16.6 COMMUNICATION WITH THE BOARD

The Chief of Staff representing the medical staff may directly communicate with the Chairperson of the Board. The Medical Staff has the right to propose adoption and amendment of Bylaws, Rules and Regulations and Associated Details directly to the Board pursuant to **Article XVII**.

16.7 HISTORY AND PHYSICALS

a. **General**

i. There must be a complete history and physical examination (H & P), and an update, as applicable, in the medical record of every patient (inpatient or outpatient) prior to surgery, or a procedure requiring anesthesia services, moderate or deep sedation procedures, except in emergencies.

ii. H&Ps may only be performed by physicians, oral maxillofacial surgeons, or other qualified licensed individuals authorized and licensed in accordance with New Mexico State law and hospital policy.

iii. The H&P may be handwritten or transcribed, but always must be placed within the patient's medical record within 24 hours of admission or registration or prior to procedure whichever occurs first as described below in *Timeframe for Completing and Updating H&Ps*. Documentation of "*See dictated H&P"* DOES NOT meet the intent of this requirement. In these instances, if the timeframes are met as defined below, a handwritten H&P containing all required elements would suffice.

b. **Responsibilities**

i. Privileges - H&Ps may only be performed by physicians, oral maxillofacial surgeons, or other qualified licensed individuals authorized and licensed in accordance with New Mexico State law and hospital policy. H&P updates may only be completed by a practitioner who has been granted privileges by the hospital to do so.

ii. Requirements for Non-Licensed Independent Practitioners

1) Such privileges granted to other licensed individuals who are not licensed independent practitioners may only be granted such privileges within State scope of practice laws and regulations.

2) The individual must function under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy, which is accountable for the patient's H&P.

3) H&Ps completed by Physician Assistants must be validated and countersigned by the supervising physician with appropriate privileges within seventy-two (72) hours.

c. **Time Frame for Completing and Updating** - A durable, legible copy of the H&P must be completed and recorded in the patient's medical record as follows:

i. Inpatients

1) H&P will be completed within **24 hours** after admission or prior to surgery or procedure requiring anesthesia, deep or moderate sedation, whichever occurs first; or

2) If using a H&P that was performed up to **30 calendar days** prior to admission, an update documenting any changes in the patient's condition is completed **24 hours** after the inpatient admission or registration, but prior to surgery or procedure requiring anesthesia, deep or moderate sedation, whichever occurs first.

3) H&P performed greater than **30 calendar days** prior to admission or procedure as described above ARE NOT ACCEPTABLE.

ii. Outpatients requiring H&P as required by the medical staff

1) H&Ps may be completed up to **30 calendar days** prior to outpatient procedure provided an update documenting any changes in the patient's condition is completed prior to surgery or procedure requiring anesthesia, deep or moderate sedation, whichever occurs first; and

2) The update occurs at the time of (day of) and prior to the outpatient procedure.

3) H&Ps performed greater than **30 calendar days** prior to procedure as described above ARE NOT ACCEPTABLE.

d. **Update Requirements**

i. The update must document the examination by an appropriate privileged practitioner of any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment.

ii. The update must be documented even if no changes have occurred with the patient's status. In this case the update should reflect the patient's H&P was reviewed, the patient was examined and no changes have occurred in the patient's conditions since the H&P was completed.

iii. The update must be on or attached to the H & P.

iv. Additionally, if the practitioner finds that the H&P that he/she is updating is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document in the medical record a new H&P within timeframes described in above *Timeframe for Completing and Updating H&Ps*.

e. **Cancelation/Delay of Procedures** - Elective inpatient or outpatient surgery/invasive procedures will be canceled or delayed until a complete history and physical examination is recorded in the medical record.

f. **Emergency Situations** - If an emergency situation exists and the history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure for which an H&P is required, the surgeon or proceduralist will document that such delay would be a threat to the patient's health.

g. **Dentists, Podiatrists, Maxillofacial Surgeons** – Dentists, podiatrists and maxillofacial surgeons shall be responsible for recording in the medical record a history and physical examination relative to the portion of the patient's history and physical which relates to their specialty and for which they have clinical privileges. Any medical problem present on admission or arising during the hospitalization of a dental or podiatric patient shall become the responsibility of a qualified physician.

h. **Content Requirements** - The content of the H&P may vary depending on the level of care, treatment or services provided. The content requirements for H&Ps will be defined in the Medical Staff Rules and Regulations.

16.8 CONFLICT RESOLUTION

a. **Board and MEC and/or Medical Staff**

i. Whenever the Board's there is a conflict between the Board and the MEC or the Board and the Medical Staff, a Joint Conference will be convened.

ii. The Joint Conference will consist of an equal numbers of Medical Staff, and Board members if the conflict is between the Board and the Medical Staff.

iii. If the conflict is between the Board and the MEC, the Joint Conference will consist of an equal number of MEC and Board members.

b. **MEC and Medical Staff** – Whenever there is a conflict between the MEC and the Medical Staff, including but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto affecting the elements required by the Joint Commission to be included in the Medical Staff Bylaws, the Medical Staff or MEC may request a Joint Conference consisting of the MEC and an equal number of Medical Staff members as selected by the Medical Staff. Board members may be invited to attend the Joint Conference, if agreed upon by the MEC and Medical Staff Members attending the Joint Conference.

c. **Conflict Management Process**

i. The involved parties will meet as early as possible to identify and clarify the conflict and attempt to resolve the issue through direct communication among the groups. Conflict management and resolution through direct communication will be an attempt to settle disputes by focusing on basic interests and then developing mutually satisfying options, while acknowledging the rights and responsibilities of the leadership groups involved.

ii. If direct communication and initial attempts to clarify the conflict do not provide resolution or when direct communication does not hold much promise or could potentially do more harm than good:

1) A facilitator may be utilized. The facilitator will work with the involved parties to manage and, when possible, resolve the conflict.

2) Designated individual(s) will gather additional information regarding the conflict to assist in seeking further clarification of the conflict.

16.9 SPECIAL CONSIDERATIONS FOR RESIDENTS OR FELLOWS IN TRAINING

a. Residents or fellows in training shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the appropriate medical department director in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows, including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must co-sign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

b. The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care, as well as work with the MEC to ensure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

ARTICLE XVII ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATIONS AND ASSOCIATED DETAILS

17.1 MEDICAL STAFF BYLAWS

a. **Development** - The medical staff shall have the initial responsibility to formulate, adopt and recommend to the Board, Medical Staff Bylaws, and amendments which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely, and responsible manner, in the interest of providing patient care of the generally recognized professional level of quality, safety and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community.

b. **Adoption, Amendment & Review**

i. When necessary, the Bylaws will be revised to reflect changes in regulatory requirements, Hospital policies, and current practices with respect to Medical Staff organization and functions.

ii. These Bylaws will be reviewed periodically, but at least every **three (3)years**.

iii. Neither the Medical Staff, MEC nor the Board may unilaterally amend the Medical Staff Bylaws.

iv. Adoption or amendment may not be delegated to the MEC by the Medical Staff. The Medical Staff must be included in the process pursuant to **this Section**.

c. **Medical Staff**

i. The Medical Staff Bylaws may be amended, adopted, or repealed by a majority vote of the medical staff at a meeting where a quorum is present. The medical staff must be given **five (5) business days** written notice of the proposed Bylaws changes. Any action with respect to Medical Staff Bylaws requires the approval of the Board.

ii. The voting members of Medical Staff have the right to adopt or amend the Bylaws and propose them directly to the Board. Proposals directly to the Board must first be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process pursuant to **Section 16.8** may be implemented.

d. **Board** - The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a majority of the Board. Should the medical staff fail to exercise its responsibility and authority as required and after notice to the medical staff and a reasonable response time, the Board may resort to its own initiative in formulating or amending medical staff Bylaws. In such event, the Board shall take staff recommendations and views into account during its deliberations. If necessary, the conflict resolution process will be initiated.

17.2 MEDICAL STAFF RULES AND REGULATIONS

a. **Adoption, Amendment and Medical Staff Action**

i. Subject to the approval of the Board, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as to the level of practice that is to be required of each practitioner or AHP in the Hospital.

ii. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed, without previous notice, at any regular meeting at which a quorum is present, or with prior notice at any special meeting by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

iii. The voting members of Medical Staff have the right to adopt or amend the Rules and Regulations and propose them directly to the Board. Proposals directly to the Board must first be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process pursuant to **Section 16.8** may be implemented.

iii. The Medical Staff Rules and Regulations cannot be unilaterally amended by the Medical Staff, MEC or the Board.

b. **Review -** The Medical Staff Rules and Regulations shall be reviewed periodically, but at least every **three (3) years**, and shall be revised as necessary to reflect changes in regulatory requirements, Hospital policies, and current practices with respect to Medical Staff organization and functions.

c. **Urgent Amendments** – The Medical Staff delegates authority for making provisional amendments to the Rules and Regulations in cases when a documented need is urgently needed to comply with law and regulation to the MEC without prior notification of the Medical Staff. In such cases, the Board may provisionally approve the urgent amendment. The Medical Staff has the right to retrospectively review and comment on the provisional amendment. The Medical Staff Office will provide notification to the Medical Staff of the urgent amendment within **5 business day**s of the urgent provisional amendment being approved by the Board. If there is a conflict between the organized medical staff and the MEC amendment, the process for resolving conflict will be implemented. If necessary, a revised amendment may be made only if the revision is consistent with law and regulation and is collaboratively made by the MEC and the Medical Staff. The revised amendment, consistent with law and regulation shall thereafter proceed as provided herein for adoption and amendment of the Rules and Regulations.

d. **Board** - The Rules and Regulations and amendments thereto shall be effective when approved by the Board.

17.2.1 DEPARTMENTAL RULES AND REGULATIONS

a. Subject to the review of the Medical Executive Committee and approval by the Board, each department may formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall be consistent with these Bylaws, the general Rules and Regulations of the Medical Staff or other policies of the Hospital.

b. The voting members of Medical Staff have the right to adopt or amend Departmental Rules and Regulations and propose them directly to the Board. Proposals directly to the Board must first be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process pursuant to **Section 16.8** may be implemented.

c. Departmental Rules and Regulations shall be incorporated into the general Medical Staff Rules Regulations.

d. Departmental Rules and Regulations shall be reviewed periodically, but at least every **three (3) years.**

e. Adoption and amendments, review, and Board processes described in **Section 17.2** will apply to Departmental Rules and Regulations after a simple majority vote by voting members of the applicable Department. Urgent amendments may be made pursuant to **Section 17.2c.**

f. The Departmental Rules and Regulations cannot be unilaterally amended by the Medical Staff, MEC or the Board.

17.3 RELATED MEDICAL STAFF DOCUMENTS AND ASSOCIATED DETAILS OF THE BYLAWS

a. **What Constitutes Associated Details** – The Medical Staff shall formulate such policies and procedures which may provide associated details to Medical Staff Bylaws and Rules and Regulations as it may deem necessary for the proper execution of its functions, prerogatives, duties and responsibilities under these Bylaws. Associated details are those documents which may supplement the Medical Staff Bylaws and Rules and Regulations Such documents include any documents related to practitioner or AHP:

i. Credentialing or privileging process;

ii. Peer review, Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation or any other form of quality review or peer review processes;

iii. Health related issues impacting privileges performed and/or requested;

iv. Disruptive Behavior;

v. Management of conflict between medical staff members, MEC and/or Board

vi. Corrective Action, Grievance or Fair Hearing processes;

vii. Requests for New Procedures or Procedures Involving New Technologies;

viii. Hospital related clinical policies and procedures impacting care, treatment, services and privileges; and

ix. Any document the Board or MEC determines or requests fall within the scope of associated details.

b. **Where Associated Details Reside** - Associated details as indicated above, will reside as appropriate in the Emergency Operations Plan, on the on-line RMCHCS website under "Administrative Policies", "Medical Staff Policies" or other appropriate designated area.

c. **Adoption and Amendment of Associated Details**

i. The adoption of such documents which supplement the Bylaws is delegated to the MEC by the medical staff**.** Such documents will become effective upon approval by the Board. Associated details which are strictly clinical in nature may not require Board approval.

ii. The voting members of Medical Staff have the right to adopt or amend associated details of the Bylaws and propose them directly to the Board. Proposals directly to the Board must first be communicated to the MEC. If there is a conflict between the MEC and the Medical Staff the conflict resolution process pursuant to **Section 16.8** may be implemented.

17.4 SUSPENSION, SUPPLEMENTATION OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Medical Staff Bylaws or Medical Staff Rules and Regulations, including Department Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of care to patients. However, should the Board so suspend, override, supplement or replace such Bylaws or Rules and Regulations, it shall consult with the Medical Staff at the next regular Medical Staff meeting (or at a special called meeting as provided in these Bylaws), and shall thereafter proceed as provided in **Sections 17.1 – 17.3** for amendment and adoption of Bylaws and Rules and Regulations provisions.

17.5 DOCUMENTATION & DISTRIBUTION

a. Amendments to the Bylaws and Rules and Regulations and Associated Details approved as set forth herein shall be documented by either:

   i. Bylaws
      1) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board; or

      2) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board.

   ii. Rules and Regulations - Appending to the Rules and Regulations the approved amendment, this shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board.

   iii. Associated Details – Appending and or developing associated and the approved revisions, which will be dated, and signed by the Chief of Staff, the CEO and the Chairperson of the Board, with the exception of clinical related policies which will be signed by the applicable Administrator instead of the Chairperson of the Board.

b. Each Member of the Medical Staff and AHPs shall be given a copy of any amendments to these Bylaws and Rules and Regulations in a timely manner, if requested. Associated details will be communicated to the Medical Staff and AHPs through appropriate mechanisms identified by the Medical Staff Office.

CERTIFICATION OF ADOPTION AND APPROVAL

(Original signatures on file in the medical staff office)

APPROVED BY:

_____

Chief of Staff Date of Action

_____

Board Chairperson Date of Action

REVIEWED BY:

_____

CEO Date of Action

Date	Brief Summary of Revision(s) Made, When Applicable
1986	Original approved
1988	Retyped
1991	Retyped
May 1992	Reviewed and revised
May 1994	Reviewed and revised
May 1996	Reviewed and revised
January 1997	Retyped
August 1998	Reviewed and revised
May 2000	Reviewed and revised
January 2001	Retyped
May 2001	Reviewed and revised
September 2001	Reviewed and revised
September 2002	Reviewed and revised
May 2004	Reviewed and revised
October 2006	Reviewed and revised
January 2007	Reviewed and revised
April 2007	Reviewed and revised
July 2007	Reviewed and revised
August 2009	Reviewed and revised
July 2011	Comprehensive update. Revisions made to all Articles. New Articles added.
December 2013	Reviewed and revised
January 2014	Reviewed and revised