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Trinity Health Of New England
Mercy Medical Center

January 1, 2025

Part I: Governance

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 Of New England hospital 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 the Trinity Health Of New England. Henceforth, whenever the term "the hospital" is used, it shall mean a facility of Trinity Health Of New England; and whenever the term "the Board" is used, it shall mean Board of Directors. Whenever the term "Hospital President" or Chief Administrative Officer ("CAO") is used, it shall mean the person appointed by the Board to act on its behalf in the overall management of the hospital. The term Hospital President or CAO includes a duly appointed acting administrator serving when the Hospital President or CAO is away from the hospital.

If Trinity Health Of New England, or any of its member hospitals, is acquired, merged, dissolved, or assets acquired going forward, the current bylaws in effect at the time of that transition would continue until amended or revised by the medical staff and approved by the new board of directors.

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 the evaluation and treatment of patients including documentation in the medical record and the prescribing of medications. Individuals in this category are clinical psychologists, physician assistants (PAs), Doctors of Physician Assistant Studies (DPASs), advanced practice registered nurses (APRNs), and Doctors of Nursing Practice (DNPs).

"Advanced Practice Registered Nurse" or "APRN" means those individuals who are Doctors of Nursing Practice (DNPs), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists or nurse practitioners (NPs).

"Adverse recommendation" means a recommendation to limit, restrict, or terminate privileges due to a reason related to competence or conduct.

"Application" means an application for appointment and/or privileges to the Medical Staff of this Hospital as described in Part III, Section C of the *Medical Staff Bylaws.*

"Appointee" means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff of this Hospital.

"Chief Administrative Officer" or "CAO" is the individual appointed by the Board of Directors to serve as the Board's representative in the overall administration of the Hospital. The CAO may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws. For the purposes of these bylaws this term has equivalent meaning to/ is interchangeable with "Hospital President."

"Chief Medical Officer" or "CMO" is the individual appointed by the CAO or Hospital President to serve as a liaison between administration and the Medical Staff. If there is no CMO, the Hospital President/ CAO shall serve in his/her stead.

"Clinical Privileges" or "Privileges" mean 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 the state(s) where the practitioner practices, as applicable.

"Department" means a grouping of like practitioners as noted in Part I, Section 5 of the *Medical Staff Bylaws* and further defined in the *Organization and Functions Manual*.

"Department Chair" means an Active Medical Staff Member who has been selected in accordance with and has the qualifications and responsibilities for Department Chair as outlined in Part I, Section E of these Bylaws.

"Executive Committee" and "Medical Executive Committee" shall mean the Executive Committee of the Medical Staff of this Hospital as 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 a reason of competence or conduct.

"Governing Body," "Board of Directors" or "Board" means the Board of Directors of Trinity Health Of New England.

"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 D of these *Medical Staff Bylaws.*

"Hospital" means a facility of Trinity Health Of New England.

"Hospital Bylaws" mean those Bylaws established by the Board of Directors. Interchangeable with "*medical staff bylaws*."

"Medical Staff or "Staff" means an individual who is either a medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist who has obtained membership status and has been granted privileges that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at this Hospital. As contextually appropriate, "Medical Staff" may also refer to all members of the medical staff in plural.

"*Medical Staff Bylaws"* means these Bylaws covering the operations of the Medical Staff of a Hospital of Trinity Health Of New England.

"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 period beginning on January 1st of each year and ending on December 31st.

"Member" is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been granted this status by the Board of Directors of this Hospital.

"Oral and Maxillofacial Surgeon" means a licensed dentist with advanced training qualifying him/her 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 the state(s) where the practitioner practices, as applicable.

"Podiatrist" means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in the state(s) where the practitioner practices, as applicable.

"Practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, or Advanced Practice Professional who has been granted clinical privileges.

"Prerogative" means the right to participate, 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 in other Hospital and Medical Staff policies.

"Provider-based Clinic" is a clinic that is considered to be part of this Hospital by either: 1) working under the tax identification number of the Hospital, 2) working under the Medicare certification number (CCN) of the Hospital, or 3) is part of the Hospital survey by an accreditation agency.

"Representative" or "Hospital Representative" means the Board of Directors and any trustee or committee thereof; the Hospital President or CAO or his or her designee; other employees of the Hospital; a Medical Staff organization or any member, officer, Department or Division or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use of dissemination of information.

"Special Notice" means written notice sent via certified mail, return receipt requested, by overnight delivery with confirmation of delivery, or by hand delivery evidenced by a receipt signed by the practitioner to whom it is directed.

Section 2 Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of this 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 based on 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 have 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 twenty-four (24) 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.

2.6 Medical Staff Members Responsibilities

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and member specifically agree to the following:

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her 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 practitioner with similar privileges at this Hospital that can care for the practitioner's patients when the practitioner is absent.

2.6.2 Each staff member and practitioner with privileges 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 Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by any two (2) individuals from the following (Medical Staff Officer, Department Chair, Hospital President, CMO, or administrator on call) 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 health or impairment.

2.6.5 Each staff member and practitioner with privileges 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 with privileges must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the CMO (local or regional), or Hospital President or CAO if no CMO, or designee immediately, within seven (7) days, of all malpractice claims or notices of intent to sue against the Medical Staff member or practitioner with privileges.

2.6.7 Each staff member and practitioner with privileges 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 practitioner provides care in the hospital, or within its facilities, divisions, 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, dentist, podiatrist, APRN, PA, or other qualified licensed individual in accordance with State law and hospital policy.

b) An updated examination of the patient, including any changes in the patient's condition, shall be completed, and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed, and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, APRN, PA, or other qualified licensed individual in accordance with State law and hospital policy.

c) The content of complete and focused history and physical examinations is delineated in the rules and regulations.

2.6.8 Each staff member and practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For 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.

2.6.9 Each staff member and practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board to properly delineate that member's clinical privileges.

2.6.10 Each Medical Staff leader 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 Conflict of Interest policy.

2.6.11 Each staff member and practitioner with privileges will comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance; to comply with clinical practice protocols and guidelines pertinent to their medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

a. Each staff member and practitioner with privileges will comply with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee or Board, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

b. Each staff member and practitioner with privileges will abide by the Hospital's electronic record user access agreement, which includes exercising due diligence in appropriately accessing and safeguarding confidential information and protecting the individual's ability to access the Hospital's applications, including the electronic medical record.

c. Each staff member and practitioner with privileges agrees to inform the Medical Staff Office, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

Any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization.

i. Any changes in professional liability insurance coverage

ii. The filing of a professional liability lawsuit against the practitioner

iii. Changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity or group affiliation because of peer review activities

iv. Knowledge of a criminal investigation involving the practitioner, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation

v. Exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed.

vi. Any changes in the practitioner's ability to exercise clinical privileges safely and competently or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the practitioner health policy

vii. Any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the practitioner health policy with notification to the Credentials Committee and MEC

2.6.12 Each staff member and practitioner with privileges agrees to maintain and monitor a current e-mail address [Trinity Health Of New England staff address preferred] or other approved electronic communication channel (e.g., secure portal or text) with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the practitioner

2.6.13 Each staff member and practitioner with privileges agrees to provide a valid mobile phone number with texting capability in order to facilitate physician-to-physician communication.

2.6.14 Each staff member and practitioner with privileges acknowledges: if there is any misstatement in, or omission from, their staff application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). *In either situation, there shall be no entitlement to a hearing or appeal.* The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual is not eligible to reapply.

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 practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the President of the Medical 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 1 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. If a rule, regulation, or policy is thought to be inappropriate, any 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 Section I will be followed.

2.7.5 Each staff member in the Active category may call for a department meeting by presenting a petition signed by twenty percent (20%) of the members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

2.7.6 The above subsections (2.7.1-2.7.5, Medical Staff Members Rights) 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 practitioner eligible for Medical Staff appointment has 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

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff Officers, Department Chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

Section 3 Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Members of this category must be involved in at least forty (40) patient contacts per two (2) years (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure). All hospital-based practitioners (e.g. emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic) are given Active status.

If 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 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, Department, and Division 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, Department, Division, and 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 Courtesy Category

3.2.1 Qualifications

The Courtesy category is reserved for Medical Staff members who do not meet the Active category's eligibility requirements and who are granted clinical privileges.

For MSO processing, all locum tenens practitioners are considered in the Courtesy category regardless of the number of clinical contacts. However, locum tenens practitioners are granted privileges without membership and the following 3.2.2 does not apply.

3.2.2 Prerogatives

Members of this category may:

a) Attend Medical Staff, Department, and Division 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, Department, or Division or be an officer of the Medical Staff; and

c) Serve on Medical Staff committees, including 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 The Community Category

3.3.1 Qualifications

The Community category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category and who are not granted clinical privileges. The Community Physician Category is restricted to those individuals recommended by the MEC. Appointment to this category is meant for those physicians who refer patients to the hospital and require access to the computerized medical record. These community physicians maintain an active practice in the state but have no intention of obtaining privileges at this institution, nor do they intend to become active in medical staff matters. There shall be no requirement for them to be board certified in their specialty.

3.3.2 Prerogatives

Members of this category may:

a) Attend Medical Staff, Department, and Division 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, Department, or Division or be an officer of the Medical Staff; and

c) Serve on Medical Staff committees, including the MEC, and may vote on matters that come before such committees.

3.3.3 Responsibilities

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

3.4 Emeritus Recognition

Emeritus 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. Practitioners granted Emeritus Recognition shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned. They do not pay dues. Emeritus recognition does not require recredentialing.

3.5 Privileges without membership

3.5.1 **Locum tenens** and **telemedicine** practitioners shall be granted clinical privileges without membership. Qualifications and processing of staff applications are addressed in **Part III, Credentialing.**

a) Prerogatives

Members of this category may:

i. Attend Medical Staff, Department, and Division meetings of which s/he is a member and any Medical Staff or hospital education programs.
ii. Not vote on matters presented by the entire Medical Staff, Department, or Division or be an officer of the Medical Staff; and
iii. Not serve on Medical Staff committees.

b) **Responsibilities**

Members of this category shall have the same clinical responsibilities as Active staff members.

3.6 Advanced Practice Provider

3.6.1 Qualifications

Shall meet the credentialing requirements and procedures as outlined in the Medical Staff Bylaws

3.6.2 Prerogatives

i. May have full access to the EMR and may enter orders on patients (see note below)
ii. May serve on the MEC, Credentials Committee, Peer Review Committee, and other medical staff committees with voting privilege.
iii. Are not voting member of medical staff.
iv. Shall attend medical staff meetings.
v. Shall not be Officers of the Medical Staff.

3.6.3 Obligations

i. Should have a supervising Physician Member (see note below);
Contribute to and participate in the organizational and administrative activities of the Medical Staff.
ii. Shall satisfy attendance requirements at meetings and conferences required under these bylaws, or as may be requested by the applicable Department Chair or other Medical Staff leader.
iii. Shall pay all dues and assessments.

Note: The extent to which an APP has a supervising physician member, can enter orders, admit and otherwise manage patients will be governed by their respective department guidelines, Mercy Medical Center's Medical Staff Rules and Regulations, and applicable Massachusetts state or federal statute.

Section 4 Officers of the Medical Staff

4.1 Officers of the Medical Staff

a) President of the Medical Staff
b) Vice President of the Medical Staff
c) Secretary/Treasurer
d) Immediate Past President of the Medical Staff

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing of the Active category and be actively involved in patient care in the hospital; indicate a willingness and ability to serve; have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges; have at least two (2) years' leadership experience; and be in compliance with the professional conduct policies of the hospital. An Officer cannot simultaneously serve as Hospital President or CMO. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers and MEC at-large members may not simultaneously hold a leadership position (position on the MEC or Board) on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

4.3 Election of Officers

4.3.3 Every two years the Nominating Committee of the Hospital, as defined in the Rules and Regulations, shall nominate at least one (1) candidate for each of the positions of Vice President of the Medical Staff, and Secretary/Treasurer. The current Vice President will automatically succeed to the position of President. The President of the Medical Staff automatically succeeds to the position of Immediate Past President of the Medical Staff when his/ her term is completed. Nominations must be announced, and the names of the nominees announced at least six (6) weeks prior to the election.

4.3.4 Any Active Member may add nomination(s) to the ballot, with the written consent of the individual(s) being nominated. The Medical Staff Member must submit such a petition to the Medical Staff Office at least four (4) weeks 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 he/she can be placed on the ballot.

4.3.5 Ballots will be delivered on paper or electronically to all Active Members at least two (2) weeks prior to the election. Elections shall take place by ballots cast by Active Medical Staff Members returned to the Medical Staff Office within ten (10) days. The Officers will be voted upon by all Active Members. The nominee(s) who receives a plurality of votes cast will be elected.

4.3.6 If 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 serve a term of two (2) years. They shall take office on January 1st following their election. The Medical Staff President may run again for the same position (initially, Vice President) after having not been an officer for one two-year cycle. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office

The MEC shall fill vacancies of office via appointment during the Medical Staff year, except the office of the President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term.

4.6 Duties of Officers

4.6.1 President of the Medical Staff:

The President of the Medical Staff is the chair of the Medical Executive Committee. The President of the Medical Staff shall represent the interests of the Medical Staff to the MEC and the Board. The President of the Medical Staff 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 President of the Medical Staff, 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 President of the Medical Staff, 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 to participate as invited by the CMO or Hospital President 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 regional committee chairs and all members of regional Medical Staff standing and ad hoc committees; in consultation with the chair of the Board, appoint the 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 regional interdisciplinary clinical performance improvement activities.

g) Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, 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 MEC and the Board regarding the effectiveness of the credentialing and privileging processes.

i) Review and enforce, in conjunction with Hospital medical staff leadership, compliance with standards of ethical conduct and professional demeanor among the practitioners 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 the MEC and the Board.

k) Attend Board meetings, with vote.

l) Attend Board committee meetings as invited by the Board.

m) Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and

n) 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 President of the Medical Staff: In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. S/he shall:

a) Perform such duties as may be delegated by the Medical Staff President to the Medical Staff Vice President.

b) Serve as chairperson of the Credential Committee; and

c) Attend to and perform such other duties as ordinarily pertain to such office.

4.6.3 Secretary/Treasurer of the Medical Staff: This officer will collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. S/he shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.6.4 Immediate Past President of the Medical Staff: This officer will serve as a consultant to the President of the Medical Staff and Vice President of the Medical Staff.

4.6.5 MEC At-Large Members: 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 for conduct or statements that damage the hospital, its goals, or programs. The Medical Staff may initiate the removal of any officer 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 votes.

4.7.2 Removal by Vote of the Medical Executive Committee: 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 for conduct or statements that damage the hospital, its goals, or programs. The Medical Executive Committee may initiate the removal of any officer if at least twenty percent (20%) of the MEC members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those MEC members casting ballot votes.

4.7.3 Automatic Removal: Automatic removal shall be for failure to meet or maintain any of the qualifications, as noted in Section 4.2, for being an Officer. This removal is not discretionary and is effectuated by the President of the Medical Staff.

4.7.4 Resignation: Any elected officer 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 be organized into Departments; no Department shall have fewer than three (3) Members. The Medical Staff may create Divisions within a Department to facilitate Medical Staff activities. A list of Departments organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is part of the Rules and Regulations.

5.1.2 The MEC, with approval of the Board, may designate new Medical Staff Departments or Divisions or dissolve current Departments or Divisions as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Department Chairs, and Division Chiefs

5.2.1 Appointment of Department Chairs and Division Chiefs

Qualifications for Department Chairs and Division Chiefs: All Chairs and Chiefs must be members of the Active medical staff, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. In addition, Department Chairs and Division Chiefs shall indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, and follow the professional conduct policies of the hospital. Department Chairs and Division Chiefs may not simultaneously hold a leadership position (any position in which the Member serves on the MEC or the Board) on another hospital's medical staff. Noncompliance with this requirement will result in the Department Chair or Division Chief being automatically removed from office.

5.2.2 Selection of Department Chairs and Division Chiefs

a) Department Chairs: The Department Chairs are appointed by the Hospital President, in consultation with the Medical Staff and Hospital CMO, if available. All Department Chairs are ratified by majority vote of the MEC.

b) Division Chiefs: The Division Chiefs are appointed by the Hospital Department Chair.

5.2.3 Removal of Department Chairs or Division Chiefs

a) Automatic Removal of Department Chairs and Division Chiefs: A Department Chair or Division Chief may be automatically removed from his/her position if he/she no longer meets the qualifications of the position as defined in these bylaws.

b) Department Chairs may be removed by the Hospital President, in consultation with the Medical Staff President and CMO.

c) Division Chiefs may be removed by the Department Chair.

d) If a Department Chair, or Division Chief is removed, or a vacancy occurs for any other reason, a replacement will be selected using the process in Section 5.2.2.

5.3 Responsibilities of Department Chairs

The responsibilities of the Department Chairs are:

a) To oversee all clinically related activities of the Department.

b) To oversee all administratively related activities of the Department, unless otherwise provided by the hospital.

c) To provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges.

d) To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Department.

e) To recommend clinical privileges for each member of the Department and other licensed independent practitioners practicing with privileges within the scope of the Department.

f) To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the Medical Staff Department or the hospital.

g) To integrate the Department into the primary functions of the hospital.

h) To coordinate and integrate interdepartmental and intradepartmental services and communication.

i) To develop and implement Medical Staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes.

j) To recommend to the CMO, or Hospital President if no CMO, enough qualified and competent persons to provide patient care and service.

k) To provide input to the CMO, or Hospital President if no CMO, regarding the qualifications and competence of Department or service personnel who are not licensed independent practitioners (LIPs) but provide patient care, treatment, and services.

l) To continually assess and improve of the quality of care, treatment, and services.

m) To maintain quality control programs as appropriate.

n) To orient and continuously educate all persons in the Department; and

o) To make recommendations to the MEC and the hospital administration for space and other resources needed by the Medical Staff Department to provide patient care services.

5.4 Assignment to Department

The MEC will, after considering the recommendations of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department assignment.

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 President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee

6.2.1 Committee Membership: The MEC shall be a standing committee consisting of the following members:

i) Voting members of the MEC: Medical Staff Officers, Department Chairs, up to 4 At-Large Members appointed by the Medical Staff President, 1 active staff member appointed by and from Mercy Inpatient Medical Associates, and 1 APP.

ii) Nonvoting members of the MEC: Hospital President, CMO, and the CNO/VP of Patient Care Services

iii) Removal from MEC: A Medical Staff Officer or department chair removed from his/her position in accordance with Section 4.7 and/or Section 5.2.3 above will automatically lose his/her membership on the MEC.

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

i) 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.

ii) Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action.

iii) Report to the Board and to the 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.

iv) 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.

v) The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

vi) Coordinate the implementation of policies adopted by the Board.

vii) Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted.

viii) Make recommendations to the Board on medical administrative and, as requested, on hospital management matters. Keep the Medical Staff up to date concerning the licensure and accreditation status of the hospital.

ix) Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs.

x) Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups.

xi) 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.

xii) 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.

xiii) Assist with that portion of the corporate compliance plan that pertains to the Medical Staff.

xiv) Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities; and

xv) Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws.

MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

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 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 paper or electronically, and their vote recorded in accordance with procedures approved by the MEC. Such a vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a) The President of the Medical Staff may call a special meeting of the entire Medical Staff at any time; the President of the Medical Staff may call a special meeting of the Hospital Medical Staff at any time. The President of the Medical Staff 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 President of the Medical Staff 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 and Departments

Committees, Departments, and Divisions may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments, Divisions, and committees shall meet at least annually, unless otherwise stipulated in these bylaws. Attendance at meetings may be by physical presence or by videoconferencing from an approved hospital videoconferencing site. Telephonic participation is permitted when confidential items are discussed and only when confidentiality is assured.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee, Department, or Division may be called by the committee chair or Chair of the Department/division chief thereof or by the President of the Medical Staff.

7.4 Quorum; Voting

7.4.1 Medical Staff Meetings: TWENTY percent (20%) of the Active Medical Staff will constitute a quorum when unification of the Medical Staff among all Trinity Health Of New England hospitals is being voted upon. For all other issues, a quorum will consist of those present and eligible Active Medical Staff members voting on an issue.

7.4.2 MEC, Credentials Committee, and Peer Excellence (Peer Review) Committee: A quorum will exist when fifty percent (50%) of the voting members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least two (2) members.

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

7.4.4 Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding, even if attendance drops below a quorum during the meeting.

7.4.5 When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a department or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

7.4.6 Recommendations and actions of the Medical Staff, departments, and committees not otherwise described in these bylaws shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be completed by any secure means, at the discretion of the Presiding Officer, defined as a committee or department chair or division chief.

7.5 Attendance Requirements

7.5.7 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff and of the Departments.

7.5.8 MEC, Credentials Committee, and Peer Review/ Peer Excellence Council meetings: Members of these committees are expected to attend at least three/fourths (3/4) of the meetings held. Failure to meet the attendance requirement may result in replacement on the committee.

7.6 Participation by the President and the CMO

The Hospital President and the CMO or their designees may attend any general, committee, Department or Division meetings of the Medical Staff as an ex-officio member without vote. Committees may go into executive session, with medical staff members only, when desired.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run 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 Department or 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. A member's attendance at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Department

Only items noted on the agenda, posted at least three (3) days before the meeting, may be voted on, except for MEC, Credentials Committee, and Peer Excellence Council. The recommendation of a majority of its Active members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendations will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only to break a tie.

7.10 Rights of Ex Officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

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

Section 8 Conflict Resolution

8.1 In the event the Regional 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.

8.2 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 President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.3 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 periodically, 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 a 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 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 of the Hospital.

9.2.2 Votes on the proposed amendment will be voted upon by the Active Medical Staff.

9.2.3 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.

9.2.4 The amendment shall be considered approved by the Medical Staff if the amendment has at least two-thirds (2/3rd) approval of the Active Staff casting ballots.

9.2.5 Amendments so adopted shall be effective when approved by the Board.

9.2.6 The MEC may adopt such amendments to these bylaws, that are, in the committee's judgment, technical or non-substantive 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.

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 Medical Staff) will communicate the proposal to the other party prior to vote.

9.3.3 Votes on the proposed amendment will be voted upon by the MEC. Once passed by the MEC, the amendment will go to the Board for approval; or

9.3.4 In addition to the process described in 9.2 above, the 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 Section H. Upon presentation of such petition, the adoption process outlined above 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 immediately informs the Medical Staff. The Medical Staff can retrospectively review 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 in 9.2 for resolving conflict between the Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

9.3.6 The MEC may adopt such amendments to these rules, regulations, and policies that are, in the committee's judgment, technical or non-substantive 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.

9.4 Provision related to Unification of Staff

9.4.1 Acceptance of a unified medical staff. If the Trinity Health Of New England Board of Directors elects to have a unified medical staff, then the medical staff of each affected separately certified Hospital must vote, such vote requires 25% of voting members as quorum and simple majority, in accordance with medical staff bylaws, whether to accept unification or remain a separate Medical Staff. Votes for unification of the medical staff shall occur no more frequently than every two (2) years. Each Active member of the medical staff can vote on the proposed unification via printed or secure electronic ballot as determined by the MEC. All Active members of each medical staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by each medical staff:

a) If the vote is taken at a meeting, when the proposed unification amendment receives a simple majority (fifty percent plus one) of those present and eligible to vote, or

b) If the vote is taken solely by ballot, when the proposed unification amendment receives a simple majority (fifty percent plus one) of the ballots cast.

9.4.2 Once there is a unified medical staff, the Active members at each Hospital in which the Members have clinical privileges, can vote to "opt out" of the unified medical staff. This would require a petition signed by twenty five percent (25%) 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 member who would qualify for voting privileges at the Hospital will be eligible to vote on the proposed "opt out" proposal. Each Active member of the medical staff can vote on the proposed amendment via printed or secure electronic ballot as determined by the MEC. All Active members of each Hospital's medical staff shall receive at least thirty (30) days' advance notice of the proposed changes. The amendment shall be considered approved by the Hospital's medical staff:

a) when the proposed de-unification amendment receives a simple majority (fifty percent plus one) of 25% of members with voting privilege (Quorum), or

b) when the proposed de-unification amendment receives a simple majority (fifty percent plus one) of the ballots cast. If the medical staff of a hospital has voted to "opt out" of the unified medical staff, the medical staff will need to approve bylaws to take effect after opting out. These bylaws may, or may not be, the bylaws that were in effect at the time of medical staff unification, based on the vote of the medical staff that is opting out.

Trinity Health Of New England
Mercy Medical Center

Educational and/or Informal Proceedings

Section 1 Criteria for Initiation

These bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions 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. When any observations arise suggesting opportunities for a practitioner to improve his/her 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. 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 privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

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

Following educational intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while educational interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation, the MEC may authorize an investigation to gather and evaluate any evidence and its sufficiency.

1.1 Mandatory Meeting requirement

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, the President of the Medical Staff or the applicable Department Chair or Medical Staff 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 before. 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 twice, unless excused by the MEC for an adequate reason, will result in an automatic suspension of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

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).

Section 2 Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff officer, committee chair, Department Chair, Hospital President, CMO, or Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

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 if it deems a consultant is necessary and such action is approved by the MEC and the CMO. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination ;the practitioner shall cover the cost of any requested exam and may access the results of such exams. The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body 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 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 suspension, termination of the investigative process, or other action.

2.3 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, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.4 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a) Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file.

b) Deferring action for a reasonable time when circumstances warrant.

c) Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chairs 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.

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.

e) Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges.

f) Recommending reductions of membership status or limitation of any prerogatives related to the practitioner's delivery of patient care.

g) Recommending suspension, revocation, or probation of Medical Staff membership; or

h) Taking other actions deemed appropriate under the circumstances.

2.5 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, the practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3 Corrective Action

3.1 Automatic Suspension and/or Relinquishment

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered suspended or relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff with the approval of the CMO may reinstate the practitioner's privileges or membership 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, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

a) Licensure

i) **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.

ii) **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.

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

b) 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 privileges.

c) Controlled Substances

i) **DEA Certificate or State CSR, as applicable:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or State 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.

ii) **Probation:** Whenever a practitioner's DEA certificate or State 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.

d) **Medical Record Completion Requirements:** A practitioner will be considered to have their privileges to admit new patients or schedule new procedures voluntarily suspended whenever s/he fails to complete medical records within time limits 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 from the Medical Staff.

e) **Professional Liability Insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic 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 from 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.

f) **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 sixty (60) calendar days after written warning of delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership and privileges on the Medical Staff.

g) **Felony Conviction:** A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, 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. 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 acting on charges or indictments of the above offenses.

h) **Failure to Satisfy the Special Appearance Requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have all clinical privileges automatically suspended apart from emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

i) **Failure to Participate in an Evaluation:** A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills) and authorizes 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 from the Medical Staff.

j) **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 from the Medical Staff.

k) **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.

l) **Failure to Maintain Board Certification:** A practitioner who fails to maintain their board certification will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges unless an exception is granted, for a period of up to two (2) years for extenuating circumstances, by the Board upon recommendation from the MEC.

m) **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 Chief/President of the Medical Staff 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 thirty 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 from the staff and must reapply for staff membership and privileges.

n) **Suspension at a Trinity Hospital Within the Region:** A practitioner who is suspended at another Trinity Hospital within the Region, except for suspensions due to medical records violations or the payment of dues, shall be considered to have all privileges at this Hospital automatically suspended. If the suspension is terminated at the other Trinity Hospital in the Region, the suspension will be automatically rescinded at this Hospital.

o) **Involuntary Termination at a Trinity Hospital:** A practitioner whose membership or privileges are involuntarily terminated at another Trinity Hospital shall undergo automatic loss of membership and privileges at this Hospital.

p) **Loss of supervising/collaborating physician for Advanced Practice Professionals:** If an APP who is required to have a supervising physician loses their relationship with a supervising/collaborating physician on staff at this Hospital, then the APP may be automatically suspended until the APP 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 automatically relinquishes his/her privileges.

q) **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); to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person; or when Medical Staff leaders (medical staff officer or department chair) and/or the CMO. Under such circumstances any two individuals from the following (Medical Staff Officer, Department Chair, Hospital President, CMO, or if no other option, 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.

a) Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the Hospital President shall promptly, within forty-eight (48) hours, give written notice to the practitioner, the MEC, the CMO, and the Board. The written notice will include the reasons for the summary suspension and the practitioner's rights if the summary suspension lasts longer than fourteen (14) days. 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.

b) 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 Chief/President of the Medical Staff 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 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. The practitioner shall not be represented by legal counsel at this preliminary interview. At no time shall any meeting of the MEC during this process of investigation, 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 member or other physician or dentist with privileges without membership shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4 Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation regarding clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

i) Denial of Medical Staff appointment or reappointment.

ii) Revocation of Medical Staff appointment.

iii) 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 member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

iv) Involuntary reduction or revocation of clinical privileges.

v) 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 individual Medical Staff member and is imposed for more than fourteen (14) calendar days; or

vi) Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member'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

i) Issuance of a letter of guidance, warning, or reprimand.

ii) Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer to provide information to a Medical Staff peer review committee) with no restriction on privileges.

iii) Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege.

iv) Investigating any matter or the appointment of an ad hoc investigation committee.

v) Requirement to appear for a special meeting under the provisions of these bylaws.

vi) Automatic relinquishment or voluntary resignation of appointment or privileges.

vii) Imposition of a summary suspension that does not exceed fourteen (14) calendar days.

viii) Denial of a request for leave of absence, or for an extension of a leave.

ix) Determination that an application is incomplete or untimely.

x) Determination that an application will not be processed due to misstatement or omission.

xi) Decision not to expedite an application.

xii) Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct.

xiii) Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.

xiv) 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.

xv) Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted.

xvi) Termination of any contract with or employment by hospital.

xvii) Proctoring, monitoring, and any other performance monitoring requirements imposed to fulfill any accreditation standards on focused professional practice evaluation.

xviii) Any recommendation voluntarily accepted by the practitioner.

xix) Expiration of membership and privileges because of failure to apply for reappointment within the allowable time.

xx) Change in assigned staff category.

xxi) Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges after a final adverse decision at any hospital within the Trinity Health System regarding such request.

xxii) Removal or limitations of emergency department call obligations.

xxiii) Any requirement to complete an educational assessment.

xxiv) Retrospective chart review.

xxv) Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws.

xxvi) Grant of conditional appointment or appointment for a limited duration; or

xxvii) Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action

When a summary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the CMO delivered either 1) in person, 2) by certified mail, return receipt requested, or 3) by overnight delivery with delivery confirmation. This notice shall contain:

i) A statement of the recommendation made and the general reasons for it (Statement of Reasons).

ii) Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation.

iii) Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

iv) The individual shall receive a copy of Part II of these bylaws outlining procedural rights regarding the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the [CMO / Medical Staff Office]. 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.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the CMO, in conjunction with the President of the Medical Staff, 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), at the hearing.

c) The names of the Hearing Committee members and Presiding Officer or Hearing Officer, if known; and

d) A statement of the specific reasons for the recommendation and the list of patient records and/or information supporting it. 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 individual requesting the hearing, and that the individual and the 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, at the discretion of the Presiding Officer, be supplemented or amended at any time during the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses.

Section 5 Hearing Committee and Presiding Officer or Hearing Officer

5.1 Hearing Committee

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 CMO, in conjunction with the Chief/President of the Medical Staff. 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 practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

a) The Hearing Committee shall not include anyone in direct financial competition with the affected practitioner or anyone in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the Presiding Officer.

b) The CMO shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the Hearing Committee or to the Hearing Officer or Presiding Officer shall be made in writing to the [CMO / Medical Staff Office]. The CMO, in conjunction with the President of the Medical Staff, shall determine whether a replacement panel member should be identified. Although the practitioner 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 In lieu of a Hearing Committee chair, the CMO, acting for the Board and after considering the recommendations of the President of the Medical Staff (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 practitioner. 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 serve as the Presiding Officer 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 relevant to the continued appointment or clinical privileges of the 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 panel chair.

5.3 Hearing Officer

5.3.1 As an alternative to the Hearing Committee described above, the CMO, acting for the Board and in conjunction with the President of the Medical Staff (or the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer may be an attorney in non-clinical matters.

5.3.2 The Hearing Officer may not be any individual who is in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references to the "Hearing Committee" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context clearly requires otherwise.

Section 6 Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. The Presiding Officer, Hearing Committee chair, or Hearing Officer 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 individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the 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 his or her expense.

b) Reports of experts relied upon by the MEC.

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 practitioners shall be requested, provided, or considered; and

f) Evidence unrelated to the reasons for the recommendation or to the 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 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 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 his/her counsel.

6.2 Pre-Hearing Conference

The Presiding Officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer 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 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, chair of the Hearing Committee, or Hearing Officer.

6.4 Record of Hearing

The Hearing Committee shall maintain a record of the hearing by a reporter present to make a record of the hearing 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 hearing at that 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 practice.

6.5 Rights of the Practitioner 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:

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 his/her 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 **A**ny 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 relying 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 practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and hospital policies.

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the Hearing Committee may request such a memorandum to be filed within ten (10) business days, following the close of the hearing.

6.9 Official Notice

The Presiding Officer 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.

6.10 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 the Hospital President on a showing of good cause. The hearing shall not proceed unless all hearing panel members are present.

6.11 Persons to be Present.

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

6.12 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 individual who requested the hearing to present evidence.

6.13 Adjournment and Conclusion

The Presiding Officer 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.

6.14 Deliberations and Recommendation of the Hearing Committee

Within twenty (20) 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.

6.15 Basis of Recommendation

The Hearing Committee shall recommend in favor of the MEC (or the Board) unless it finds that the 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.

6.16 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 Board for further action. The CMO shall also send a copy of the report and recommendation, certified mail, return receipt requested or by overnight delivery with delivery confirmation, to the individual who requested the hearing, and to the MEC for information and comment. If the Hearing Committee report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below. If the Hearing Committee report differs from the original MEC or Board recommendation, the MEC or Board may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

Section 7 Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the Hearing Committee makes a recommendation, or after the MEC or Board makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing and shall be delivered to the CMO 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.

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, considering 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 three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner 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 or Hearing Officer. 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 practice.

c) Each party shall have the right to present a written statement supporting 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-minute (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 and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

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 of a current member or a physician or dentist with privileges without membership, that individual may not apply for Medical Staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Fair hearing and appeal for those with privileges without medical staff membership and who are not physicians or dentists.

Psychologists, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), and Allied Health Professionals (AHPs) are not entitled to the hearing and appeals procedures set forth in the medical staff Bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner, and his/her supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The practitioner and the supervising physician, if applicable, must request such a meeting in writing to the Hospital President within ten (10) business days from the date of receipt of such notice. At the meeting, the practitioner, and the supervising physician, 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 practitioner, the MEC and the Board.

The practitioner and the supervising physician, 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. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. 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 practitioner and the supervising physician will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the practitioner, they will not be allowed to reapply for privileges.

7.8 Reporting Requirements

The CEO and CMO or his/her 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.

Section 1 Medical Staff Credentials Committee

1.1 Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or President of the Medical Staff. The composition of this Credentials Committee shall be outlined in the Rules and Regulations.

1.2 Responsibilities

a) To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category.

b) To review and recommend action on all requests regarding privileges from eligible practitioners.

c) To recommend eligibility criteria for the granting of Medical Staff membership and privileges, including new privileges.

d) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.

e) To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff, or hospital leaders.

f) To perform such other functions as requested by the MEC.

1.3 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.3.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical Staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Hospital President or designee.

1.3.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the President of the Medical Staff, Hospital President, credentials chair or Chief Medical Officer (CMO). Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner; no photographs may be taken. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2 Qualifications for Membership and/or Privileges

2.1 Initial Review of Application:

a) A completed application form with copies of all required documents must be returned to the Medical Staff Office.

b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

2.2 Eligibility

To be eligible to apply for initial appointment, reappointment, and/or clinical privileges and as a condition of maintaining ongoing appointment and/or clinical privileges, individuals must satisfy the applicable eligibility criteria:

a) have a current, unrestricted license to practice in Massachusetts that is not subject to any restrictions, conditions, or probationary terms.

b) Not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency; (past issued will be grandfathered in**)**

c) in specialties deemed required by the Hospital, have a current, unrestricted DEA registration and state-controlled substance license linked to an address in this state and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended.

d) have not had appointment or clinical privileges denied, suspended, revoked, or terminated by any health care facility or health plan, including this Hospital, for reasons related to clinical competence or professional conduct.

e) not currently be under any criminal investigation or indictment and have not been convicted of or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same.

f) not currently be under any criminal investigation or indictment and have not been convicted of or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence, or (vii) the Practitioner-patient relationship.

g) have appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed Practitioner with appropriate specialty-specific privileges as determined by the Credentials Committee) with other Practitioners for those times when the individual will be unavailable.

h) Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, advanced practice nursing, physician assistant program, or applicable recognized course of training in a clinical profession eligible to hold privileges threshold criteria.

i) Have a current state or federal license, that is not suspended, as a practitioner, applicable to his or her profession, and providing permission to practice within the state where the practitioner practices. The license must be unrestricted for initial appointment don't need.

j) Have a record that is free from current Medicare/Medicaid exclusions/preclusions and not be on the OIG List of Excluded Individuals/Entities.

k) Have a record that shows the applicant has not been convicted of or entered a plea of guilty or no contest to, any felony, relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder) in the past ten (10) years.

l) Have a record that is free from involuntary termination at another hospital or voluntary resignation in lieu of termination.

m) Have appropriate written and verbal communication skills. threshold criteria

n) Possess a valid NPI number.

o) Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board.

p) Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which independent clinical privileges are sought adequate to meet current clinical competence criteria.

q) The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved Medical Staff development plan.

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

2.2.1 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency and/or fellowship program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and be currently board certified or become board certified within five (5) years of completing formal training or longer as defined by the appropriate specialty board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association or foreign boards which are deemed to be of equivalent status. Recertification may be through the ABMS, AOA, or the National Board of Physicians and Surgeons (NBPAS), or foreign boards accepted by the American board or deemed to meet the training/qualifications of the American board.

2.2.2 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation.

2.2.3 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training, or longer as defined by the appropriate specialty board, as defined by the American Board of Oral and Maxillofacial Surgery, or any foreign board accepted by the American board or is deemed to meet the training/qualifications of the American board.

2.2.4 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training, or longer as defined by the appropriate specialty board, as determined by the American Board of Foot and Ankle Surgery, the American Board of Podiatric Medicine, or any foreign board accepted by the American board or is deemed to meet the training/qualifications of the American board.

2.2.5 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants or be actively seeking initial certification and obtain the same on the first examination for which eligible and reapplicants eligibility.

2.2.6 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB) or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants and reapplicants eligibility.

2.2.7 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) for family nurse practitioners, psychiatric-mental health nurse practitioners, or adult-gerontology nurse practitioners , the American Academy of Nurse Practitioners Certification Board for family nurse practitioners, adult-gerontology nurse practitioner, or emergency nurse practitioners, the American Association of Critical Care Nurses (AACN) for adult/adult-gerontology/pediatric and neonatal nurse practitioners, or an equivalent body is required for initial applicants or be actively seeking certification and obtain the same on the first examination for which he/she is eligible and reapplicants.

2.2.8 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and reapplicants.

2.3 Waiver of Threshold Eligibility Criteria:

a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

b) **Expedited Processing:** All requests for a waiver will be submitted to the Chair of the Credentials Committee, who will make a recommendation on behalf of the Committee regarding whether to grant the waiver. In reviewing the request for a waiver, the Chair of the Credentials Committee may consider the specific qualifications of the applicant in question, including the application form and any additional information submitted, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. If the Chair of the Credentials Committee recommends waiver, the recommendation will be forwarded to the President of the Medical Staff, who will review the request and make a recommendation on behalf of the MEC. If the President of the Medical Staff recommends waiver, the basis for the waiver recommendation shall be articulated in writing and forwarded to the CMO. The CMO will receive the request and determine, on behalf of the Board, whether to grant a waiver. The determination should articulate the basis for the waiver recommendation. If the CMO's determination is to grant a waiver, that determination will be final. If any of the individuals listed above recommend not granting the waiver, the request for waiver will be immediately forwarded for full processing, as set forth below (without the need to first continue through any remaining stages of the expedited process).

c) **Full Processing:** If the Chair of the Credentials Committee, President of the Medical Staff, or CMO recommend against granting a waiver, or if any of those individuals has any questions or concerns about the appropriateness of the waiver, those concerns shall be noted, and the request will be forwarded to the full Credentials Committee for consideration and recommendation. The Credentials Committee will review, considering the information referenced above, and forward its recommendation to the MEC, articulating the basis for it. The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver, articulating the basis for its recommendation. Thereafter, the Board will consider the recommendation of the MEC and decide whether to grant a waiver. The Board's determination is final.

d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not reportable to the state licensure board or the National Practitioner Data Bank.

e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

g) If a waiver is granted that does not specifically include a time limitation, it is considered permanent, and the individual does not have to request a waiver at subsequent recredentialing cycles.

h) No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.4 Privileges:

a) Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested.

b) Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her 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 practitioner acceptable to the Credentials Committee.

2.5 Grand Father provision for

a) All practitioners who are current Medical Staff members and have continuously held privileges since February 12, 2007, and who have met prior qualifications for membership and/or privileges shall be exempt from the board certification requirements listed above in Section 2.2.

Section 3 Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant with an application package, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a) A completed, signed, dated application form.

b) A completed privilege delineation form if requesting privileges.

c) Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency.

d) All applicable fees.

e) Receipt of all references; references shall be selected by the Credentials Committee and come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one reference must be from someone in the same professional discipline.

f) Relevant practitioner-specific data as compared to aggregate data, when available; and

g) Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information while reviewing an application. 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.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, notification requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

a) Upon receipt of a completed application the CMO or credentials chair, in collaboration with the Medical Staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed, and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.

b) Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

c) Upon receipt of a completed application, the Medical Staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff office will collect relevant additional information which may include:

d) Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past ten (10) years, excluding scrub techs and registered nurse first assistants.

e) Verification of the applicant's past clinical work experience for at least the past ten (10) years with the exception that ten (10) affiliations over the past five (5) years will be checked for telemedicine and locum tenens practitioners;

f) Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

g) Information from the AMA or AOA Physician Profile, FCVS, and OIG list of Excluded Individuals/Entities or SAM (System for Award Management) for applicants with out-of-state experience.

h) Information from professional training programs including residency and fellowship programs;

i) Information from the National Practitioner Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested through use of the continuous query process;

j) Other information about adverse credentialing and privileging decisions;

k) Three (3) peer recommendations, as selected by the organization, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges.

l) At both initial appointment and reappointment, criminal background checks and/or others will be conducted in accordance with Trinity Health System policy and procedures regarding practitioner information.

m) Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and

i) Morbidity and mortality data and relevant practitioner-specific data (OPPE data) as compared to aggregate data, when available.

ii) Note: In the event there is undue delay in obtaining required information, the Medical Staff office will request assistance from the applicant. During this period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application. Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

iii) Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

iv) A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings

3.1.3 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant:

a) Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may terminate effective immediately upon notification of the individual without the right to a fair hearing or appeal.

b) Consents to appear for any requested interviews in regard to his/her application.

c) Authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

d) Consents to hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of:

e) Professional qualifications and competence to carry out the clinical privileges requested.

f) Physical and mental/emotional health status to the extent relevant to safely perform requested privileges.

g) Professional and ethical qualifications.

h) Professional liability actions including currently pending claims involving the applicant; and

i) Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

j) Acknowledges that the applicant has had access to the Medical Staff bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

k) Agrees to provide accurate answers to the questions on the application, and agrees to immediately, within twenty-four (24) hours, notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Grant of Immunity and Authorization to Obtain/Release Information

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

a) **Immunity To the fullest extent permitted by law:** the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or any of its affiliates or subsidiaries, or any of their Boards, Board members, Medical Staffs, Medical Staff members, Advanced Practice Professionals, representatives or agents, or any third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individuals that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

b) **Authorization to Obtain Information from Third Parties:** The individual specifically authorizes the Hospital, its Medical Staff, Medical Staff Leaders, and their authorized representatives.

i) To consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on is or her qualifications for initial and continued appointment to the Medical Staff and/or clinical privileges, and

ii) To obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes these third parties to release this information to the Hospital, its Medical Staff, Medical Staff Leaders, and their authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report to the Hospital.

c) Authorization to Release Information to Third Parties:

The individual also a authorizes Hospital, its Medical Staff, and their authorized representatives to release information to

i) Other hospitals, health care facilities, managed care organizations, and their a agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility.

ii) Persons or entities external to the Hospital that are assessing the individual's professional qualifications, competence, or health pursuant to a review that the individual has been notified is occurring under applicable Hospital or Medical Staff policies, and

iii) Any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any peer review information in response to such inquiries does not waive any associated privilege, and any and all disclosures shall be made with the understanding that the receiving entity will only use such peer review information for peer review purposes.

d) **Authorization to Share Information among Trinity Health of New England Entities:**

The individual specifically authorizes entities affiliated with Trinity Health of New England to share with one another any information maintained in any format (verbal, written, or electronic) that involves:

i) The evaluation of the quality, safety, necessity, and compliance with applicable law of services ordered or performed by the individual, or

ii) The individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices. This information and documentation may be shared at any time, including, but not limited to any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

e) Procedures Fair Under the Circumstances:

The individual agrees that the credentialing, privileging, quality improvement, and peer review/professional practice evaluation procedures set forth in the Medical Staff Bylaws and other pertinent Hospital and Medical Staff policies constitute procedures that are fair under the circumstances and those procedures are the sole and exclusive remedy to challenge any matter that falls within the scope of this Section.

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

g) Legal Actions: If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting an appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff members, Advanced Practice Professionals, authorized representatives, agents, and employees who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

h) **Scope of Section:**
All of the provisions in this Section are applicable in the following situations:

i) whether or not appointment or clinical privileges are granted throughout the term of any appointment or reappointment period and/or grant of clinical privileges and thereafter.

ii) should appointment, reappointment, and/or clinical privileges be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities.

iii) as applicable to any third-party inquiries received after the individual leaves the Medical Staff or no longer practices as an Advanced Practice Professional about his or her tenure at the Hospital; and

iv) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

3.4 Application Evaluation

3.4.1 Credentialing Process: An expedited review and approval process may be used for initial appointment or for reappointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows:

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Department Chair, credentials chair acting on behalf of the Credentials Committee, the MEC and a committee consisting of at least two (2) Board Members.

Category 2: If one or more of the following criteria are identified while reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Department Chair, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a) The application is deemed to be incomplete.

b) The final recommendation of the MEC is adverse or with limitations.

c) The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration.

d) Applicant is, or has been, under investigation by a state medical board, state-controlled substance registration authority, DEA or has prior disciplinary actions or legal sanctions.

e) Applicant has had two (2) or more or an unusual pattern of malpractice cases judged adversely against the practitioner within the past five (5) years or one final adverse judgment or settlement in a professional liability action in excess of $750,000 within the past five (5) years.

f) Applicant changed medical schools, or residency programs or has unexplained gaps in training or practice twenty-eight (28) days or greater.

g) Applicant has changed practice affiliations three or more times in the past ten (10) years, excluding telemedicine and locum tenens practitioners and those serving in the military.

h) Applicant has one or more reference responses that raise concerns or questions.

i) Substantive discrepancy is found between information received from the applicant and references or verified information.

j) Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions.

k) The request for privileges is not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria.

l) Applicant has been removed from a managed care panel for reasons of professional conduct or quality.

m) Applicant has potentially relevant physical, mental, and/or emotional health problems.

n) Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.4.2 Applicant Interview

All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chair, Credentials Committee, MEC, or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

3.4.3 Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.4.4 Department Chair Action

a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. Each chair shall prepare a written report regarding whether the applicant has satisfied all the qualifications for appointment and the clinical privileges requested on a form provided by the Medical Staff Office.

b) The department chair shall be available to the Credentials Committee, Medical Executive Committee, and the Board to answer any questions raised about the report and findings of that individual.

3.4.5 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the credentials chair, or designee, for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair can determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the Medical Staff Credentials Committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the Medical Staff Credentials Committee reviews the application and forwards the following to the MEC:

a) A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

b) A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

3.4.6 Comments to support these recommendations.

The Credentials Committee may recommend specific conditions on Appointment and/or Clinical Privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that Appointment be granted for less than two years to permit closer monitoring of an individual's compliance with any conditions. **Unless these matters involve the specific recommendations set forth in Part II, Section 4.1 of these Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Part II, Section 4 of these Bylaws**

3.4.7 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing as noted in Part I, Section 7.4.2. The President of the Medical Staff can determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

a) A recommendation as to whether the application should be acted on as Category 1 or Category 2.

b) A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c) A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d) Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.4.8 Board Action:

The Board reviews the application and votes for one of the following actions:

a) If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) Board Members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

b) If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:

c) The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months.

d) If the Board's action is averse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

e) The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.4.9 Notice of Final Decision: Notice of the Board's final decision shall be given, through the Hospital President to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment include the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the period of the appointment, and any special conditions attached to the appointment.

3.4.10 Time Periods for Processing: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4 Reappointment

4.1 Criteria for Reappointment

It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members or other practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation. A suitable peer shall substitute for the Department Chair in the evaluation of current competency of the Department Chair and recommend appropriate action to the Credentials Committee.

4.2 Information Collection and Verification

4.2.1 From appointee: On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days after release of the reapplication, the practitioner must return the following to the Medical Staff office:

a) A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues.

b) Information concerning continuing training and education internal and external to the hospital during the preceding period; and

c) By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.1 above.

The following information is also collected and verified:

a) A summary of clinical activity at this hospital for each practitioner due for reappointment.

b) Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.

c) Attestation of any required hours of continuing medical education activity.

d) Service on Medical Staff, Department, and hospital committees.

e) Timely and accurate completion of medical records.

f) Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff.

g) Any significant gaps in employment or practice since the previous appointment or reappointment twenty-eight (28) days or greater.

h) Verification of current licensure.

i) Verification of identity by comparing a current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card and comparing it to the applicant.

j) National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards).

k) When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and

l) Malpractice history for the past three (3) years, which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s).

4.2.2 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment may result in automatic expiration of appointment when the appointment period is concluded if the application cannot be processed within the shortened timeframe. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 Expedited review reappointment applications will be categorized as described in PART 3 Section 2.3(b)

4.3.2 The reappointment application will be reviewed and acted upon as described in Sections 4.2. For reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

Section 5 Clinical Privileges

5.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or temporary, emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be clinical psychologists, APPs, physicians serving short locum tenens positions, telemedicine physicians, or others deemed appropriate by the MEC and Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

5.3.2 Requests for clinical privileges will be consistently evaluated based on prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

5.3.3 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

5.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

5.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff recorded in the medical record. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence.

5.6 Telemedicine Privileges

Telemedicine privileges are limited to those services the MEC, acting for the medical staff, has approved for telemedicine delivery.

Applicants for Telemedicine Privileges will not be required to submit supporting data outlined in this Part III, Section 2, not relevant to the privileges and practice requested. (Examples: tuberculosis testing or status, DEA and MA CSR)

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:

a) The Hospital fully privileges and credentials the practitioner if the telemedicine Hospital/entity is not Joint Commission accredited, or

b) Abiding by current Massachusetts statute regarding delegated hospital credentialing of medical staff, the Hospital privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited Hospital or telemedicine entity. 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 where the patient is located AND must have an active and unrestricted medical license in Massachusetts.

5.7 Temporary Privileges

The Hospital President or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

a) 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, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.

b) Clean (Category 1) Application Awaiting Approval: The expedited credentialing process will be preferentially used in this circumstance. If a condition exists such that the applicant needs clinical privileges more rapidly than would be granted under the expedited processing pathway, temporary privileges will be granted following review by the Credentials Committee Chair as described in Section 3.3.4, above. Request for such temporary privileges must be made by the President of the Medical Staff, or designee, to the Hospital President.

c) Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

d) **Termination of temporary privileges**: The Hospital President, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the President of the Medical Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

e) Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.8 Emergency Privileges:

In the case of a medical emergency, any practitioner on the Medical Staff is authorized to do everything possible to save the patient's life or to save the patient from serious harm to the degree permitted by the practitioner's license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.9 Disaster Privileges:

If the institution'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 institution'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.

5.9.1 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer Practitioners who have been granted disaster privileges.

5.9.2 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 decides (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

5.9.3 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 organization. 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.

5.9.4 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.

5.9.5 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.

5.10 Leave of Absence

Being granted a leave of absence is a courtesy, not a right. LOA must be requested if a practitioner with clinical privileges will be absent from hospital/committee responsibility or clinical practice for greater than 90 days. *Routine maternity/ paternity leaves are excluded from the need to request a medical staff LOA.*

Must be requested via letter directly to the Medical Staff President, who will in turn present the request to the MEC. Requirements:

a) Must list general reason for the requested LOA; accepted indications include military service, personal physical or emotional health challenge, or professional sabbatical/educational opportunity.

b) Must estimate the amount of time for which leave is requested, with maximum 1 year.

c) Practitioners on LOA **must** notify med staff president/MEC and MSO in writing of intention to resume practice at end of LOA.

d) Practitioners on LOA for medical/emotional health reasons must provide MEC with a basic "fitness for duty" note from their treating physician before being approved to conclude the LOA and resume clinical privileges.

e) Extending an LOA beyond 1 year will occur only at the discretion of MEC and only in the case of extenuating circumstances/significant hospital need for that practitioner. Extension of a leave of absence is not guaranteed. Otherwise, the practitioner will be considered to have voluntarily resigned membership and privileges after 1 year of absence. *This administrative resignation does not constitute an adverse action and does not provide the practitioner with fair hearing rights*.

f) For LOA more than 6 months, practitioners on a leave of absence will NOT be able to renew hospital privileges if their 2-year reappointment falls during their LOA. Instead, they will be able to renew, as opposed to becoming a new applicant, at the time their LOA ends, after appropriate written notification of the Medical Staff President and request for a renewal application from MSO.

g) MEC may recommend the following to the Board: limits to the practitioner's privileges, a shorter period of reapplication, etc., after review of the reason for LOA and any concerns about fitness for clinical duty. Any such recommendation, if accepted by the Board, that meets the definition of "adverse action" from Section 4 in Part II of these bylaws will then provide the affected practitioner with fair hearing rights.

Section 6 Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, after receiving a report from the Department Chair and with the approval of the MEC, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

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. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.3 Physician Re-Entry

6.3.1 A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, that is acceptable to the Credentials Committee and MEC, either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital.

6.3.2 If a practitioner has not provided any clinical care within the past five (5) years as determined by the state(s) where the practitioner practices, to have an application for medical staff membership and privileges qualify for consideration s/he may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other approved formal process to assess and confirm clinical competence. Failure on the part of the applicant to complete such required formal re-entry training will preclude consideration of the application and is not an "adverse action" as defined in Part II of these bylaws. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Department Chair, Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a) The scope and intensity of the required activities.

b) The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 7 Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges.

7.2 Request for Modification of Appointment Status or Privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, department assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information supporting the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed the same way as a reappointment outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the Medical Staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of Staff Appointment or Privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide thirty (30) days' written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to complete fully and accurately all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting Requirements

Reporting requirements are noted in Part II Section 3

Section 8 Practitioners Providing Contracted Services

8.1 Exclusivity policy

Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

8.2 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee. There may be a waiver of qualification as per Part III, Section 2.3 of these Bylaws.

The terms of the Medical Staff bylaws will govern disciplinary action taken by or recommended by the MEC.

8.3 Effect of Contract or Employment Expiration or Termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 9 Medical Administrative Officers

9.1 A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

9.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

9.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

a) Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.

b) In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

c) A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.