



Trinity Health Specialty Hospital – Grand Haven

MEDICAL STAFF BYLAWS

Part I: Governance

Approved May 2, 2024

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at Trinity Health Specialty Hospital – Grand Haven (THSH-GH) in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Hospital Board of Directors.

1.2 Authority

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies and under the corporate bylaws of Trinity Health-Michigan and the local Board charter of THSH-GH.

1.3 Definitions

“Advanced Practice Professional” or “APP” means those individuals eligible for Privileges but not Medical Staff Membership who provide a level of service including evaluation and treatment of patients, documentation in the medical record and prescribing of medications, as applicable in accordance with their scope of practice. APP categories are listed in the Organization and Functions Manual which is part of the Rules and Regulations.

“Adverse Recommendation” means a recommendation to limit, restrict, or terminate Membership or Privileges due to a reason related to professional competence or conduct.

“Affected Individual” means a physician, dentist or podiatrist who holds or is an applicant for Membership or Privileges against whom an Adverse Recommendation has been made that may entitle such individual to the fair hearing rights described in Part II.

“Hospital President” or “President” is the individual appointed by the Board of Directors to serve as the Board’s representative in the overall administration of the Hospital. The term Hospital President includes a representative appointed by the President who may, consistent with his or her authority granted by the Hospital Bylaws, perform certain administrative duties identified in these Bylaws, as well as a duly appointed acting administrator serving when the Hospital President is away from the Hospital.

“Chief Medical Officer” or “CMO” is the individual appointed by the Hospital President to serve as a liaison between administration and the Medical Staff. This term is meant to include Chief Clinical Officers and, unless otherwise specified, is inclusive for the purposes of this document of both Hospital level and regional positions. If there is no CMO, the Hospital President shall serve in their stead. CMO may also serve as the Chief of Staff.

“Clinical Assistant” means those individuals eligible for Privileges but not Medical Staff Membership or APP status who provide a limited scope of activity that require them to be privileged. Clinical Assistant categories are listed in the Organization and Functions Manual which is part of the Rules and Regulations.

“Clinical Privileges” or “Privileges” means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services with the Hospital.

“Days” shall mean calendar days unless otherwise stipulated in the *Medical Staff Bylaws*.

“Dentist” means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Michigan.

“Executive Committee” and “Medical Executive Committee” shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the *Medical Staff Bylaws*.

“Good Standing” means having no adverse actions, limitations, or restriction on Privileges or Medical Staff Membership at the time of inquiry based on professional competence or conduct.

“Governing Body”, “Board of Directors” or “Board” means the Trinity Health Specialty Hospital – Grand Haven Board and its committees.

“Hearing Committee” means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these *Medical Staff Bylaws*.

“THM Hospital” means any Trinity Health-Michigan Hospital.

“Hospital” means Trinity Health Specialty Hospital – Grand Haven and includes any associated ambulatory facility under the hospital’s license.

“Hospital Bylaws” mean those corporate bylaws established by the Board of Directors and the Board charter of THSH-GH.

"House Physicians" means a physician in good standing in a residency training or in a fellowship, who is under direct or indirect contract with the Hospital to provide specified limited services outside the scope of their residency or training program at the Hospital (e.g., moonlighters). House Physicians may provide services only within the scope of their clinical Privileges, and are not Members of the Medical Staff.

“Medical Staff or “Staff” means the physicians, dentists and podiatrists who are granted Privileges and admitted to the Medical Staff of the Hospital in accordance with these Bylaws..

“Medical Staff Bylaws” or “Bylaws” means these Bylaws covering the operations of the Medical Staff of THSH-GH.

“Medical Staff Rules and Regulations” means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

“Medical Staff Year” is defined as the 12-month time period beginning on January 1 of each year

and ending December 31.

“Meeting attendance” is defined as in person, secure videoconference, or telephonically from a private location.

“Member” is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been granted this status by the Board of Directors of THSH-GH.

“Oral and Maxillofacial Surgeon” means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery. The term “dentist” as used in these Bylaws includes oral surgeons.

“Physician” means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in Michigan.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Michigan.

“Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, Advanced Practice Professional, or Clinical Assistant who has been granted Membership and/or Clinical Privileges.

“Prerogative” means the rights, by virtue of Staff category or otherwise, granted to a Practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and Medical Staff or Hospital policies.

“Special Notice” means written notice sent via certified mail, return receipt requested, by overnight delivery with confirmation of delivery, or by in person delivery.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the Hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff Membership are delineated in Part III of these Bylaws (*Credentials Procedures Manual*).

2.3 Nondiscrimination

The Hospital shall not discriminate in granting Membership and/or Clinical Privileges on the basis of national origin, race, gender, gender identification, sexual orientation, religion, color, age, veteran status, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC), except for temporary, emergency and disaster Privileges. Appointment and reappointment to the Medical Staff shall be for no more than thirty-six (36) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff Membership and/or Clinical Privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or Privileges will be granted and administered as delineated in Part III (*Credentials Procedures Manual*) of these Bylaws and applicable Medical Staff and Hospital policies and procedures.

2.6 Medical Staff Members and Practitioner Responsibilities

2.6.1 Each staff Member and Practitioner must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a Member with similar Privileges at this Hospital that can care for the Member's patients when the Member is absent.

2.6.2 Each staff Member and Practitioner must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Intentionally omitted.

- 2.6.4 Each staff Member and Practitioner must submit to any pertinent type of health evaluation as requested by any of the Officers of the Medical Staff, CMO, or Hospital President if no CMO, and/or their Program Medical Director when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the Member's or Practitioner's ability to exercise Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician/Practitioner health or impairment.
- 2.6.5 Each staff Member and Practitioner must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital, including the Ethical and Religious Directives for Catholic Health Care Services.
- 2.6.6 Each staff Member and Practitioner must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff Members and Practitioners shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff Member and Practitioner, upon receipt or other knowledge of any and all malpractice claims or notices of intent to sue against the Member or Practitioner, shall notify the CMO, or Hospital President if no CMO, or designee, immediately, within seven (7) days.
- 2.6.7 Each applicant for Privileges, staff Member and Practitioner agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Member or Practitioner and his/her credentials.
- 2.6.8 Each staff Member and Practitioner shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Member or Practitioner provides care in the Hospital, or within its facilities, Sections, or Departments.
 - a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, podiatrist, nurse practitioner, nurse midwife, CRNA, PA, or other qualified licensed individual in accordance with State law and Hospital policy.
 - b. The content of complete and focused history and physical examinations is delineated in the rules and regulations or other Medical Staff or Hospital policy.

- 2.6.9 Each staff Member and Practitioner will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, for conducting authorized research activities, or for performing Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives prior to disclosure.
- 2.6.10 Each staff Member and Practitioner must participate in any type of clinical competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that Member's or Practitioner's Clinical Privileges.
- 2.6.11 Each Medical Staff Officer, MEC At-Large Member, Program Medical Director and other Medical Staff leader designated by the MEC shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital. Medical Staff leadership will deal with conflict of interest issues per the Trinity Health System and Hospital Conflict of Interest policies.
- 2.6.12 Each Member and Practitioner must report, in writing, to the Hospital Medical Staff Office any of the following circumstances as soon as possible but no later than 5 days after imposition:
- 2.6.12.1. Loss, limitation, reduction, suspension or termination of medical staff membership or clinical privileges at any health care organization or loss of employment for cause.
 - 2.6.12.2. Voluntary relinquishment of any medical staff membership or clinical privileges at any health care organization while under investigation or to avoid investigation or disciplinary action.
 - 2.6.12.3. Loss, limitation, reduction, suspension, probation, termination, lapse or relinquishment of medical licensure in any state.
 - 2.6.12.4. Any loss or cancellation of, or material change in, professional liability insurance under any circumstance.
 - 2.6.12.5. Any felony charge or other charge relating to or arising out of the practice of health care.
 - 2.6.12.6. Any misdemeanor or felony conviction, guilty plea, or no contest plea.
 - 2.6.12.7. Any imposition of sanctions by any health care insurer or the federal government.
- 2.6.13 Each Member and Practitioner must work cooperatively and harmoniously with the Board, administration, staff, patients and other Members and Practitioners so that the Hospital and Medical Staff can operate in an orderly, productive manner that promotes efficient, high quality patient care, supports patient safety and patient rights, complies with rules and policies and promotes the community's confidence in the Hospital and Medical Staff.

- 2.6.14 Acceptance of a unified medical staff. If the Board of Directors elects to have a unified medical staff, then the medical staff of each affected separately certified THM Hospital must vote, by majority, in accordance with their respective medical staff bylaws, whether to accept unification or to remain a separate medical staff. Each Active Member of the Hospital's Medical Staff will be eligible to vote on the proposed unification via printed or secure electronic ballot in a manner determined by the MEC. All Active Members of the Hospital's Medical Staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by Hospital's Medical Staff if the vote for the proposed unification amendment is taken at a meeting and receives a simple majority (fifty percent plus one) of those present and eligible to vote.
- 2.6.15 Opting out of a unified medical staff. Once there is a unified medical staff, the Active category Members at each affected THM Hospital in which the Members have clinical privileges have the ability to vote to "opt out" of the unified medical staff. This would require a petition signed by ten percent (10%), but not less than two (2), of the Members who would qualify for voting Privileges at that hospital. Upon presentation of such a petition, a medical staff meeting will be scheduled. Each Active category member who would qualify for voting privileges at that hospital will be eligible to vote on the proposed "opt out" proposal. Each Active category Member of the Medical Staff at each affected THM Hospital will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active category Members of each affected THM Hospital's Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by each affected THM Hospital's Medical Staff if the vote for the proposed unification amendment is taken at a meeting and receives a simple majority (fifty percent plus one) of those present and eligible to vote.

2.7 Medical Staff Member Rights

- 2.7.1 Each staff Member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such Member is unable to resolve a matter of concern after working with their Program Medical Director or other appropriate Medical Staff leader(s), that Member may, upon written notice, which may be mailed or delivered electronically, to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.
- 2.7.2 Each staff Member in the Active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Part I Section 4.7 of these Bylaws, regarding removal and resignation from office.
- 2.7.3 Each staff Member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the Members of the Active category. Upon presentation of such a petition, 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.

- 2.7.4 Each staff Member in the Active category may challenge any rule, regulation, or policy established by the MEC exempting those policies mandated by Trinity Health System, law, or regulatory standard. In the event that a rule, regulation, or policy is thought to be inappropriate, any Active Medical Staff Member may submit a petition signed by twenty percent (20%) of the Members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Part I Section 9.3 will be followed.
- 2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving 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. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.
- 2.7.7 Any individual eligible for Medical Staff appointment may have a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

2.8 Staff Dues

Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff Member to pay dues shall be considered a voluntary resignation from the Medical Staff.

2.9 Indemnification

- 2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the Hospital and Medical Staff.
- 2.9.2 Subject to applicable law and policy, the Hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff Member in connection with the defense of any pending or threatened action, suit, or proceeding to which he or she is made a party by reason of his or her having acted in an official capacity in good faith on behalf of the Hospital or Medical Staff. Official capacity for purposes of this provision means any instance wherein the Member is
- a) acting in their official capacity as an Officer of the Medical Staff; or
 - b) a duly appointed member of a Medical Staff committee; or
 - c) a member of a peer review investigatory process; or
 - d) requested by an Officer/Chair or duly charged member to:
 - i) participate in a peer review investigation;
 - ii) consult on a credentialing matter; or
 - iii) participate on an ad hoc or support basis to a Medical Staff committee.
- 2.9.3 However, no Member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Members of this category must satisfy one of the following (a. or b.):

- a. Has served on the Medical Staff for one (1) year and has either:
 - i. At least thirty (30) patient contacts per three (3) years (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, hospitalist, pathologist, radiologist, anesthesiologist, , **OR**
 - ii. Attended at least twenty (20) Medical Staff or Hospital meetings per three (3) years.
- b. Is appointed to a medical leadership role (i.e., Program Medical Director) or another key role identified and approved by the MEC at Hospital.

In the event that a Member of the Active category does not meet the qualifications for reappointment to the Active category, and if the Member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and the Hospital, the Member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff or committee meetings of which s/he is a member and any Medical Staff or Hospital education programs;
- b. Vote on all matters presented by the Medical Staff or committee(s) to which the Member is assigned; and
- c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities

Members of this category shall:

- a. Contribute to the organizational and administrative affairs of the Medical Staff;
- b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review; credentialing, risk, and utilization management; medical records completion and in the discharge of other staff functions as may be required; and
- c. Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

3.2 The Associate Category

3.2.1 Qualifications

The Associate category is reserved for Medical Staff Members with Privileges who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff or committee meetings of which s/he is a member and any Medical Staff or Hospital education programs;
- b. Not vote on matters presented by the entire Medical Staff or be an Officer of the Medical Staff; and
- c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities

Members of this category shall have the same responsibilities as Active Category Members.

3.3 Affiliate Category

3.3.1 Qualifications

The Affiliate category is reserved for Medical Staff Members who do not have Privileges and who do not meet the requirements for eligibility for the Active category.

3.3.2 Prerogatives

Members of this category may:

- a. Attend Medical Staff or committee meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Not vote on matters presented by the entire Medical Staff or be an Officer of the Medical Staff; and
- c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.3.3 Responsibilities

Members of this category shall have the same responsibilities as Active Category Members, with the exception of those responsibilities related to the possession of Clinical Privileges.

3.4 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. The rescission of Honorary Recognition or failure by MEC to recommend such recognition for an individual is not an Adverse Recommendation and shall not entitle the individual to a hearing or appeal as set forth in these Medical Staff bylaws. Practitioners granted Honorary Recognition shall be those Members who have retired from active hospital practice, who are of outstanding reputation, and who have provided distinguished service to the Hospital. They may attend Medical Staff meetings, continuing medical education activities, and may be appointed to committees. They shall not hold Clinical Privileges, pay dues, hold office or be eligible to vote on Medical Staff matters although they may vote on matters in committees to which they are assigned. Honorary recognition does not require recredentialing.

Section 4. Officers and At-Large Members of the Medical Staff

4.1 Officers and MEC At-Large Members

4.1.1 Officers of the Medical Staff.

- a. Chief of Staff (COS)
- b. Vice Chief of Staff
- c. Immediate Past COS

4.1.2 Program Medical Directors. Each Program Medical Director.

4.2 Qualifications of Officers and MEC At-Large Members

4.2.1 Officers must meet the following qualifications:

- a. COS and Vice Chief of Staff must be members in Good Standing of the Active category, preferably for at least five (5) years; indicate a willingness and ability to serve; have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges; have previous leadership experience either as a Program Medical Director, or membership on a committee; and be in compliance with the professional conduct policies of the Hospital. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.
- b. Immediate Past COS shall be the individual who served as COS during the term immediately preceding the current term. The Immediate Past COS must be a Member in Good Standing, indicate a willingness and ability to serve, have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges, and be in compliance with the professional conduct policies of the Hospital. The Medical Staff Nominating Committee will have discretion to determine if the individual who served as COS during the preceding term meets the qualifying criteria.

4.2.2 Program Medical Director members must be members in Good Standing of the Active Category for at least three (3) years, indicate a willingness and ability to serve, have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges, and be in compliance with the professional conduct policies of the Hospital. Previous leadership is preferred, but not mandatory.

4.2.3 Officers, Program Medical Directors members may not simultaneously hold a leadership position (position on the MEC or Board) on another unaffiliated hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the Officer or MEC Program Medical Directors member being automatically removed from office.

4.3 Nominating Committee and Election of Officers and MEC Program Medical Director Members

4.3.1 The Nominating Committee shall consist of at least three (2) Active Members and the CMO/COS. The members of the Nominating Committee shall be recommended by the Chief of Staff and appointed by the MEC. The committee shall provide an annual slate of nominees for the elected Medical Staff positions.

- 4.3.2 The Nominating Committee shall nominate at least one (1) candidate MEC Program Medical Directors Nominations must be announced and the names of the nominees announced thirty (30) days prior to the election.
- 4.3.3 A petition signed by at least twenty percent (20%) of the Members of the Active staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office at least fifteen (15) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating Committee must determine if the candidate meets the qualifications in section 4.2 above before they can be placed on the ballot.
- 4.3.4 Ballots will be delivered electronically to all Active Members at least 14 days prior to the election. Elections shall take place by ballots cast by Active Medical Staff Members submitted on or before a date specified by MEC. The nominee(s) who receives a plurality of votes cast will be elected, as long as they receive at least one-third (1/3) of the votes cast. If no one receives at least one-third (1/3) of the votes cast, a run-off election will occur with the top three (3) vote receivers.
- 4.3.5 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position.

4.4 Term of Office

All Officers and MEC Program Medical Director members serve continuously, without defined term

4.5 Vacancies of Office

The MEC shall fill vacancies of office and MEC Program Medical Director positions via appointment during the Medical Staff year except the office of the Chief of Staff and Immediate Past COS. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term. If there is a vacancy in the office of the Immediate Past COS, such office shall remain vacant for the remainder of the term.

4.6 Duties of Officers

- 4.6.1 **Chief of Staff (COS):** The COS shall represent the interests of the Medical Staff to the MEC and the Board. The COS is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the Hospital. The COS, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority of the COS, or designee, are to:
- a. Call and preside at all general and special meetings of the Medical Staff;

- b. Serve as chair of the MEC and as ex officio member of all other Medical Staff standing committees without vote, and participate as invited by the CMO, or Hospital President if no CMO, or the Board on Hospital or Board committees;
 - c. Serve as the individual assigned the responsibility for the organization and conduct of the Hospital's medical staff;
 - d. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/Hospital policies;
 - e. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with Hospital administration, appoint Medical Staff Members to appropriate Hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; advise the chair of the Board regarding the appointment of Medical Staff Members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
 - f. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
 - g. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of Clinical Privileges, and corrective action with respect to Practitioners who are applying for appointment or Privileges, or who are granted Privileges or providing services in the Hospital;
 - h. Continuously evaluate and periodically report to the Hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;
 - i. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Members on the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community the Hospital serves;
 - j. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, and the Board;
 - k. Attend Board meetings and Board committee meetings as invited by the Board;
 - l. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and
 - m. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.
- 4.6.2 **Vice Chief of Staff:** In the absence of the COS, the Vice Chief of Staff shall assume all the duties and have the authority of the COS. S/he shall perform such further duties to assist the COS as the COS may request from time to time.
- 4.6.3 **Immediate Past Chief of Staff:** This Officer will serve as a consultant to the COS and Vice Chief of Staff. The Immediate Past Chief of Staff shall serve on the MEC for two years.
- 4.6.4 **MEC Program Medical Directors:** 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.

4.7 Removal and Resignation from Office

- 4.7.1 **Removal by Vote of the Medical Staff:** Criteria for removal are failure to meet the responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff or Hospital, or conduct or statements that damage the Hospital, its goals, or programs. The Medical Staff may initiate the removal of any Officer or MEC Program Medical Directors member if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those Active staff Members casting ballot/electronic votes.
- 4.7.2 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications, as noted in Section 4.2.1, for being an Officer or MEC Program Medical Director member. This removal is not discretionary and is effectuated by the COS.
- 4.7.3 **Resignation:** Any elected Officer or MEC Program Medical Director member may resign at any time by giving thirty (30) days' written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

- 5.1.1 The Medical Staff shall not be organized into Departments. The medical staff will act as a unified single unit under MEC.

Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The COS may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

- a. **Composition - voting:** The MEC shall be a standing committee consisting of the following voting members: COS, VCOS, PCOS and Program Medical Directors.
- b. **Composition – nonvoting:** The non-voting attendees to the MEC shall consist of the Hospital President, THGH Chief Medical Officer (CMO), the Chief Quality Officer (CQO), the Chief Nursing Officer (CNO).
- c. **Removal from MEC:** Any individual serving on the MEC ex officio who is removed from that position (e.g., a Medical Staff Officer, MEC Program Medical Director removed from such position in accordance with Section 4.7 and/or Section 5.2 above) will automatically lose their membership on the MEC.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

- a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, Medical Staff category, Clinical Privileges, and corrective action;
- d. Report to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;
- e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of Practitioners including educational efforts and investigations when warranted;

- f. Make recommendations to the Board on medical administrative and, as requested, on Hospital management matters;
 - g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;
 - h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
 - i. Review and act on reports from Medical Staff committees and other assigned activity groups;
 - j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures, including but not limited to rules, policies and procedures containing details associated with requirements outlined in these Bylaws;
 - k. Request evaluations of Practitioners privileged through the Medical Staff process when there is question about an applicant or Practitioner's ability to perform Privileges requested or currently granted;
 - l. Make recommendations 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 for physician, dentists and podiatrists, and other procedures for APPs, and Clinical Assistants;
 - m. Consult with administration on the quality, timeliness, and quality metrics of contracts for patient care services provided to the Hospital by entities outside the Hospital;
 - n. Assist with that portion of the corporate compliance plan that pertains to the Medical Staff;
 - o. Hold Medical Staff leaders and committees accountable for fulfilling their duties and responsibilities;
 - p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws; and
 - q. Act for the organized Medical Staff between meetings of the organized Medical Staff.
- 6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Records of its proceedings and actions shall be maintained in accordance with Hospital's record retention policies.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

- 7.1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff Members.
- 7.1.2 The action of a majority of the Active Members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these Bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each Member eligible to vote, in person, via telephone, and/or by mail or Internet and by recording their vote in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the Active Member votes cast.
- 7.1.3 Special Meetings of the Medical Staff
 - a. The COS may call a special meeting of the Medical Staff at any time. The COS must call a special meeting if so directed by resolution of the MEC, the Board, or by a petition signed by twenty percent (20%) of the Active Medical Staff. Such request or resolution shall state the purpose of the meeting. The COS shall designate the time and place of any special meeting.
 - b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Committees shall meet at least annually, unless otherwise stipulated in these Bylaws and Regulations. Attendance at meeting may be by physical presence or by secure videoconferencing. Telephonic participation is permitted when confidential items are discussed only when confidentiality is assured.

7.3 Special Meetings of Committees

A special meeting of any committee may be called by the committee chair or by the COS.

7.4 Quorum

- 7.4.1 Medical Staff Meetings: Those present (in person, or via video/telephonically) and eligible Active Medical Staff Members voting on an issue.
- 7.4.2 MEC, Credentials Committee, and Practitioner Excellence Committee: When dealing with Category 1 requests for routine appointment, reappointment, and Clinical Privileges the MEC quorum will consist of at least two (2) members. When dealing with Category 1 requests for routine appointment, reappointment, and Clinical Privileges the Credentials Committee quorum will consist of the committee chair or designee. For all other matters, a quorum will exist when fifty percent (50%) of the members are present.

7.4.3 Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible members voting on an issue.

7.5 Attendance Requirements

7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

- a. MEC, Credentials Committee, and Practitioner Excellence Committee meetings: Members of these committees are expected to attend at least two-thirds (2/3rds) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee.
- b. Special meeting attendance requirements: Whenever there is a reason to believe that a Practitioner is not complying with Medical Staff or Hospital policies or has deviated from standard clinical or professional practice or there are other circumstance meriting review, the COS or committee chair may require the Practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such meeting may result in automatic suspension as provided in Part II, Section 3.1.8.
- c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of Clinical Privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the Hospital President and the CMO

The Hospital President and the CMO, or their designees, may attend any general or committee meetings of the Medical Staff as an ex-officio member without vote.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee not less than three (3) days before the time of such meeting, unless otherwise deemed necessary, by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee

Only items noted on the agenda, posted 3 days in advance of the regularly scheduled meeting, may be voted upon at the meeting. However, in the event of an emergent issue where it is not possible to provide 3 days notice, as determined by the chair of the meeting, the emergent issue may be added to the agenda without advance notice. The recommendation of a majority of its members who are eligible to vote and present at a meeting at which a quorum is present shall be the action of a committee. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.10 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or another designated committee. A file of the minutes of each meeting shall be maintained in accordance with document retention procedures.

Section 8. Conflict Resolution

8.1 Conflict Resolution

- 8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.
- 8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, Hospital President, or the COS may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.
- 8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.5 of Part I of these Bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

- 9.1.1 The Medical Staff shall have the responsibility to formulate, review at least triennially, and recommend to the Board any Medical Staff Bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws and rules & regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its Membership.
- 9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

- 9.2.1 Proposed amendments to these Bylaws may be originated by the MEC or by a petition signed by twenty percent (20%) of the Members of the Active category.
- Each Active Member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active Members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes.
- Except as otherwise provided in Section 9.3.6, the amendment shall be considered approved by the Medical Staff when the amendment receives a simple majority (fifty percent plus one) marked “yes” of the Active Members voting.
- Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, and Policies

- 9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
- 9.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.
- 9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.
- 9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the Active category using the Conflict Resolution Mechanism noted in Part I Section 8.1.3. Upon presentation of such petition, the adoption process outlined in Part I Section 9.2.1 above for vote by the Active Members of the Medical Staff will be followed.

- 9.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC shall immediately inform the Medical Staff after provisional adoption. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action. During the pendency of the conflict resolution process, the provisional amendment shall continue to be effective.
- 9.3.6 The MEC may adopt such amendments to these Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or nonsubstantive legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations.



Trinity Health Specialty Hospital – Grand Haven

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Approved May 2, 2024

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Section 1. Educational and/or Informal Proceedings

1.1 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and Hospital management to use progressive steps, where appropriate, beginning with education and other remedial monitoring 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 resolve questions that have been raised. All educational 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. Educational intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. Educational intervention efforts may include but are not limited to the following:

- a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Following up on any questions or concerns raised about the clinical practice and/or conduct of Practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- c. Sharing summaries of comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following educational intervention efforts, the applicable Medical Staff leaders and/or Hospital management representative shall evaluate the appropriate next steps, if any, for the Practitioner. Educational intervention is a discretionary process and is not intended to prohibit or restrict other options, including peer review and/or disciplinary action or intervention. When any observations arise before, during or after educational intervention suggesting opportunities for a Practitioner to improve their clinical skills or professional behavior, 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. If, at any point before, during or after educational intervention efforts, it appears that corrective action is merited or that other intervention described in these Bylaws or in Medical Staff or Hospital policies is more appropriate, such action may be implemented in accordance with Section 2.

Section 2. Corrective Action and Investigations

2.1 Initiation of Corrective Action

Any of the Medical Staff Officers, standing committee chairs, Hospital President, Program Medical Directors, CMO, or the Board may initiate a request for corrective action with respect to a Practitioner based on reasonable grounds including, but not limited to, any of the following:

- 2.1.1 It appears the Practitioner no longer possesses the qualifications for Medical Staff Membership or for the Clinical Privileges held.
- 2.1.2 Personal activity, professional conduct, or clinical practice that is, or is likely to be, detrimental to patient safety or to delivery of patient care, or disruptive to Hospital operations.
- 2.1.3 Unethical professional practice in or outside of the Hospital.
- 2.1.4 Conduct that constitutes sexual harassment or morally offensive conduct toward any Medical Staff Member, APP, Clinical Assistant, Hospital personnel, patient, or Hospital visitor.
- 2.1.5 Violation of these Bylaws or the rules and regulations or other Hospital and Medical Staff policies and procedures.
- 2.1.6 Conduct that indicates unwillingness or inability to work harmoniously with Medical Staff Members, APPs, Clinical Assistants, Hospital personnel, or patients.

The request must be in writing and supported by references to the specific activities or conduct that are of concern. Upon receipt of a request for corrective action, the MEC may, in its discretion, elect to conduct an investigation in accordance with Section 2.2 below, or may determine that an investigation is unnecessary and take action on the request. If the MEC itself initiates corrective action, it shall appropriately document its reasons.

2.2 Investigation

If, after a request for corrective action, the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution.

The MEC shall assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

The committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant, consistent with Section 2.2.1 below, if it deems a consultant is necessary and such action is approved by the MEC and the CMO. The investigating committee may also require the Practitioner under investigation to undergo a physical and/or mental examination and may access the results of such exams. The investigating committee may, in its discretion, provide to the Practitioner an opportunity to provide information in a manner and upon such terms as the investigating committee deems appropriate. Any such meeting between the Practitioner in question and the investigating committee (and meetings with any other individuals the investigating committee chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to such a meeting, nor to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation.

Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, taking action on the correction action request, as provided in Section 2.3, or other action. The MEC may also direct the investigating committee to interview individuals, compile reports or other documents, investigate other issues, or provide additional information. The MEC will evaluate the report generated by the investigating committee and take prompt action after the conclusion of the investigation.

2.2.1 An external peer review consultant may be considered when:

- a. The Hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances, consideration may be given by the MEC or the Board to retain an objective external reviewer;
- b. There is no one on the Medical Staff with expertise in the subject under review;
- c. The only Members on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the Practitioner under review.

2.3 MEC Action

As soon as practical after receiving the corrective action request or, if an investigation was performed, after receipt of the investigating committee’s report, the MEC shall act on the request. The MEC’s response to a corrective action request may include, without limitation:

- a. Determining no corrective action is warranted and, if the MEC determines there was not credible evidence for the investigation in the first instance, removing any adverse information from the Practitioner’s file;
- b. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Program Medical Directors from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in the Practitioner’s file;
- c. Recommending completion of one or more training or other educational courses;

- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring with or without limiting privileges;
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of Clinical Privileges;
- f. Recommending reductions of Membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff Membership;
- h. Requiring the Practitioner to undergo a physical and/or mental examination and provide access to the results of such exams; or
- i. Taking other actions deemed appropriate under the circumstances.

In addition to considering and acting upon recommendations of the MEC regarding corrective action, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Practitioner subject to the Practitioner's right, if applicable, to hearing or review.

2.4 Subsequent Action

All MEC actions relating to a corrective action request shall be reported promptly to the Board. If the MEC recommends any of the actions triggering a fair hearing and appeal right for a physician, dentist or podiatrist under Section 4.1 or other due process procedures for other Practitioners under Section 7.7, the Board will not act on the recommendation until the affected Practitioner has either waived or completed a hearing. The Board may then adopt, modify, or reject the MEC's recommendation.

Section 3. Corrective Action

3.1 Automatic Suspension and/or Relinquishment

In the following triggering circumstances, which are not based on professional competence or conduct, the Practitioner's Privileges and/or Membership (if applicable) will be considered suspended, or relinquished, or limited as described. The action shall be final without a right to hearing and generally does not constitute a reportable event. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand unless the MEC determines it is not applicable. The MEC will evaluate the circumstances, and make such a determination as soon as feasible. The COS, with the approval of the CMO, may reinstate the Practitioner's Privileges or Membership (as applicable) after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days of such circumstance, the Practitioner will have to reapply for Membership (if applicable) and/or Privileges as a new applicant. In addition to triggering automatic suspension and/or relinquishment/voluntary resignation further corrective action may be recommended in accordance with these Bylaws whenever any of the following circumstances occur:

3.1.1 Licensure

- a. **Revocation and suspension:** Whenever a Practitioner's license or other legal credential authorizing practice in this 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 license or other legal credential authorizing practice in this 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 is placed on probation by the applicable licensing or certifying authority, his or her Membership status and/or 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.

- 3.1.2 **Medicare, Medicaid, Tricare or other federal programs:** Whenever a Practitioner is excluded, precluded, or barred from participation in 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 the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her Membership and/or Privileges.

3.1.3 **Controlled Substances**

- a. **DEA Certificate or Michigan CSR:** Whenever a Practitioner's United States Drug Enforcement Agency (DEA) certificate or Michigan Controlled Substance Registration (CSR) 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.
- b. **Probation:** Whenever a Practitioner's DEA certificate or Michigan Controlled Substance Registration (CSR) 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.

3.1.4 **Medical Record Completion Requirements:** A Practitioner will be considered to have their Privileges to admit new patients or schedule new procedures voluntarily suspended whenever they fail to complete medical records within time frames established by the MEC. The suspended Privileges will be automatically restored upon completion of the medical records and compliance with medical records policies. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation of Privileges and Membership on the Medical Staff.

3.1.5 **Professional Liability Insurance:** Failure of a Practitioner to maintain professional liability insurance of the type and in the amount required by state regulations and the Board policies and sufficient to cover the Clinical Privileges granted shall result in immediate automatic suspension of a Practitioner's Clinical Privileges. If within sixty (60) calendar days of the suspension the Practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the Practitioner shall be considered to have voluntarily resigned their Privileges and Membership on the Medical Staff. The Practitioner must notify the Medical Staff office immediately, within twenty-four (24) hours, of any change in professional liability insurance carrier or coverage.

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic suspension of a Practitioner's appointment and Privileges. If within the time period set by the MEC in Medical Staff policy after written warning of the delinquency the Practitioner does not remit such payments, the Practitioner shall be considered to have voluntarily resigned Membership and Privileges on the Medical Staff.

3.1.7 **Felony Convictions:**

- a. A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to any of the following: death or injury of another person, insurance or healthcare fraud or abuse, violence, abuse (physical, sexual, child, or elder) in any jurisdiction shall automatically relinquish Medical Staff Membership and Privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed.
- b. Except as provided in 3.1.7.a, a practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to alcohol, controlled substances or illegal drugs, in any jurisdiction shall automatically relinquish Medical Staff Membership and Privileges. Such relinquishment shall become effective immediately upon such 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. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

- 3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A Practitioner who fails without good cause to appear at a meeting where their special appearance is required in accordance with these Bylaws shall be considered to have all Clinical Privileges automatically suspended with the exception of emergencies and imminent deliveries. These Privileges will be restored when the Practitioner complies with the special appearance requirement, subject to the reapplication requirements in Section 3.1. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation of Privileges and Membership on the Medical Staff.
- 3.1.9 **Failure to Participate in an Evaluation:** A Practitioner who fails to participate in an evaluation of their 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) and fails to authorize the release of this information to the MEC, shall be considered to have all Privileges automatically suspended. These Privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation of Privileges and Membership on the Medical Staff.
- 3.1.10 **Failure to Fulfill Mandatory Health Requirements:** A Practitioner who fails to be compliant with the Trinity Hospital policy on required testing (i.e., Tb testing) or required vaccinations/immunizations shall be automatically suspended until compliance is noted. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation of Privileges and Membership on the Medical Staff.
- 3.1.11 **Failure to Become Board Certified:** A Practitioner who fails to become board certified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and Clinical Privileges.
- 3.1.12 **Failure to Maintain Board Certification:** A Practitioner who fails to maintain their board certification in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and Clinical Privileges unless an exception is granted in accordance with Medical Staff policy.
- 3.1.13 **Failure to Execute Release and/or Provide Documents:** A Practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the COS or designee to evaluate the competency and credentialing/privileging qualifications of the Practitioner shall be considered to have all Privileges automatically suspended. If the release is executed and/or documents provided within sixty (60) calendar days of notice of the automatic suspension, the Practitioner may be reinstated. After sixty (60) calendar days, the Member will be deemed to have resigned voluntarily their Privileges and Membership on the Medical Staff and must reapply for Staff Membership and Privileges as a new applicant.

- 3.1.14 **Summary Suspension at a THM Hospital:** If a Medical Staff Member's delineated clinical privileges are summarily suspended or summarily restricted at a THM Hospital, the Member's delineated Clinical Privileges at this Hospital shall automatically be subject to the same restriction or suspension at such time as the summary suspension or restriction is affirmed by the MEC at the THM Hospital. If the summary suspension or restriction is lifted at the THM Hospital, the summary suspension or restriction is automatically lifted at this Hospital as well, subject to the Medical Staff's/Hospital's right to take any appropriate action provided for in these Bylaws.
- 3.1.15 **Other Adverse Action at a THM Hospital:** If a Medical Staff Member's medical staff membership or delineated clinical privileges at another THM Hospital is/are involuntarily terminated, restricted, or subject to conditions, the Medical Staff member's status at this Hospital shall automatically be subject to the same action or restrictions at such time as the final adverse decision of the Board at the other THM Hospital is made. This Section shall not be triggered by automatic or administrative action at another THM Hospital.
- 3.1.16 **Loss of supervising/collaborating Member for Advanced Practice Professionals or Clinical Assistants:** If an APP or Clinical Assistant loses their relationship with a supervising/collaborating Member on Staff at this Hospital for any reason or the supervising/collaborating Member will no longer supervise the full scope of the APPs, or Clinical Assistant's Privileges for any reason, then the APP or Clinical Assistant is automatically suspended until the APP or Clinical Assistant develops a new supervision/collaboration relationship with another Member of the Medical Staff. If another supervising/collaborating relationship is not developed within sixty (60) days, then the APP or Clinical Assistant shall be deemed to have automatically relinquished their Privileges.
- 3.1.17 **Leave of Absence:** Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation of Membership and Privileges. A request for Medical Staff Membership or Privileges subsequently received from a Member or Practitioner whose Membership and Privileges were terminated under this Section shall be submitted and processed in the manner specified for applications for initial applicants.
- 3.1.18 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

3.2 Summary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CMO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient, employee or staff safety or the effective operation of the Hospital. Under such circumstances any two individuals from the following (Medical Staff Officer, Program Medical Director, Hospital President, CMO, or administrator on call) may restrict or suspend the Medical Staff Membership or Clinical Privileges of such Practitioner. If there is a dispute over whether the Practitioner should be summarily suspended, a third individual from the above-named group shall make the decision. A suspension of all or any portion of a Practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the Practitioner's Clinical Privileges at this Hospital.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Practitioner, the MEC, the CMO, the Hospital President, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Medical Staff Member by the COS or designee, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute Practitioner.

3.2.2 **MEC Action:** As soon as feasible and within fourteen (14) calendar days after such summary restriction or suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the Practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the Practitioner with notice of its decision.

3.2.3 **Procedural Rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the physician, dentist or podiatrist with Membership or Privileges (or applicant for the above) may be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days. All summary actions shall be reported promptly to the Board. If the summary action entitles the physician, dentist or podiatrist to a fair hearing or entitles an APP or Clinical Assistant to the procedural rights afforded by the Part II, Section 7.7, the Board will not act on the action until such procedural right has been waived or completed. The Board may then adopt, modify, or reject the MEC's action.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any Affected Individual shall be entitled to request a hearing whenever an Adverse Recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following “Adverse Recommendations” when the basis for such action is related to clinical competence or professional conduct:

- a. Denial of Medical Staff appointment or reappointment;
- b. Revocation of Medical Staff appointment;
- c. Denial or restriction of requested Clinical Privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the Affected Individual’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;
- d. Involuntary reduction, limitation, or revocation of Clinical Privileges;
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an Affected Individual and is imposed for more than fourteen (14) calendar days; or
- f. Suspension of Medical Staff appointment or Clinical Privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the Affected Individual’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

- a. Issuance of a letter of guidance, warning, or reprimand;
- b. Imposition of a requirement for proctoring (i.e., observation of the physician, dentist, or podiatrist’s performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on Privileges;
- c. Failure to process a request for a Privilege when the physician, dentist, or podiatrist does not meet the eligibility criteria to hold that Privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these Bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or Privileges;
- g. Imposition of a suspension related to competence or conduct that does not exceed fourteen (14) calendar days;
- h. Denial of a request for leave of absence, or for an extension of a leave;
- i. Determination that an application is incomplete or untimely;
- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;

- l. Denial, termination, or limitation of temporary Privileges unless for demonstrated incompetence or unprofessional conduct;
- m. Determination that an applicant for Membership does not meet the requisite qualifications/criteria for Membership;
- n. Ineligibility to request Membership or Privileges or continue Privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of Privileges as a result of the termination of any contract with or employment by Hospital or termination of a contract with the entity that employed or contracted with the physician, dentist or podiatrist to provide services for or at Hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any accreditation standards on focused professional practice evaluation;
- r. Any recommendation voluntarily accepted by the Affected Individual waiving their right to a hearing;
- s. Expiration of Membership and Privileges as a result of failure to submit an application for reappointment within the allowable time period;
- t. Change in assigned Medical Staff category that is not related to professional competence or conduct;
- u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or Privileges after a final adverse decision at any THM Hospital regarding such request;
- v. Removal or limitations of emergency department call obligations;
- w. Any requirement to complete an educational assessment that does not limit Privileges for more than fourteen (14) days or is not based on professional competence or conduct;
- x. Retrospective chart review;
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;
- z. Grant of conditional appointment or appointment for a limited duration; or
- aa. Appointment or reappointment for duration of less than 36 months.

4.3 Notice of Adverse Recommendation

When a summary suspension lasts more than fourteen (14) calendar days or when an Adverse Recommendation is made which entitles an individual to request a hearing prior to a final decision of the Board, the Affected Individual shall promptly be given written notice by the CMO/Medical Staff Office delivered by Special Notice. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the individual shall have thirty (30) calendar days following the date of such Special Notice within which to request a hearing on the recommendation.

4.4 Request for Hearing

An Affected Individual shall have thirty (30) calendar days following the date of the Special Notice within which to request the hearing. The request shall be made in writing to the CMO/Medical Staff Office, or designee. In the event the Affected Individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action. The Affected Individual shall provide the name of their counsel, if known, in the request for hearing.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the Affected Individual's timely request for a hearing, the CMO, in conjunction with the COS, shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place, and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC (or the Board if the Board made the Adverse Recommendation) at the hearing;
- c. The names of the Hearing Committee members and Presiding Officer, if known; and
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or Clinical Privileges of the Affected Individual requesting the hearing, and that the Affected Individual and the Affected Individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Committee and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the Presiding Officer (or Hearing Committee chair), be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer (or Hearing Committee chair) shall have the authority to limit the number of witnesses.

Section 5. Hearing Committee and Presiding Officer (or Hearing Committee Chair)

5.1 Hearing Committee

- a. When a hearing is requested, a Hearing Committee of not fewer than three (3) individuals will be appointed. This panel will be appointed by the Chief of Staff/CMO and Hospital President. No individual appointed to the Hearing Committee shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Committee. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Committee. Hearing Committee members need not be Members of the Hospital Medical Staff but should be a member of a Trinity Health System hospital. When the issue before the panel is a question of clinical competence, all panel members shall be clinical providers. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- b. The Hearing Committee shall not include any individual who is in direct economic competition with the Affected Individual or any such individual who is in professional practice with or related to the Affected Individual. This restriction on appointment shall include any individual designated as the chair or the Presiding Officer (or Hearing Committee chair).
- c. The CMO/Medical Staff Office, or designee shall notify the Affected Individual requesting the hearing of the names of the panel members and the date by which the Affected Individual must object, if at all, to appointment of any member(s). Any objection to any member of the Hearing Committee or Presiding Officer (or Hearing Committee chair) shall be made in writing to the CMO/Medical Staff Office. The President/Chief of Staff, in conjunction with the CMO, shall determine whether a replacement panel member should be identified. Although the Affected Individual who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CMO.

5.2 Hearing Committee Chairperson or Presiding Officer

- 5.2.1 The CMO/COS, acting for the MEC (or Board, if the hearing is occasioned by a Board determination or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as Presiding Officer. The Presiding Officer should have no previous relationship with either the Hospital (other than in the capacity of a Presiding Officer), organized Medical Staff, or the Affected Individual. Such Presiding Officer will not act as a prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Committee and may serve as a legal advisor to it but shall not be entitled to vote on its recommendation.
- 5.2.2 If no Presiding Officer has been appointed, a chair of the Hearing Committee shall be appointed by the CMO to preside over the hearing and shall be entitled to one vote.
- 5.2.3 The Presiding Officer (or Hearing Committee chair) shall do the following:

- a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;
- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or Clinical Privileges of the Affected Individual requesting the hearing is considered by the Hearing Committee in formulating its recommendations;
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the Hearing Committee; and
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the Hospital may advise the Presiding Officer or Hearing Committee chair.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 The Hearing is not a court of law and Affected Individuals are not afforded the same rights as defendants in a civil or criminal matter. There is no right to formal “discovery” in connection with the hearing. The Presiding Officer or Hearing Committee chair shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the Affected Individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the Affected Individual’s counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the Affected Individual’s expense;
- b. Reports of experts relied upon by the MEC or Board;
- c. Copies of redacted relevant committee minutes;
- d. Copies of any other documents relied upon by the MEC or the Board;
- e. No information regarding other Affected Individuals shall be requested, provided, or considered; and
- f. Evidence unrelated to the reasons for the recommendation or to the Affected Individual’s qualifications for appointment or the relevant Clinical Privileges shall be excluded.

6.1.2 Prior to the hearing, on dates set by the Presiding Officer (or Hearing Committee chair) or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The Presiding Officer (or Hearing Committee chair) shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the Hospital’s witness list concerning the subject matter of the hearing; nor shall there be contact by the Hospital with individuals appearing on the affected individual’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or their counsel.

6.2 Pre-Hearing Conference

The Presiding Officer (or Hearing Committee chair) may require a representative for the Affected Individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer (or Hearing Committee chair) shall resolve all procedural questions including any objections to exhibits or witnesses, and determine the time to be allotted to each witness’s testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the Affected Individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the Presiding Officer or chair of the Hearing Committee.

6.4 Record of Hearing

The Hearing Committee shall maintain a record of the hearing by a court reporter present to make a record of the hearing or a recording of the proceedings. The cost of such court reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the Affected Individual requesting the hearing at the Affected Individual's expense. The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Michigan.

6.5 Rights of the Affected Individual and the Hospital

- 6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer (or Hearing Committee chair):
- a. To call and examine witnesses to the extent available;
 - b. To introduce exhibits;
 - c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
 - d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may not argue the case for their client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
 - e. To submit a written statement at the close of the hearing.
- 6.5.2 Any Affected Individuals requesting a hearing who do not testify on their own behalf may be called and examined as if under cross-examination.
- 6.5.3 The Hearing Committee may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC (or Board of Directors) to demonstrate that the action recommended is valid and appropriate. It is the burden of the Affected Individual under review to demonstrate by a preponderance of the evidence that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.8 Official Notice

The Presiding Officer (or Hearing Committee chair) shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.9 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the Presiding Officer (or Hearing Committee chair) or the Hospital President on a showing of good cause. The hearing shall not proceed unless all hearing panel members are present.

6.10 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the COS or CMO. All members of the Hearing Committee shall be present, absent good cause, for all stages of the hearing and deliberations.

6.11 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the Affected Individual who requested the hearing to present evidence.

6.12 Adjournment and Conclusion

The Presiding Officer (or Hearing Committee chair) may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the Hearing Committee, the hearing shall be closed.

6.13 Deliberations and Recommendation of the Hearing Committee

Within thirty (30) calendar days after final adjournment of the hearing, the Hearing Committee shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.14 Basis of Recommendation

The Hearing Committee shall recommend in favor of the MEC (or the Board) unless it finds that the Affected Individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

6.15 Disposition of Hearing Committee Report

The Hearing Committee shall deliver its report and recommendation to the CMO who shall forward it, along with all supporting documentation, to the MEC or, if the Board made the original recommendation, to the Board for further action. The CMO shall also send a copy of the report and recommendation, by Special Notice, to the individual who requested the hearing. The MEC or Board, as applicable, may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the Affected Individual, including a statement of the basis for its recommendation. If the final recommendation is an Adverse Recommendation, the Affected Individual shall have the right to appellate review as outlined in Section 7 below. If an appeal is not requested in accordance with Section 7, the Board shall render a final decision as provided in Section 7.1.

Section 7. Appeal to the Hospital Board and Final Decision

7.1 Time for Appeal

Within ten (10) calendar days after the final Adverse Recommendation, the Affected Individual subject to the hearing may appeal. The request for appellate review shall be in writing, and shall be delivered to the CMO/Medical Staff Office either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the Hearing Committee's report and recommendation shall be forwarded to the Board. If an appeal is not requested in accordance with Section 7, the Board shall render a final decision in writing within thirty (30) calendar days after receiving the final recommendation, including specific reasons for its action, and shall deliver copies thereof to the Affected Individual by Special Notice and notify the chairs of the Credentials Committee and MEC.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or
- b. The recommendation of the Hearing Committee was made arbitrarily, capriciously, or with prejudice; or
- c. The recommendation of the Hearing Committee was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The Affected Individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

- a. The Chair of the Board shall appoint a review panel composed of at least one (1) member of the Board to consider the information upon which the recommendation before the Board was made. Member(s) of this review panel may not be direct competitors of the Affected Individual under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the Hearing Committee. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Michigan.

- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty (30) minute oral argument. The review panel shall recommend final action to the Board.
- d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and Clinical Privileges.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the Affected Individual by Special Notice and notify the chairs of the Credentials Committee and MEC.

7.6 Right to One Appeal Only

No applicant or Medical Staff Member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges or to deny the application of an Affected Individual, that Affected Individual may not apply for Medical Staff appointment or for those Clinical Privileges at this or another THM Hospital unless the Board advises otherwise.

7.7 Fair hearing and appeal for APPs and Clinical Assistants

APPs and Clinical Assistants are not entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. In the event one of these APPs/Clinical Assistants is notified by Special Notice of a recommendation by the Medical Executive Committee described in Section 4.1 and based on professional competence or conduct, the APP/Clinical Assistant and their supervising Member, if applicable, shall have the right to meet personally with two Members and a peer assigned by the COS to discuss the recommendation. The APP/Clinical Assistant and the supervising Member, if applicable, must request such a meeting in writing to the Hospital President within ten (10) business days from the date of the Special Notice. At the meeting, the APP/Clinical Assistant and the supervising Member, if applicable, must be present to discuss, explain, or refute the recommendation but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected APP/Clinical Assistant and the MEC. The MEC shall make its recommendation, including any modifications to the review body's recommendations, to the Board.

The APP/Clinical Assistant and the supervising Member, if applicable, may request an appeal in writing to the Hospital President within ten (10) days of receipt of the findings of the review body, if such finding continue to be adverse to the APP/Clinical Assistant. At least one (1) member of the Board assigned by the chair of the Board shall hear the appeal from the APP/Clinical Assistant and the supervising Member. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The APP/Clinical Assistant and the supervising Member will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the APP/Clinical Assistant, they will not be allowed to reapply for Privileges.

7.8 Reporting Requirements

The CMO or their designee shall be responsible for assuring that the Hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's Privileges are limited, revoked, or in any way constrained, the Hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician, dentist or podiatrist (i.e., an action related to clinical incompetence or misconduct that adversely affects, or could affect, the health or welfare of a patient), which leads to a denial of appointment and/or reappointment; reduction in Clinical Privileges for greater than thirty (30) calendar days; resignation, surrender of Privileges, or acceptance of Privilege reduction either during an investigation or to avoid an investigation.



Trinity Health Specialty Hospital- Grand Haven

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Approved May 2, 2024

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Section 1. Medical Staff Credentials Committee

1.1 Composition

THSH-GH will participate in the unified credential committee with Trinity Health Muskegon.
THSH-GH will send one active category member to serve on this committee.

1.2 Responsibilities

See Integrated Credentialing below

Section 2. Qualifications for Membership and/or Privileges

- 2.1** No Practitioner shall be entitled to Membership on the Medical Staff or to Privileges merely by virtue of licensure, membership in any professional organization, affiliation with a Hospital contracted group, or privileges at any other healthcare organization.
- 2.2** The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or Clinical Privileges:
- 2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, advanced practice nursing, physician assistant program, dietetics, or applicable recognized course of training in a clinical profession eligible to hold Privileges;
 - 2.2.2 Demonstrate clinical performance consistent with the standards set by the medical staff, and current competence in the Privileges requested;
 - 2.2.3 Have a current valid state or federal license applicable to and/or required for their profession, and providing permission to practice within the state of Michigan. The license must be active and permit the Practitioner to practice within the scope of the Privileges being requested. The license must be unrestricted for initial appointment;
 - 2.2.4 Is free from current Medicare/Medicaid sanctions and is not on the OIG List of Excluded Individuals/Entities;
 - 2.2.5 Have a record that is free from involuntary termination or other adverse action at another THM Hospital or voluntary resignation or surrender of Privileges in lieu of such termination;
 - 2.2.6 Have appropriate written and verbal communication skills;
 - 2.2.7 Have appropriate personal qualifications, including consistent observance of ethical and professional standards. These standards include, at a minimum:
 - a. Abstinance from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
 - b. Demonstrated capacity for acting in a professional, appropriate, and collegial manner with others.
 - 2.2.8 For Privileged Practitioners, provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a Member with similar Privileges at this Hospital that can care for the Member's patients when the Member is absent;
 - 2.2.9 Must be board eligible or certified (and maintain such certification) in accordance with applicable policies and procedures;
 - 2.2.10 Demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all Privileges requested;
 - 2.2.11 Possess a current and valid drug enforcement administration (DEA) number if applicable. The DEA or Michigan Controlled Substance Registration (CSR) must be unrestricted for initial appointment;
 - 2.2.12 Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of their responsibilities of Medical Staff Membership and/or the specific Privileges requested by and granted to the applicant. This certification of physical and

mental health must be from a clinician acceptable to the Credentials Committee;

2.2.13 Provide evidence of professional liability insurance appropriate to all Privileges requested and of a type and in an amount established by the Board.

2.2.14 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony, relating to the death or injury of another person, insurance or health care fraud or abuse, violence, or abuse (physical, sexual, child or elder) in any jurisdiction; and

2.2.15 Have a record that shows the applicant has not been convicted of or entered a plea of guilty or not contest to any felony, relating to alcohol, controlled substances, illegal drugs in the past ten (10) years.

2.2.16 Possess a valid NPI number, if applicable;

2.3 The Hospital will also consider the needs of the Hospital and the community it serves, any relevant Hospital contractual obligations, and the availability at the Hospital of adequate facilities and resources to support each Privilege requested.

Section 3. Initial Appointment and Reappointment Procedure

3.1 INTEGRATED CREDENTIALING

3.1.1 Trinity Health Muskegon, Trinity Health Shelby Campus and Trinity Health Specialty Hospital – Grand Haven have integrated their credentialing procedures and will conduct integrated primary source verification as defined by the National Commission on Quality Assurance, American Osteopathic Association, and The Joint Commission, as well as integrated review of the application and supporting documents concerning the credentialing criteria set forth in these Bylaws. The integrated credentialing process is described in Sections 3.1 through 3.3 of these Bylaws.

3.1.2 Trinity Health Muskegon, Trinity Health Shelby Campus, Trinity Health Specialty Hospital – Grand Haven and the licensed health care professionals employed, credentialed/privileged, or retained by them constitute a single “review entity” for purposes of Michigan Public Act 270 of 1967. As a review entity, these organizations and their respective peer review committees (including the Credentials Committee) are charged with performing integrated credentialing as described in these Bylaws including review activities in support of one another.

3.1.3 Trinity Health Muskegon, Trinity Health Shelby Campus and Trinity Health Specialty Hospital – Grand Haven will review credentials jointly through the Credentials Committee, each reserving the right to approve the membership of the Credentials Committee. The Credentials Committee’s recommendation will be forwarded to the organizations to which the applicant has applied. Each organization’s respective governing body will make an independent determination of whether their respective organization will appoint/contract with an applicant.

3.2 INITIAL APPLICATION

3.2.1 Application Form. Each application for appointment to the Medical Staff shall be submitted in the format approved by the MEC and Board, and signed by the applicant. The application will elicit information relevant to the qualifications and criteria described in Section 2 above and Part 1, Section 2 shall indicate the Clinical Privileges requested, and shall include the applicant’s statement that no health problem exists that could affect the applicant’s ability to perform safely the Clinical Privileges requested.

3.2.2 Effect of an Application. Submission of an application for Medical Staff Membership constitutes the applicant’s agreement to be bound by the terms of these Bylaws if the applicant is granted Membership or Privileges, and by the terms of the Bylaws relating to consideration of the application (including Section 4.8) whether or not the applicant is granted Medical Staff Membership.

3.2.3 Applicant’s Responsibilities. The applicant is responsible for producing adequate information for a proper evaluation of their qualifications and for resolution of any doubts about their qualifications. The applicant shall notify the Medical Staff Office immediately in writing of any change to information contained in his application that occurs while their application is pending. The applicant may be required by the Credentials Committee, MEC or Board to appear for an interview regarding their application or related matters and/or to submit answers to written questions posed by those bodies.

3.2.4 Credentials Verification. An application is complete when the Hospital has received and verified all information specified in Medical Staff policy. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for Membership or Privileges, the

credentialing process will be terminated and no further action taken, without right to a fair hearing. After the Hospital has verified the applicant's credentials and identity and obtained written peer recommendations and a National Practitioner Data Bank report, the complete application shall be referred to the Department Chair in which the applicant seeks Medical Staff Membership and/or Clinical Privileges.

3.2.5 Material Omission or Misrepresentation. Any material omission or misrepresentation by an applicant in connection with their application shall be grounds for return of the application which shall be deemed a withdrawal of the application, with no right to any hearing described in Part II.

3.2.6 Chief of Staff Action. The COS shall review the applicant's qualifications. The COS may interview the applicant. The COS shall submit a written report and recommendation (as defined in Section 3.2.12) to the Credentials Committee.

3.2.7 Credentials Committee Action. The Credentials Committee shall review the applicant's qualifications. The Credentials Committee may also interview the applicant. The Credentials Committee shall submit its written report and recommendation, along with the Department Chair's report and recommendation, to the MEC.

3.2.8 MEC Action. Upon receipt of the report of the Credentials Committee, the MEC shall review the reports of the Credentials Committee and COS and other relevant information. The MEC shall submit its written report and recommendation to the Board. If the MEC disagrees with the recommendation of the Credentials Committee, the MEC shall also deliver to the Board a copy of the reports and recommendations of the Credentials Committee and the COS.

3.2.9 Board Action. The Board has final authority for all appointments to the Medical Staff and for granting Clinical Privileges. It is the Hospital's and Medical Staff's goal that applications typically be acted on by the Board within 60 days after the application is complete, recognizing however that a longer period may be needed in some cases, for example, to evaluate an applicant's credentials or to complete any applicable hearing process under Part II. Clinical Privileges are determined in accordance with Part III, Section 4. The Board shall either (1) adopt the recommendation of the MEC, or (2) refer it back to the MEC for further consideration with a statement of the reason(s) for such action. If an application is referred back, the MEC shall again make a written report and recommendation to the Board, which shall consider the recommendation before taking final action on the application.

3.2.10 Adverse Recommendations. If the MEC makes an Adverse Recommendation or the Board makes a preliminary adverse decision with respect to an application, a physician, dentist and podiatrist applicant may request a hearing to the extent available under Part 2, Section 4. If an applicant who is the subject of an adverse preliminary decision does not make a timely request for a hearing or is not entitled to a hearing, the application is considered to have been withdrawn and shall not receive further consideration. If a decision is unfavorable with respect to scope of Clinical Privileges only, an applicant who either does not timely request a hearing or is not entitled to a hearing, will be deemed to have requested only those Clinical Privileges the Board is willing to grant.

3.2.11 Reapplication. An individual whose application for Medical Staff Membership is deemed withdrawn pursuant to Section 3.2.5 or 3.2.10 or whose application is denied shall not be eligible to reapply to the Medical Staff for a period of three (3) years from the date of withdrawal or denial, as applicable, unless the Board specifies otherwise.

3.2.12 Reports and Recommendations. As used in this Section 3, “written report and recommendation” means a written recommendation regarding Medical Staff appointment and, if appointment is recommended, Staff category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment, with the reasons for any unfavorable recommendation stated in writing.

3.2.13 Expedited Credentialing. A completed Category 1 initial application, as defined in Medical Staff policy, may be processed in an expedited manner in accordance with Medical Staff policy, after review and action by the following: COS, credentials chair acting on behalf of the Credentials Committee, two (2) members of the MEC acting on behalf of the MEC as provided in Part I, Section 7.4.2, and a Board committee consisting of at least two (2) members.

3.3 PROCEDURE FOR REAPPOINTMENT

3.3.1 Reappointment Application. Each Member who desires reappointment to the Medical Staff shall submit a timely, signed and complete reappointment application to the Hospital in accordance with Medical Staff policy on a form approved by the MEC and Board. The application will indicate the Medical Staff category and Clinical Privileges requested. If a timely and complete reappointment application is not submitted, the Member’s Medical Staff Membership and Clinical Privileges will expire at the end of the current term of appointment. The reappointment application will require submission of information that will allow a determination of whether the Member meets the ongoing qualifications for Medical Staff Membership and for requested Clinical Privileges, including providing reasonable evidence of current ability to perform capably the Clinical Privileges requested and information concerning any changes in the Member’s qualifications since his last (re)appointment. A Member who does not comply with the Board Certification requirements stated in Section 2.2.9, if applicable, is not eligible for reappointment.

3.3.2 Reappointment Criteria. The reappointment process will include evaluation of:

- a. The Member’s professional performance and judgment.
- b. The Member’s current Clinical and technical skills and competence to perform the Clinical Privileges requested, as measured in part by the results of the Hospital’s performance improvement activities and ongoing professional practice evaluation, and as assessed by the COS
- c. Professional ethics and conduct, including compliance with the Bylaws and rules, and working relationships with others at the Hospital.
- d. Current appraisal of the Member’s physical and mental ability to perform the Privileges and practice quality patient care.
- e. Participation in continuing education.
- f. Compliance with activity requirements applicable to the Medical Staff category requested by the Member.
- g. All information supplied in the Member’s reappointment application.

3.3.3 Processing Reappointment Applications. Applications for reappointment shall be processed in the same manner as initial applications, using the procedures described in relevant portions of Section 3.2 of these Bylaws, except interviews of the applicant are not routinely required. The

consequences of failure to complete or follow Bylaw requirements during the reapplication process shall be identical to the consequences of failure to complete or follow requirements during initial application for Membership and Clinical Privileges.

3.3.4 MEC Input Required. The Board will not take action on an application for reappointment without first seeking the recommendation of the MEC with respect to the application.

3.3.5 Board Action. The Board shall take final action on applications for reappointment and renewal of Clinical Privileges, except that only short term actions to finalize the process will be taken with respect to any Member for whom an Adverse Recommendation or decision has been made who has not either waived or completed the fair hearing process provided for in Part II, if applicable.

3.3.6 Expedited Credentialing. A completed Category 1 reappointment, as defined in Medical Staff policy, may be processed in an expedited manner in accordance with Medical Staff policy, after review and action by the following: COS, credentials chair acting on behalf of the Credentials Committee, two (2) members of the MEC acting on behalf of the MEC as provided in Part I, Section 7.4.2, and a Board committee consisting of at least two (2) individuals.

Section 4. CLINICAL PRIVILEGES

4.1 DELINEATION OF CLINICAL PRIVILEGES

4.1.1 Clinical Privileges Are Required. Each Practitioner shall exercise only those Clinical Privileges granted to him/her by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 4.5 and 4.6.

4.1.2 Criteria. Requests for Clinical Privileges shall be evaluated on the basis of the factors and categories of information listed in Sections 2, 3.3.2 and Part I, Section 2. Privilege determinations shall take into account pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the Practitioner has exercised Clinical Privileges. The Practitioner has the burden of establishing his qualifications and competency in the Clinical Privileges he/she requests. The Clinical Privileges available within a department and the specific qualifications required for each Privilege shall be recommended by the COS and approved by the MEC and Board.

4.1.3 Dentists and Oral Surgeons. An oral surgery patient may be admitted by an Oral Surgeon Member who has admitting Clinical Privileges. A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a dental or oral surgery patient. In all cases, a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization and shall be identified in the medical record by the Oral Surgeon/Dentist at the time of admission.

4.1.4 Podiatrists. A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a podiatric patient. In all cases a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization and shall be identified in the medical record by the Podiatrist at the time of admission.

4.1.5 Non-Members. Clinical Privileges may be granted to Non-Members pursuant to Sections 4.4 and 4.6 and Section 5. Non-Members may not be granted admitting Clinical Privileges, except as otherwise permitted by Sections 4.4 and 4.6. A non-Member may participate in the care of patients, including performance of histories and physicals, only in accordance with the scope of Clinical Privileges granted to the non-Member.

4.2 PRIVILEGE MODIFICATION

4.2.1 Privilege Increase. A Member may request an increase in Clinical Privileges during the term of his appointment by submitting a written request in accordance with Medical Staff Policy. Any such request will be processed using substantially the same procedures as for a request for reappointment.

4.2.2 Privilege Decrease. A Member may request a decrease in Clinical Privileges during the term of his appointment by written request to the Credentials Committee. The Credentials Committee shall promptly notify the MEC and the Board of any Privilege reduction request that it approves.

4.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION AND ONGOING PROFESSIONAL PRACTICE EVALUATION

4.3.1 Focused Professional Practice Evaluation. Clinical Privileges granted to initial applicants and additional Clinical Privileges granted in connection with reappointment or a mid-appointment request for additional Clinical Privileges shall be subject to Focused Professional Practice Evaluation as provided in Medical Staff policy. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through OPPE or other processes.

4.3.2 Ongoing Professional Practice Evaluation. 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 maintain existing Privileges, to revise existing Privileges, or to revoke an existing Privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of Practitioner's current clinical competency.

4.4 TEMPORARY CLINICAL PRIVILEGES

4.4.1 Types of Temporary Clinical Privileges. Temporary Clinical Privileges may be granted in the following circumstances:

- a. Pendency of Application. An applicant with a complete application for Staff appointment (or, in the case of an applicant for APP, Clinical Assistant or House Physician status, a complete application for Clinical Privileges) may be granted temporary Clinical Privileges after a positive recommendation from the Credentials Committee/designee in accordance with Section 4.4.2 during the pendency of the application or for up to 120 calendar days, whichever is shorter. An applicant is eligible for temporary Clinical Privileges under this Section only if the applicant is not/has not been subject to licensure sanction, adverse action on medical staff membership or privileges at another facility, or any other disqualifying criteria specified in Medical Staff policy.
- b. Important Patient Care, Treatment, or Service Need. Temporary Privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such Privileges, the organized Medical Staff verifies current licensure and current competence.

4.4.2 Procedures. A Practitioner may be granted temporary Clinical Privileges by the Hospital President or designee, upon the recommendation of the Chief of Staff or designee, and the Credentials Committee Chair or designee. Practitioners who hold temporary Clinical Privileges are not Members. Temporary Clinical Privileges shall be granted only (a) when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, competence and judgment to exercise the Clinical Privileges requested, (b) after the Practitioner has provided evidence of professional liability insurance as required by the Board, and (c) after the Practitioner's license has been verified. Temporary Clinical Privileges must be for a specified time period, consistent with the time limits stated in this Section.

4.4.3 Supervision. Practitioners granted temporary Clinical Privileges shall be subject to the supervision of the Program Medical Director to which assigned and, in the case of a Practitioner who is not a Physician, Dentist, or Podiatrist, shall be under the supervision of an identified Member. Practitioners granted temporary Clinical Privileges shall comply with these Bylaws and other documents that apply to Members. A Practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws because their request for temporary Privileges is refused or because all or any part of their temporary Privileges are terminated or suspended unless the decision is based on clinical competence or unprofessional conduct.

4.5 EMERGENCY CLINICAL PRIVILEGES

In case of emergency, any Practitioner who holds Clinical Privileges and any Member is permitted to do everything possible within the scope of his license to save the life of the patient or to save the patient from serious harm, regardless of Clinical Privileges or Staff category. For the purpose of this section, an “emergency” is defined as a condition in which serious, permanent harm may result to the patient or in which the life of the patient is in immediate danger and any delay in administering treatment might add to that danger.

4.6 DISASTER CLINICAL PRIVILEGES

- 4.6.1 If the Hospital’s Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the Hospital President and other individuals as identified in the hospital’s Disaster Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster Privileges to selected practitioners. These practitioners must 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:
- a. A current picture hospital ID card that clearly identifies professional designation;
 - b. A current license to practice;
 - c. Primary source verification of the license;
 - d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 - e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - f. Identification by a current Hospital or Medical Staff Member (s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.
- 4.6.2 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster Privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster Privileges should be continued.

- 4.6.3 Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the Hospital. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.
- 4.6.4 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster Privileges will terminate immediately.
- 4.6.5 Any individual identified in the institution's Disaster Plan with the authority to grant disaster Privileges shall also have the authority to terminate disaster Privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to a right to a fair hearing or an appeal.

4.7 EFFECT OF CONTRACTS ON CLINICAL PRIVILEGES

It is recognized that certain clinical activities at the Hospital may be operated under exclusive contracts. The right to provide services within those clinical areas shall be controlled by the specific agreements to which the Hospital is a party. Individuals granted Clinical Privileges pursuant to these Bylaws shall not be deemed to have obtained the right to exercise those Clinical Privileges in a manner contrary to the Hospital's contractual arrangements.

4.8 CONDITIONS TO CLINICAL PRIVILEGES

The provisions of this Section are express conditions to any Practitioner's application for, and exercise of, Clinical Privileges at the Hospital. By applying for Clinical Privileges and/or Medical Staff Membership, the Practitioner accepts these conditions with respect to the processing and consideration of his application, whether or not Membership/Clinical Privileges are granted, and with respect to all activities relating to Membership/Clinical Privileges granted.

4.8.1 Release of Liability. The Practitioner absolutely releases the Hospital, the Medical Staff, and any of their representatives from any liability relative to any communication, recommendation or action, concerning the Practitioner's qualifications or conduct and evaluation thereof, whether in connection with the Practitioner's initial application for Clinical Privileges/Medical Staff Membership or any subsequent activities relating to the Practitioner's Clinical Privileges/Medical Staff Membership. This release also extends to third parties that furnish information described in this Section, including otherwise privileged or confidential information, to the Medical Staff, the Hospital, or their representatives.

4.8.2 Authorize Communication. The Practitioner authorizes the representatives of the Medical Staff and Hospital to consult with other hospitals, medical associations, licensing boards and other organizations and individuals who may have information bearing on the Practitioner's character, conduct, ethics, physical and mental health, competence and other qualifications (collectively, "Qualifications"), and authorizes said individuals and organizations to provide information to representatives of the Medical Staff and Hospital.

4.8.3 Authorize Document Inspection. The Practitioner consents to representatives of the Medical Staff and Hospital inspecting all records and documents relevant to an evaluation of the Practitioner's qualifications.

4.8.4 Authorize Release of Information. The Practitioner authorizes representatives of the Hospital and the Medical Staff to provide other hospitals, medical associations, licensing boards, and other organizations and individuals concerned with provider performance and the quality of patient care with any relevant information regarding the Practitioner.

4.8.5 Confidentiality of Professional Practice Review Material. The Practitioner agrees to maintain the confidentiality of all Hospital professional practice review materials.

4.8.6 Health Status. The Practitioner agrees to submit to mental and physical examination and testing (including drug, alcohol and infection screens) by a health professional or at a facility satisfactory to the MEC, Credentials Committee, or Board, if requested in order to determine that the Practitioner's current physical or mental health does not threaten or interfere with his ability to practice safely. The results of such examination and testing shall be submitted directly to the body that requested them or the body's designee.

4.9 TELEMEDICINE PRIVILEGES

Telemedicine Privileges are limited to those services the MEC, acting for the Medical Staff, has approved for telemedicine delivery. Requests for telemedicine Privileges at the Hospital that includes patient care, treatment, and services will be reviewed by the MEC and will be processed through one of the following mechanisms:

4.9.1 The Hospital fully privileges and credentials the Practitioner; OR

4.9.2 The Hospital privileges Practitioners using credentialing information from the distant site if the distant site is a Medicare participating hospital or telemedicine entity and the information is then processed through the routine Medical Staff credentialing and privileging process. The distant-site Practitioner must have a license that is issued or recognized by the State of Michigan; OR

4.9.3 The Hospital accepts the credentialing and privileging decision from the distant site if all of the following requirements are met:

- a. The distant site is a TJC accredited hospital or ambulatory care organization or Medicare participating hospital or telemedicine entity;
- b. The Hospital has a written agreement with the distant site which satisfies the requirements of the Medicare Hospital Conditions of Participation;
- c. The Practitioner is privileged at the distant site for those services to be provided at this Hospital and the Practitioner has a license that is issued or recognized by the State of Michigan; and
- d. The Hospital has evidence of the distant site's internal review of the Practitioner's performance of these privileges and the Hospital sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent Practitioner from patients, licensed independent practitioners, or staff at the Hospital.

Section 5. PROVISION OF CARE BY NON-MEMBERS

5.1 ADVANCED PRACTICE PROFESSIONALS AND CLINICAL ASSISTANTS

5.1.1 Assignment, Supervision and Compliance. Although responsible to the Medical Staff and the Board, Advanced Practice Professionals and Clinical Assistants are not Members of the Medical Staff. Each APP and Clinical Assistant may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him/her in accordance with these Bylaws, except as otherwise permitted by Sections 4.5 and 4.6. Each APP and Clinical Assistant acts under the overall supervision of an identified Supervising Member approved by the Board, acting on the recommendation of the Medical Executive Committee. The APP or Clinical Assistant shall immediately notify the Chief of Staff in writing if the APP's or Clinical Assistant's supervisory arrangement with the Supervising Member ends. An APP or Clinical Assistant may not be granted Clinical Privileges that exceed those of their Supervising Member. The Hospital may grant Clinical Privileges that are less extensive than the scope of activities an APP or Clinical Assistant is licensed to perform. APPs and Clinical Assistants shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

5.1.2 Qualifications. APPs and Clinical Assistants must possess a license or registration to practice their profession in the state of Michigan, if applicable. Applications for initial, renewed, increased and decreased Clinical Privileges will be processed using the procedures and criteria set forth in Sections 3 and 4 (subject, however, to procedures in accordance with Part II, Section 7.7) to the extent applicable to the APP's/Clinical Assistant's profession

5.1.3 Meeting Attendance. APPs/Clinical Assistants may attend meetings of the Medical Staff and/or their department at the request of their Supervising Member and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, APPs/Clinical Assistants may not vote, nor may they otherwise participate unless requested by the committee chair or other individual presiding over the meeting.

5.1.4 Suspension and Termination. An APP's/Clinical Assistant's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Part II) in the same manner as a Member of the Medical Staff (subject, however, to the procedures in accordance with Part II, Section 7.7), as well as in accordance with Part II Section 3.1.15, the terms of any written contract the APP/Clinical Assistant may have with the Hospital and, in the case of a Hospital-employed APP/Clinical Assistant, in accordance with any applicable Hospital policy.

5.2 HOUSE PHYSICIANS

5.2.1 Assignment, Supervision and Compliance. Although responsible to the Medical Staff and the Board, House Physicians are not Members of the Medical Staff. Each House Physician may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him in accordance with these Bylaws, except as otherwise permitted by Sections 4.5 and 4.6. Each House Physician acts under the overall supervision of the Program Medical Director to which assigned. When participating in the care of a patient admitted to the Hospital, the House Physician shall work under the supervision of the attending Member. House Physicians shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

5.2.2 Qualifications. House Physicians must possess a full license to practice allopathic or osteopathic medicine in the state of Michigan (e.g. not a limited license that restricts practice to activities within the scope of graduate medical education program). Applications for initial and renewed Clinical

Privileges will be processed using the procedures and criteria set forth in Sections 3 and 4 excluding those relating to Board Certification and Eligibility. The Board grants or denies Clinical Privileges to prospective House Physicians, upon recommendation of the MEC.

5.2.3 Meeting Attendance. House Physicians may attend meetings of the Medical Staff and/or their department at the request of their Program Medical Director and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, House Physicians may not vote nor may they otherwise participate unless requested by the committee chair or other individual presiding over the meeting.

5.2.4 Suspension and Termination. A House Physician's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Part II) in the same manner as a Member of the Medical Staff, as well as in accordance with the terms of any written contract governing the House Physician's services to the Hospital and, in the case of a Hospital-employed House Physician, in accordance with any applicable Hospital policy.

5.3 PHYSICIAN RE-ENTRY

A Practitioner who has not provided patient care within the past two (2) years who requests clinical Privileges at the Hospital must comply with the Practitioner re-entry requirements defined in Hospital or Medical Staff policies and procedures