***LIGHTHOUSE***

***SURGERY***

***CENTER***

 **MEDICAL STAFF BYLAWS**

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**PREAMBLE**

**WHEREAS, *Lighthouse Surgery Center*** is an ambulatory surgical center owned and operated by ***Lighthouse Surgery Center, LLC*** in the State of Connecticut; and

**WHEREAS,** the purpose of ***Lighthouse Surgery Center*** is to operate as an ambulatory surgical center to provide quality care for eligible patients who are scheduled to undergo procedures which meet the criteria for ambulatory care; and

**WHEREAS,** the Center's Medical Staff is subject to the ultimate authority of the Governing Board of ***Lighthouse Surgery Center,*** who is responsible for the quality and appropriateness of medical care rendered at the Center; and

**WHEREAS,** the cooperative efforts of the Medical Staff and the Governing Board are essential to the fulfillment of the Center's obligations to its patients and owners; and

**NOW, THEREFORE,** the members of the Medical Staff practicing at the Center hereby formally organize themselves as the Ambulatory Surgery Center Medical Staff in accordance with these Bylaws. The signature and approved application of each Medical Staff member serves as their acknowledgement of, understanding and agreement to abide by these Bylaws.

**DEFINITIONS**

As used in these Medical Staff Bylaws, the following terms are defined as follows:

**Allied Health Professional:** "Allied Health Professional" means a professional licensed, certified or trained (per law) to perform patient care services under the supervision of a practitioner who has medical staff privileges (unless allowed to practice as an independent practitioner under state law).

**ASC/ASF/Center:** "ASC", "ASF" or "Center" means ***Lighthouse Surgery Center.***

**Center Leader:** "Center Leader" means the administrator appointed by the Governing Board to provide for the overall management of the Center.

**Chairman of the Governing Board:** "Chairman of the Governing Board" means the individual appointed by the Governing Board. Responsibilities include calling meetings and keeping meeting minutes.

**Clinical Privileges:** "Clinical Privileges" or "Privileges" mean the permission granted to a practitioner to render those diagnostic, therapeutic, medical, surgical, or anesthetic services at the ASC for which they have been approved.

**Governing Board:** "Governing Board" or "Board" means the Governing Board of ***Lighthouse Surgery Center*** and shall serve as the Governing Board with ultimate authority and responsibility for all planning, quality of care and services, direction, control and management for the Center's operations. The Governing Board shall consist of five (5) individuals appointed by the medical director.

**He/Him/His:** The term is used as gender-neutral and refers to either a female or male person.

**Ineligible Person:** "Ineligible Person" means an individual or entity that is currently excluded by the United States Department of Health and Human Services Office of Inspector General (OIG) from participation in Medicare, Medicaid and other federal health care programs.

**Medical Director:** "Medical Director" means the physician **[provided from the physician entity per the legal documents of the Center] [appointed by the Governing Board]** who will be responsible for the direction and coordination of all medical aspects of the Center programs and serves as the Medical Staff President.

**Medical Executive Committee:** "Medical Executive Committee" or "MEC" means the physician members of the QAPI Committee, the Medical Staff President, and an Administrative designee as appointed by the Governing Board. The Administrative designee shall be a non-voting member of the MEC.

**Medical Staff:** "Medical Staff" means the formal organization of practitioners whose credentials are approved and privileges are granted to care for patients at the Center.

**Practitioner:** "Practitioner" means an individual with M.D., D.P.M., or D.O. degree who is fully licensed to practice medicine, surgery, podiatry, or osteopathy in the State of Connecticut.

**Quality Assessment/Performance Improvement Committee:** "Quality Assessment/Performance Improvement Committee" or "QAPI Committee" means the committee established by the Governing Board to make recommendations to the Governing Board concerning all quality assessment/performance improvement, clinical risk management, accreditation and regulatory standards compliance, and safety (collectively, QAPI) activities. The Committee shall consist of the Center Leader, Medical Director or designated Medical Staff representative(s), Admitting/Business/Reception, Pharmacy Consultant, Risk Manager, and such other members as applicable per state law that may be appointed by the Governing Board and/or QAPI Chairman in accordance with these Bylaws.

**ARTICLE I**

**PURPOSES AND RESPONSIBILITIES**

* 1. **Purposes.**

The purposes of the Medical Staff shall be:

* + 1. To ensure that all patients admitted to or treated in the Center regardless of race, sex, creed, age, or national origin, receive high quality medical care.
		2. To ensure a high level of professional performance among all Medical Staff privileged to practice in the Center.
		3. To assist the Center in satisfying applicable licensure, certification, and accreditation requirements.

1.1.4 To serve as the primary means for accountability to the Governing Board for the quality and appropriateness of the professional performance and ethical conduct of its members.

1.1.5 To provide an appropriate educational setting which will maintain scientific and clinical standards and that will lead to continuous advancement in professional knowledge and skills.

* 1. **Responsibilities.**

The responsibilities of the Medical Staff shall be:

* + 1. To provide the following:
			1. A credentialing process that provides for the appropriate appointment and reappointment of practitioners and the delineation of clinical privileges and specialized services in accordance with training and experience;
			2. Medical Staff participation in the QAPI program, which assures high quality care and safety through established and defined systems;
			3. Regular reports and recommendations to the Governing Board concerning the quality and appropriateness of patient care rendered at the Center.
		2. To provide a means whereby issues concerning the Medical Staff and the Center may be discussed by the Medical Staff with the Governing Board.
		3. To initiate and maintain self-governance of the Medical Staff.
		4. To promote the public's confidence in and utilization of services performed by the Medical Staff of the Center.
		5. To ensure that Medical Staff members participate in the review and analysis of the clinical work done in the center, including Medical Staff peer review.
		6. To ensure that all Allied Health personnel employed by a member of the Medical Staff shall be credentialed and granted appropriate privileges to provide patient care and will be under the direct authority of the Medical Staff member, who shall at all times be responsible for the actions of the Allied Health personnel.
		7. To exercise the authority granted by these Bylaws as necessary to fulfill adequately the foregoing responsibilities.
	1. **Organization.**

The Medical Staff shall be organized as a group of all Practitioners who have been granted the right to exercise Clinical Privileges within the Center.

* 1. **Meetings.**

The full Medical Staff shall meet at least annually at a time and place to be determined by the Medical Staff President, and at other times and places as requested by the Medical Staff President. Notice of the annual meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously at least fourteen (14) days in advance of the meeting. Notice of any other meetings shall be given to all Medical Staff members via appropriate media and posted conspicuously at least five (5) days in advance of the meeting. No business shall be transacted at any special meeting unless such business is stated in the notice of such meeting. Meetings shall be run in a manner determined by the individual who is the chair of the meeting.

* 1. **Quorum and Voting.**

A majority of the Medical Staff shall constitute a quorum. Except for amendments to the Bylaws or as otherwise specified in these Bylaws, the Medical Staff shall act upon the vote of a majority of the Medical Staff members at a meeting at which a quorum is present. Notwithstanding the foregoing, if any Medical Staff member has a conflict of interest as determined by a majority of the other disinterested Medical Staff Members, such member shall not be allowed to participate in discussions of the matter for which there is a conflict or be allowed to vote on the matter. In such situations, a quorum shall consist of a majority of the disinterested Medical Staff Members.

* 1. **Action Without Meeting.**

Action may be taken without a meeting by the presentation of the question to each Medical Staff member eligible to vote, in person, via telephone, facsimile, mail and/or electronic mail, and the vote recorded by the Center.

# Minutes.

Minutes of each regular and special meeting of the Medical Staff or a Medical Staff committee shall be prepared and include a record of attendance of members and the vote on each matter. The presiding officer shall sign the minutes, and a permanent file of the minutes of each meeting shall be maintained.

# Officers.

* + 1. An officer of the Medical Staff must be a member of the Medical Staff at the time of nomination and election and must remain a member in good standing during his term of office.
		2. Officers shall be elected at the full Medical Staff annual meeting by a majority vote of the Medical Staff based upon nominations by a nominating committee established by the Medical Executive Committee for the purpose of nominating officers.
		3. All officers shall serve a term of two (2) years from election date or until a successor is elected. Officers may be re-elected to additional terms.
		4. Vacancies in office may be filled by the Medical Executive Committee of the Medical Staff.
		5. An officer will be immediately terminated from office upon loss of licensure or clinical privileges at the Center. An officer also may be removed from office by a two-thirds (2/3) majority vote of all members of the Medical Staff, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Governing Body.
		6. The Medical Staffs officers shall be as follows:
			1. President. The President of the Medical Staff shall be the Medical Director. The responsibilities, duties, and authority of the President are as follows:
				1. Call, preside at, and determine the agenda of all general and special meetings of the Medical Staff.
				2. Serve as chairperson of the Medical Executive Committee and as ex-officio member without vote of all other Medical Staff committees.
				3. Enforce these Bylaws, the Code of Conduct, Rules and Regulations, and applicable Center policies, implement and administer sanctions when they are indicated, enforce the Medical Staff's compliance

with procedural safeguards in all instances when corrective action has been requested or initiated against a member of the Medical Staff.

* + - * 1. Communicate and represent the views, policies, concerns, needs, and grievances of the Medical Staff to the Governing Board.
				2. Advise the Governing Board on the effectiveness of the quality improvement program and the overall quality of patient care in the Center.
				3. Perform such other duties as are required of his office.

# ARTICLE II MEDICAL STAFF MEMBERSHIP

# Nature of Medical Staff Membership

Membership on the Medical Staff or the exercise of clinical privileges is a privilege and shall be extended only to those practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the appointee or member only such clinical privileges as have been granted by the Governing Board. Action may be initiated to terminate the membership of any Medical Staff Member who fails to meet the qualifications, standards and requirements set forth in these Bylaws. Only members of the Medical Staff shall admit or treat patients at the Center. No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of age, sex, race, or creed.

# Medical Staff Categories.

The Medical Staff shall consist of the following categories: Provisional, Active and Courtesy.

**Provisional Medical Staff Category:** The membership of the appointee shall remain under Provisional status for a minimum of three (3) months in duration and for a period of up to one (I) year at which time the appropriate specialties will review the appointee's compliance with Surgery Center and Medical Staff policies, procedures and rules. During the Provisional period, the appointee will be directly observed for the number of cases / procedures specified by the Governing Board. The appointee may be advanced to Active or Courtesy medical staff privileges if the qualifications to advance have been met. Provisional Staff members are not eligible to vote on Medical Staff matters or hold Medical Staff office.

**Active Medical Staff Category:** The Active Staff category shall consist of practitioners who regularly admit patients to the Surgery Center. Members of the Active Staff are eligible to vote, hold staff and specialty office. Active Staff members must participate in the quality and performance improvement activities required of the Medical Staff and must serve, when qualified and required to do so, as proctors for practitioners during any period of staff membership.

**Courtesy Medical Staff Category:** The Courtesy Staff category shall consist of practitioners who occasionally admit patients to the Surgery Center. Courtesy Staff members are not eligible to vote on Medical Staff matters or hold Medical Staff office. They may serve as non-voting participating members of designated Surgery Center committees.

# General Qualifications.

Membership on the Medical Staff of the Center is a privilege extended only to those practitioners who, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Governing Board the following qualifications:

* + 1. Possess a current, valid license issued by the State of *Connecticut.*
		2. Possess a current, valid federal and state Drug Enforcement Administration certificate, as applicable.
		3. Active privileges require a minimum of twenty (20) cases at the Center per year. Courtesy privileges require a minimum of five (5) cases and a maximum of nineteen (19) cases. Below five (5) cases per appointment year triggers loss of medical staff privileges. Twenty (20) or more cases per appointment year is an automatic transfer to Active Privileges.
		4. Possess a current, valid state Pharmacy license, if applicable
		5. Document their professional education, training and experience, indicating a continuing ability to provide quality patient care services.
		6. Are determined by the Medical Executive Committee to demonstrate current professional competence.
		7. Demonstrate a willingness and capability, based on current attitude and evidence of performance:
			1. To work with and relate to other staff members, members of other health disciplines, administration, employees and visitors in a cooperative, professional manner that is conducive to quality patient care; and
			2. To adhere to generally recognized standards of professional ethics.
		8. Have the physical and mental health to exercise the privileges granted.
		9. Maintain similar clinical privileges at an acute care facility within fifteen (15) miles of the Center, except that physicians practicing anesthesiology, or pain management who do not hold clinical privileges at an acute care hospital may be excused from this requirement upon submission of evidence demonstrating to the Governing Board's satisfaction that such practitioner has appropriate credentials, education, training, and experience to support his/her application.
		10. Board certification or adequate progress toward Board certification, the adequacy of which shall be made by the Governing Board.
		11. Provide proof of medical malpractice insurance in the amounts of $1 million/$3 million, unless a different amount is approved by the Governing Board.
		12. Are not Ineligible Persons as verified by the Center.
		13. Agree to notify and provide to the Medical Staff immediately any new or updated information that is pertinent to the individuals' professional qualifications or any question on the application form, including but not limited to any change in Ineligible Person status, any change in the sanctions imposed or recommended by

the United States Department of Health and Human Services or any state or state agency.

* + 1. Provide two (2) letters of recommendation from persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicants' professional competence and ethical character.
		2. Complete all applicable state-required Continuing Medical Education.
		3. Maintain BLS/ACLS/PALS certification if required by the Governing Board.

# Basic Responsibilities of Medical Staff Members.

Each Medical Staff Member shall:

* + 1. Provide his or her patients with continual care at the generally recognized professional level of quality.
		2. Abide by the Medical Staff Bylaws, Center policies and procedures, including the Disruptive Practitioner and Impaired Practitioner policies (Appendices A and B hereto), applicable legal regulatory requirements and standards, and accreditation standards.
		3. Ensure the preparation of complete medical record documentation for each patient he or she admits, including a pertinent history and physical examination that shall be performed within 30 days, or shorter time period if required by federal or state law, before or concurrent with the admission of the patient, and the completion of all records within 30 days, or shorter time period if required by federal or state law, following discharge. If records remain incomplete 30 days following discharge, the Medical Director will be notified, and disciplinary action will be undertaken at the discretion of the Medical Director.
		4. Ensure that a surgical operation or procedure is only performed with the written informed consent of the patient or his/her legal representative, except in an emergency.
		5. Ensure that all surgical specimens removed during an operation or procedure are sent for pathology except those exempted by the Governing Board.
		6. Ensure that patients are discharged only upon the written order of the attending physician.
		7. Ensure that prudence in judgment is exercised in the selection of patients appropriate for the outpatient facility.

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* + 1. Work with and relate to other staff members, members of other health disciplines, administration, employees and visitors in a cooperative, professional manner that is conducive to quality patient care.
		2. Adhere to generally recognized standards of professional ethics.
		3. Actively participate in the quality assessment and performance improvement activities of the Center.

# Prerogatives of Medical Staff Members

The Members of the Medical Staff shall enjoy the following prerogatives:

* + 1. Admit and attend to patients in the Center as provided in the Center's policies and the Medical Staff Bylaws.
		2. Exercise ***only*** such delineated privileges granted by the Governing Board.
		3. Attend and vote on matters at Medical Staff meetings.
		4. Serve as a member of a Medical Staff committee.

# Duration of Appointment

All appointments and reappointments to the Medical Staff shall be for a period not to exceed two

(2) years. In no case shall the Governing Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

**ARTICLE III**

**PROCEDURE FOR PRACTITIONER APPOINTMENT AND REAPPOINTMENT**

* 1. **General Procedures.**

All applications for appointment and reappointment to the Medical Staff shall be in writing on a form endorsed by the Governing Board and shall be signed by the applicant. The application shall contain detailed information concerning the applicant's professional experience and qualifications as required by the Governing Board and shall include a statement indicating the applicant has read the Medical Staff Bylaws and agrees to abide by the terms thereof for as long as his membership continues.

* 1. **Effect of Application.**

By filing an application for initial appointment or reappointment, and as long as the Practitioner is a member of the Medical Staff or has clinical privileges, the applicant automatically:

* + 1. Attests to the correctness and completeness of all information contained therein.
		2. Agrees to update and keep current all information contained in said application packet during the course of the application process and as long as membership on the Medical Staff is maintained.
		3. Agrees to abide by the terms of the Center's Code of Conduct, Bylaws and policies and procedures if granted membership and clinical privileges.
		4. Agrees to maintain an ethical practice and to provide care and supervision to patients utilizing the generally recognized professional level of quality.
		5. Agrees to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the Governing Board and the Medical Staff.
		6. Agrees to only request specific clinical privileges for which the applicant is qualified based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information.
		7. Agrees that any material misstatement or omission on any application, or made at any time during the appointment or reappointment process, or after Medical Staff membership and/or clinical privileges have been granted, shall be grounds for immediate denial of the application for appointment or reappointment, or summary suspension and termination of Medical Staff membership and clinical privileges if the misstatement or omission is discovered after the Practitioner is appointed or reappointed.

# Application.

The completed Medical Staff application shall be submitted to the Center Leader or designee and shall include, but not be limited to, the following information:

* + 1. Copy of state licensures with verification of expiration date and that the license is current and unrestricted.
		2. Current Drug Enforcement Administration (DEA) registration with expiration date.
		3. Copy of current state pharmacy license, if applicable, with verification of expiration date and that the license is current and unrestricted.
		4. Written verification of professional schooling, internship, residency, and/or fellowship.
		5. Past and present hospital and other health care entity affiliations, including evidence of applicable privileges held at such entities.
		6. Memberships in professional associations, societies, academies, colleges, and faculty appointments.
		7. Specialty or board certification status.
		8. Medicare and Medicaid provider numbers, if applicable.
		9. Completed Health Status Assessment Form and documentation of applicable health testing and vaccinations, which shall demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested.
		10. Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion. The applicant shall have a continuing duty to notify the Medical Director of the initiation of participation in any rehabilitation or impairment program. The Medical Director shall be responsible for notifying the Medical Executive Committee of all such actions.
		11. Any current criminal charges pending against the applicant and any past convictions or pleas. Practitioner shall notify the Center Leader and Medical Director within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Center's right to perform a background check at appointment, reappointment, and any interim time when reasonable suspicion has been shown.
		12. Any allegations of civil or criminal fraud pending against the applicant and any past allegations including their resolution and any investigations by any private, federal

or state agency concerning participation in any health insurance program, including Medicare and Medicaid.

* + 1. Copy of current professional liability insurance certificate with minimum limits as determined by the Governing Board.
		2. Information regarding professional liability and malpractice claims either filed, pending, settled, or pursued to final judgment.
		3. Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of the following:
			1. State licenses or DEA registrations;
			2. Membership/fellowship in local, state or national professional organizations.
			3. Specialty board certifications;
			4. License to practice any profession in any jurisdiction.
			5. DEA number/controlled substance license.
			6. Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges.
			7. Practitioner's management of patients which may have given rise to investigation by the state medical board.
			8. Participation in any private, federal or state health insurance program, including Medicare and Medicaid.

The applicant shall have a continuing duty to notify the Center Leader or Medical Director within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The Center Leader or Medical Director shall be responsible for notifying the Medical Executive Committee of all such actions.

* + 1. Two (2) letters of professional reference from peers or individuals from the same discipline and with essentially equal qualifications as the applicant, other than family or those affiliated by marriage, who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, and ability to work cooperatively with others.
		2. Copy of current BLS/ACLS/PALS certification if applicable.
		3. Signed release of liability and attestation.
		4. Proof of completion of state-required continuing medical education for the past two

(2) years.

* + 1. Evidence of privileges held at local hospital and Medical Staff standing, unless such physician practices anesthesiology, or pain management and has submitted appropriate documentation as described in Section 2.3.9.
		2. Delineation of Privileges Form indicating the specific clinical privileges for which the applicant wishes to be considered.
		3. Signed statement acknowledging the applicant's understanding of the scope and extent of authorization, confidentiality, immunity, and release provisions of Article IX and agreement to exhaust all administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his staff membership and/or clinical privileges.
		4. Signed statement that the applicant has received and read the Medical Staff Bylaws and agrees to be bound by the terms thereof if granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to the consideration of his application, without regard to whether or not he/she is granted membership and/or clinical privileges.

# Processing the Initial Application.

* + 1. **Applicant's Burden of Proof.** The applicant has the burden of producing all required information deemed adequate as determined by the Center for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts relating to the granting of Medical Staff membership and/or clinical privileges. It is the applicant's responsibility to ensure that the Center receives all required supporting documents verifying information on the application and providing sufficient evidence, as required in the sole discretion of the Center, that the applicant meets the requirements for Medical Staff membership and the privileges requested.
		2. **Request for Additional Information.** If information is missing from the application, or new, additional or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Center within thirty (30) days of receipt of the request letter, the application is deemed as voluntarily withdrawn.
		3. **Necessity to Meet Minimum Objective Requirements.** If an applicant fails to meet the minimum objective requirements for membership to the Medical Staff, the applicant will not be processed, and the Applicant will not be entitled to a fair hearing.

# Verification of Information and Processing of Application.

* + - 1. The completed application shall be submitted to the Center Leader who will review the submitted application for completeness and notify the applicant of any incomplete items.
			2. The Center Leader or designee, including, as applicable a Credentials Verification Organization (CVO), shall perform primary verification of submitted information as follows:
				1. American Medical Association Profile (physicians), American Board of Podiatric Surgery (podiatrists), or AANA (CRNAs).
				2. National Practitioner Data Bank query.
				3. OIG Query.
				4. State Licensure.
				5. Education and training if not available through profiles listed above.
				6. Specialty Board Certification.
				7. P.A. Certification.
				8. Current malpractice coverage and verification of claims history.
				9. Foreign Medical Graduate verification, if applicable.

3.4.4.1 The completed application will be forwarded to the Medical Director. The Medical Director shall review the application and its supporting documentation and report to the Medical Executive Committee his findings. This report shall include his recommendation as to the approval or denial of, and any special limitations on, appointment and scope of privileges.

* + - 1. The Medical Executive Committee shall review the application, the supporting documentation, the recommendation from the Medical Director and any other relevant information available to it. In addition, the Medical Executive Committee may meet with the applicant to discuss the application. The Medical Executive Committee shall communicate to the Governing Board its recommendations as to the approval or denial of, and any special limitations on, staff appointment and scope of clinical privileges.
			2. The Governing Board may adopt or reject, in whole or in part, the recommendation of the Medical Executive Committee. At its next regular meeting after receipt of a favorable initial recommendation of the Medical Executive Committee and Medical Director in regard to an application,

the Governing Board shall take action on the matter. Favorable action by the Governing Board shall be effective as its final decision. The Medical Director shall communicate the favorable decision to the Practitioner in writing.

* + - 1. If the Governing Board's decision is adverse to the practitioner with respect to either appointment or privileges, the Medical Director shall promptly notify the practitioner in writing of the adverse decision and the Practitioner's procedural rights under Article VII of the Medical Staff Bylaws.
			2. All individuals and groups required to act on an application for staff appointment must do so within 180 days.
	1. **Term of Appointment.**

All new appointments and reappointments to the Medical Staff shall be for a period of 2 years.

* 1. **Reappointment.**

**3.6.1. Application for Reappointment.** At least ninety (90) days prior to the expiration of a Practitioner's term of appointment to the Medical Staff, a Practitioner shall submit a written completed application on a form approved by the Governing Board to the Medical Executive Committee for his reappointment to the Medical Staff. The application shall be signed by the Practitioner and shall contain the information required in Section 3.3 for an initial application. If the Practitioner is requesting new privileges, such request must be accompanied by documentation of applicable training and experience to support the request.

* + 1. **Verification of Information and Processing of Application.**
			1. The completed application shall be submitted to the Center Leader. The Center Leader or designee, including, as applicable a Credentials Verification Organization (CVO), will review the submitted application for completeness and notify the applicant of any incomplete items.
			2. Processing the application for reappointment shall be completed in the same manner as for initial appointment as described in Section 3.4.4, which shall include the completion of the AMA Reappointment Profile for physicians seeking reappointment. In addition, the Medical Executive Committee shall also review the Practitioner's credentials file for relevant information regarding the Practitioner's professional activities, performance, and conduct in the Center. Relevant information may include information regarding:
				1. Patterns of care and judgment as demonstrated in the findings of QAPI activities and elsewhere.
				2. Participation in teaching and continuing education activities, timely and accurate completion of medical records.
				3. Timely and accurate completion of medical records.
				4. Compliance with all applicable Center Medical Bylaws and policies and procedures.
				5. Ability to work cooperatively with other Medical Staff members, members of other healthcare providers' staff, administration, employees and visitors.

# ARTICLE IV DELINEATION OF PRIVILEGES

# Exercise of Privileges.

Every Practitioner and Allied Health Professional providing clinical services at the Center by virtue of Medical Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges granted to him by the Governing Board and within the scope of the license authorizing the Practitioner to practice in this state and consistent with any restrictions thereon.

# Requests for Privileges.

All applications for appointment or re-appointment must contain a request for the specific clinical privileges desired by the Applicant and supported by documentation demonstrating the Practitioner's qualifications to exercise the privileges requested.

# Procedure.

The procedure by which requests for clinical privileges are processed are as outlined in Article III of these Medical Staff Bylaws.

# Temporary Privileges.

Temporary privileges may be granted when there is a patient care need that mandates an authorization to practice, for a limited period of time, while full credentials information is verified and approved.

* + 1. **Qualifications.** In addition to meeting the qualifications set forth in Section 2.3, a Practitioner or Allied Health Professional may be granted temporary staff privileges only if the following conditions are met:
			1. The Practitioner or Allied Health Professional has submitted the following documentation:
				1. A Medical Staff Application;
				2. A Delineation of Privileges Form;
				3. A copy of a current state professional license;
				4. A copy of a current DEA License;
				5. Written verification of professional schooling, internship, residency, and/or fellowship;
				6. Past and present hospital and other health care entity affiliations, including evidence of applicable privileges held at such entities;
				7. Specialty or board certification status
				8. Completed Health Status Assessment Form and documentation of applicable health testing and vaccinations, which shall demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested;
				9. Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion;

*G)* Any current criminal charges pending against the applicant and any past convictions or pleas; and

(k) A copy of a Malpractice Insurance Certificate with minimum limits and in the form as required by the Governing Board and a claims history.

* + - 1. The Medical Director or designee verifies that the Practitioner:
				1. Holds a current, unrestricted state license to practice medicine;
				2. Holds a valid DEA certificate;
				3. Possesses relevant training and experience in the medical fields in which he/she seeks clinical privileges;
				4. Possesses current competence in the medical fields in which he/she seeks clinical privileges;
				5. Has had no involuntary termination or limitation of medical staff membership or privileges at any other organization; and
				6. Has current malpractice coverage and has provided a claims history.
			2. The Medical Director obtains and evaluates the results of the National Practitioner Data Bank and OIG sanction reports.

By accepting temporary privileges, an applicant agrees to be bound by these Medical Staff Bylaws and all applicable Center and Governing Body policies and procedures.

* + 1. **Locum Tenens Practitioners.** Temporary privileges may be granted to an appropriately qualified Practitioner serving as locum tenens for a Member of the

Medical Staff if the Practitioner satisfies the requirements of 4.4.1. The granting of such clinical privileges hereunder shall not entitle any locum tenens Practitioners to admit or attend his own patients.

* + 1. **Granting of Temporary Privileges.** The Medical Director may in his sole discretion grant a Practitioner (including a Practitioner serving as a locum tenens) temporary privileges after the requirements in Section 4.4.1 are satisfied for a specific initial period of time, not to exceed ninety (90) days, subject to extension for no more than a total of one hundred twenty (120) days (inclusive of the initial period of time).

**4.4.4. Termination of Temporary Privileges.** The Medical Director or Governing Board may at any time upon reasonable notice under the circumstances and for any reason terminate any or all temporary privileges granted. The termination of temporary privileges shall not give rise to a right to a fair hearing or appeal.

# Emergency Privileges.

In the case of an emergency, which is defined as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment for the time foreseeably necessary to obtain intervention of a Practitioner holding relevant clinical privileges would add to that danger, any Practitioner, to the degree permitted by his license and regardless of Medical Staff status or clinical privileges, may administer emergency treatment, but the Practitioner is obligated to seek assistance reasonably available and to promptly arrange for follow-up care by an appropriate member of the Medical Staff.

# Disaster Privileges.

* + 1. **Granting of Disaster Privileges.** If the Center's Emergency Management Plan has been activated, the Medical Director and such other individuals that the Medical Director designate, may grant disaster privileges to provide patient care to selected Practitioners consistent with medical licensing and other relevant state statutes and provided that the Practitioner presents a valid photo identification issued by a state or federal agency, such as a driver's license or passport, and at least one of the following:
			1. Current health care organization photo identification card.
			2. Current medical license.
			3. Identification certifying the Practitioner is a licensed independent practitioner and indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or other recognized state or federal organization or group.
			4. Identification indicating that the Practitioner is a licensed independent practitioner who has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies.

4.6.4.5 Presentation by a current Center Medical Staff member who has personal knowledge regarding the volunteer's identity and ability to act as a Practitioner during a disaster.

As soon as feasible while a Practitioner is practicing under disaster privileges, but not less than seventy-two (72) hours after the granting of disaster privileges unless the Center documents its inability to do so, the Center will seek to verify the practitioner's current license and current competency in the same manner as for individuals granted temporary privileges, which shall be by primary source if required.

* + 1. **Supervision of Practitioner Granted Disaster Privileges.** A Practitioner granted disaster privileges will be required to practice under the supervision of a designated Member of the Medical Staff whose privileges at a minimum include the disaster privileges granted to the Practitioner.
		2. **Termination of Disaster Privileges.** After a determination has been made pursuant to the Center's Emergency Management Plan that the immediate situation requiring the granting of disaster privileges has passed, the Practitioner's disaster privileges will terminate immediately.

Any individual identified in the Center's Emergency Management Plan with the authority to grant disaster privileges also shall have the sole authority and discretion to terminate disaster privileges. The termination of disaster privileges shall not give rise to a right to a fair hearing or appeal.

**ARTICLE V**

**ALLIED HEALTH PROFESSIONALS**

# General.

Allied health professionals (AHPs) are health care providers other than Practitioners who are granted privileges to practice in the Center and are directly involved in patient care. They may be employed by the Center or a Medical Staff member but must be under the direct supervision and direction of a Medical Staff member, unless allowed to practice as an independent practitioner under state law.

# Qualifications.

An AHP must meet the following requirements:

* + 1. A currently valid license issued by the State of Connecticut or certification, if applicable.
		2. Documented evidence of professional education, training and experience, indicating a continuing ability to provide quality patient care.
		3. Current unrestricted participation in federal and state healthcare programs.
		4. Willingness and capability, based on attitude and evidence of performance, to work with and relate to other staff members, members of other health disciplines, administration, employees and visitors in a cooperative, professional manner that is conducive to quality patient care; and to adhere to generally recognized standards of professional ethics.
		5. Such other criteria as may be established by the Governing Board.

# Application.

An AHP seeking appointment must submit an application for appointment signed by the Applicant and submitted on the form approved by the Governing Board. The application shall outline a description of duties the applicant desires to perform at the Center, the scope of the practice, and the level of supervision to be provided by the supervising Medical Staff member.

The application form shall also include, but not be limited to, the following information:

5.3.1 Copy of current, unrestricted state license or other appropriate legal credentials.

* + 1. Evidence of training and experience relevant to the service authorization requested.
		2. Evidence of current, demonstrated professional competence as determined by the Governing Board.
		3. Completed Delineation of Privileges form.
		4. Completed Health Status Assessment Form and documentation of applicable health testing and vaccinations.
		5. Copy of current DEA Drug Enforcement Administration (DEA) registration with expiration date, if applicable.
		6. Similar service authorizations at a local accredited hospital or surgery center, if the capability to perform the same or similar services exists.
		7. Information on any history of felony convictions.
		8. Information on any complaints or adverse action reports filed against the Applicant with a state, local, or national professional society or licensure board.
		9. Notification of any refusal or cancellation of professional liability coverage and denial suspension, limitation, termination, or non-renewal of professional privileges at any other medical institution.
		10. Professional references from two (2) peers or other individuals with personal knowledge of the Applicant's recent professional performance, ethical character, current competence, and ability to work cooperatively with others.
		11. Evidence of professional liability insurance, including carrier, amount and dates of coverage, and professional litigation and liability history (past and present), in amounts deemed acceptable by the Governing Board.
		12. Copy of current BLS/ACLS/PALS certification if applicable.
		13. Signed statement acknowledging the applicant's understanding of the scope and extent of authorization, confidentiality, immunity, and release provisions of Article IX and agreement to exhaust all administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his staff membership and/or clinical privileges.
		14. Signed statement that the applicant has received and read the Medical Staff Bylaws and agrees to be bound by the terms thereof if granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to the consideration of his application, without regard to whether or not he/she is granted membership and/or clinical privileges.
		15. Evidence of continuing education units appropriate to the service authorization being requested.
		16. If the AHP's license requires supervision or direction by a physician, a signed written agreement between the AHP and the physician, who is a member in good standing of the Medical Staff, in which the physician agrees to provide such supervision or direction whenever the AHP exercises AHP Prerogatives.
		17. When requested by the Medical Staff, the employing Medical Staff member and/or supervising physician shall provide a statement in the application indemnifying the Center against the actions or omissions of the AHP requesting appointment. If the applicant is not employed by a Medical Staff member, the applicant shall provide evidence of professional liability insurance coverage or compliance with the State of Connecticut's laws concerning professional liability insurance coverage.
		18. Other criteria as may be established from time to time by the Governing Board.

# Procedure for Granting AHP Privileges.

* + 1. The completed application shall be submitted to the Center Leader who will review the submitted application for completeness and notify the applicant of any incomplete items.
		2. The Center Leader or designee, including, as applicable a Credentials Verification Organization (CVO), shall perform primary verification of submitted information and forward the completed application to the Medical Director.
		3. The Medical Director shall review the application and its supporting documentation and report to the Medical Executive Committee his findings. This report shall include his recommendation as to the approval or denial of, and any special limitations on, appointment and scope of privileges.
		4. The Medical Executive Committee shall review the application, the supporting documentation, the recommendation from the Medical Director and any other relevant information available to it. In addition, the Medical Executive Committee may meet with the applicant to discuss the application. The Medical Executive Committee shall communicate to the Governing Board its recommendations as to the approval or denial of, and any special limitations on, AHP appointment and scope of clinical privileges.
		5. The Governing Board may adopt or reject, in whole or in part, the recommendation of the Medical Executive Committee. At its next regular meeting after receipt of a favorable initial recommendation of the Medical Executive Committee and Medical Director in regard to an application, the Governing Board shall take action on the matter. The Governing Board shall have ultimate authority in all decisions concerning AHP appointments.

# AHP Prerogatives and Responsibilities.

* + 1. The AHP Prerogatives are as follows:
			1. Provide health care services at the Center consistent with the limitations for the AHP's Clinical Privileges and in accordance with these Bylaws or any other applicable policies and procedures of the Center, and, if applicable, under the supervision or direction of a Medical Staff Member.
			2. Serve on Medical Staff and Center committees to the extent assigned thereto, except that AHPs shall not be eligible to serve on the Medical Executive Committee.
			3. Attend meetings of the Medical Staff and education programs when requested to do so.
		2. The responsibilities of an AHP are as follows:
			1. Be responsible within the AHP's area of professional competence for the care and supervision of each patient in the Center for whom the AHP is providing services or arrange for a suitable alternative for such care and supervision.
			2. Active participation in QAPI activities and other quality improvement and peer review activities required of the Medical Staff.
			3. Satisfy the requirements for attendance at meetings of the Medical Staff which the AHP is requested to attend or committees of which the AHP is a member.

# Reappointment Procedure for AHPs.

The Medical Executive Committee shall review and evaluate each AHP's privileges for appointment at least every two (2) years. AHPs shall be reappointed pursuant to Section 5.4 for appointment outlined above.

# Removal of AHP from Staff.

* + 1. An AHP who ceases employment with the employing Medical Staff member will automatically be terminated from the AHP Staff, effective the date of termination from employment of the Medical Staff member. The employing Medical Staff member is responsible for notifying the Medical Executive Committee of the termination.
		2. Nothing herein shall be interpreted as limiting the ability of the Medical Executive Committee or Governing Board to limit or terminate AHP Prerogatives and/or the Clinical Privileges held by an AHP at any time with or without cause. AHPs may be terminated from the AHP Staff by the Medical Executive Committee or Governing Board. Reasons for termination may include, but not be limited to, the

following:

* + - 1. Activities or professional conduct inconsistent with the standards of the Center or which interferes with or is detrimental to the provision of quality patient care.
			2. Suspension, revocation, expiration, voluntary or involuntary restriction, termination, or the imposition of terms of probation by the applicable licensing or certifying agency of the AHP's license, certificate, or other legal credential which authorizes the AHP to provide health care services.
			3. Failure of the AHP to properly perform assigned duties.
			4. Failure of the AHP to maintain professional liability insurance in the policy amounts and according to the terms required hereunder; or
			5. Exclusion or disbarment from participation in any federal Health Care Program.
		1. An AHP is entitled to an interview with the Medical Executive Committee regarding a denial, revocation, suspension, or restriction of privileges if such action is for other than a change in employment status.
		2. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to any of the Prerogatives of Medical Staff Membership or to the Hearing and appeal rights set forth in Article VII of these Bylaws, except as may otherwise be required by applicable federal or state law. However, an AHP may challenge any action (other than monitoring) that relates to his competence or professional conduct, and that results in a denial, revocation, suspension, or restriction of his clinical privileges, by filing with the Medical Director, within fifteen (15) days of the adverse recommendation or action, a written request for a hearing. The written request shall include the specific relief or remedies sought by the AHP. Failure of the affected AHP to request a hearing under this Section within the time frame just set forth shall be deemed a waiver by such AHP of all hearing and appeal rights.
		3. If an AHP requests a hearing pursuant to Section 5.7.4, such appeal shall be conducted by the Governing Board. The Governing Board shall give the AHP notice of the time, place and date of the appellate review which shall be not less than fifteen (15) days or more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Governing Board shall thereafter decide the matter by a majority vote of the Governing Board. A record of the appellate proceedings shall be maintained.

# ARTICLE VI CORRECTIVE ACTION

* 1. **Criteria for Initiation of Investigation.**

An investigation shall be initiated against a Medical Staff Member whenever there is reason to believe that the member's acts, demeanor, conduct or professional performance, either within or outside of the Center, is detrimental to patient safety or to the delivery of quality patient care within the Center; illegal; unethical; disruptive of Center operations (including but not limited to sexual harassment or any other practices prohibited by these Bylaws or by Center policies); harassing or intimidating to colleagues, patients and their families, or staff; contrary to these Bylaws or rules and regulations or any other policies of the Center, Medical Staff, or any committee thereof; and below applicable professional standards; fails to meet and satisfy the qualifications and criteria for Medical Staff status; or is a danger to patients or others in the Center. If the danger poses an imminent threat to the life or health of any person, the suspension procedures should be followed in accordance with Section 6.7.

# Method of Initiating Investigation.

* + 1. Requests for an investigation may be initiated by the Medical Director, any Medical Staff Member, any committee of the Medical Staff, the Medical Executive Committee, or any member of the Governing Board.
		2. Any request for an investigation must be in writing and must describe with specificity the alleged activity or conduct which constitutes the grounds for the request. Such request shall be submitted to the Medical Director. If the Medical Director is the subject of the investigation or the Governing Board, in its sole discretion, determines that the Medical Director is otherwise unable to conduct the investigation for reasons, including, but not limited to, the inability to objectively perform an investigation, an interim Medical Director may be appointed by the Medical Executive Committee to conduct the investigation, and the subject Medical Director is recused from all further deliberations and duties.
		3. The Medical Director shall promptly determine whether there is sufficiently reliable information to refer the matter to the Medical Executive Committee for additional investigation or to deal with the matter in accordance with the relevant Medical Staff or Center policy. At his sole discretion, the Medical Director may delegate these responsibilities to another individual or group of individuals. If it is determined to direct the matter to the Medical Executive Committee, the Medical Director or his designee shall prepare a written request for investigation, making specific reference to the performance information, activity, or conduct that gave rise to the request. If the Medical Executive Committee initiates the request, it shall make an appropriate record of the reasons for the request. The investigation shall be conducted pursuant to Section 6.3 hereof.

# Investigation.

The Medical Executive Committee shall initiate an investigation if it concludes that one is warranted. If the Medical Executive Committee determines that an investigation is not warranted but the Governing Board determines otherwise, it may direct the Medical Executive Committee to initiate an investigation. An investigation may be conducted by the Medical Executive Committee, a Medical Staff member or ad hoc committee appointed by the Medical Executive Committee. If the Medical Executive Committee consists of only one physician and that physician is the subject of the investigation, the Governing Board shall appoint an ad hoc committee to conduct the investigation. If the investigation is delegated to a Medical Staff member or committee other than the Medical Executive Committee, such member or committee shall investigate the matter promptly and forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action.

The member shall be notified of the investigation and given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with the member or other involved persons. However, such investigation or interviews shall not constitute a "hearing" as that term is used in Section VII, nor shall the procedural rules with respect to hearings or appeals apply. While an investigation is pending, the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances including suspension, termination of the investigative process, or other action.

# Action on Investigation Report

Following the conclusion of an investigation, the Medical Executive Committee shall take action that may include the following:

* + 1. Determining that corrective action is not warranted and dismiss the matter.
		2. Determining that corrective action is not warranted and using an alternative to corrective action, such as issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Medical Director from issuing informal written or oral warnings outside of the mechanism for corrective action.
		3. Recommending probation or other special limitation upon continued medical staff membership or clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.
		4. Recommending denial, restriction, modification, reduction, suspension, or revocation of clinical privileges or medical staff membership.
		5. Taking other actions deemed appropriate under the circumstances.

# Subsequent Action

If the Medical Executive Committee recommends corrective action, the Medical Executive Committee shall submit the recommendation to the Governing Board. The recommendation of the Medical Executive Committee shall become final unless the member is entitled to and requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

* 1. **Automatic Limitations and Suspension or Termination**

A member's privileges or membership shall automatically be suspended or limited in the following instances without a right to hearing or further review:

* + 1. **Professional Licensure.** If the professional license of a Member or Allied Health Professional is revoked by a state licensing authority, staff membership and clinical privileges shall immediately and automatically be terminated.

If the professional license of Member or Allied Health Professional is restricted, suspended, or placed on probation, the staff membership and clinical privileges of the Member or Allied Health Professional shall automatically be restricted pursuant to the limitation and terms imposed by the licensing authority as of the date such action becomes effective. A Member or Allied Health Professional whose license is restricted, suspended, or placed on probation must report the restriction, suspension, or probation to the Center within fourteen (14) days of the imposition of such restriction, condition or probation. Failure to report such restriction, condition or probation will result in the automatic termination of staff membership and clinical privileges.

* + 1. **Controlled Substance Registration.** If the DEA registration of a Member or Allied Health Professional is revoked, limited, suspended, or placed on probation, the right of the Member or Allied Health Professional to prescribe medications shall be automatically restricted pursuant to the limitation imposed by the DEA as of the date of such action becomes effective and throughout its terms.
		2. **Liability Insurance.** If the professional liability insurance of a Member or Allied Health Professional is revoked or the Member or Allied Health Professional fails to maintain ongoing coverage as required in these Bylaws, he shall be immediately and automatically suspended from practicing in the Center. If within fourteen (14) days after written warnings of delinquency, the Member or Allied Health Professional provides evidence of securing the required professional liability insurance, the Medical Staff privileges of the Member or Allied Health Professional shall be reinstated. However, if the Member or Allied Health Professional does not provide such evidence within the fourteen (14) day period, the Medical Staff privileges of the Member or Allied Health Professional shall be automatically terminated.
		3. **Exclusion from Participation in Federal Program.** If a Member or Allied Health Professional is suspended or excluded from participation in any federally or state funded health care program, the Member or Allied Health Professional is automatically suspended from the Medical Staff. Such suspension shall become effective immediately upon the Center's knowledge of such exclusion and shall remain in effect until the Member or Allied Health Professional is reinstated in the federally or state funded health care program.
		4. **Felony Indictment or Conviction.** If a Member or Allied Health Professional is indicted, convicted of, or pleads "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction, the Member or Allied Health Professional is automatically suspended from the Medical Staff, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Governing Board.
		5. **Misrepresentation in Credentialing Process.** Whenever it is discovered that a Member or Allied Health Professional misrepresented, omitted or erred in answering the questions on an application for Medical Staff membership or clinical privileges or in answering interview queries, the membership and clinical privileges of such Member or Allied Health Professional shall be automatically terminated. The Member or Allied Health Professional may not re-apply until twenty-four (24) months have passed.

# Summary Suspension or Restriction.

* + 1. **Determination.**

The Medical Director, the Medical Executive Committee, or any member of the Governing Board may impose a summary suspension or restriction on all or any portion of the clinical privileges of any Member or Allied Health Professional, whenever, in the judgment of the Medical Director, Chair of the Medical Executive Committee, or Governing Board member, (I) the conduct or activity of a Member or Allied Health Professional poses a threat to the life, health, or safety, of any individual and the failure to take prompt action may result in imminent danger to the life, health or safety of such person; or (2) there are reasonable grounds to believe prompt action is necessary due to the Medical Staff member's or Allied Health Professional 's conduct or activity.

Should a Practitioner or Allied Health Professional become impaired during clinical time or presents at the Center with demonstrated signs of impairment, the Medical Director or Center Leader will be notified immediately, the Practitioner suspended, and the case will be handled by an alternative Medical Staff member designated by the Medical Director.

In a situation where the Medical Director is impaired, an alternative Medical Staff member or any Governing Board member may designate an alternative Medical

Staff member to handle the case. Impaired can mean not only illness but suspected drug abuse or alcohol intoxication if such could reasonably interfere with the Practitioner's competent performance of procedures at the Center.

Unless otherwise stated, such suspension or restriction shall become effective immediately. The individual or entity imposing the suspension or restriction shall give prompt written notice of the suspension to the Governing Board and the Medical Executive Committee. In addition, the affected individual shall be provided with a written notice of the action. This initial notice shall include a summary of facts and issues regarding the individual's conduct that led to the summary suspension or restriction, and shall not substitute for the notice required in Section VII. When the individual being suspended or restricted is a Medical Staff Member, the Medical Director shall arrange for alternative medical coverage for a suspended Medical Staff Member's patients in the Center and for coverage of patient care subject to a restriction. The wishes of the patient shall be considered in the selection of an alternative member. When the individual being suspended or restricted is an Allied Health Professional, the Medical Director shall be responsible for arranging alternative coverage for the care normally provided by the individual.

# Medical Executive Committee Action.

As soon as practicable after such precautionary restriction or suspension has been imposed, the Medical Executive Committee shall meet to review and consider the action and, if necessary, direct that an investigation be conducted within thirty (30) days or as soon thereafter as is reasonably practicable under the circumstances. At this meeting, the Medical Executive Committee, within its sole discretion, may, but is not required to, invite the member to attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose. Neither the investigation nor any other activities of the Medical Executive Committee, including an invitation to the member to appear, constitute a "hearing" within the meaning defined in Article VII, nor shall any procedural rules with respect to a hearing and appeal apply. The Medical Executive Committee shall also review the circumstances leading to the summary suspension or restriction and may determine, as a result of the review, to continue, modify, or terminate the summary suspension or restriction pending the outcome of the investigation. The Medical Executive Committee shall furnish the member with notice of its decision.

If the Medical Executive Committee consists of only one physician and that physician is the subject of the investigation, the Governing Board shall appoint an ad hoc committee to take the steps required under Section 6.7.

# Procedural Rights.

Unless the Medical Executive Committee terminates the suspension, and provided that the suspension has been in effect for more than thirty (30) days, the member shall be entitled to the procedural rights under Article VII. In no event shall a member be entitled to separate appeals with respect to the summary suspension and the merits of the matter.

# ARTICLE VII

**FAIR HEARING PROCEDURES**

# Initiation of Hearing.

* + 1. **Recommendations or Actions Entitling Practitioner to Right to Hearing.** An applicant to, or member of, the Medical Staff shall be entitled to request a hearing whenever the Medical Executive Committee or Governing Board has made an unfavorable recommendation relating to his competence or professional conduct. The following recommendations or actions, unless unrelated to the competence or professional conduct of the affected Medical Staff member, shall constitute an adverse professional review action and shall entitle the affected individual to a hearing:
			1. Denial of initial staff appointment or reappointment, except where the application is incomplete or does not meet the minimum objective requirements set forth in the Bylaws.
			2. Revocation or termination of Medical Staff appointment.
			3. Denial or restriction of requested clinical privileges, except where the Applicant fails to meet the minimum objective criteria for the requested privileges.
			4. Reduction in or revocation or limitation of clinical privileges, except where the Member no longer meets the minimum objective criteria for such privileges.
			5. Terms of probation or involuntary imposition of consultation or proctoring, if such terms materially restricts the Practitioner's exercise or privileges for more than thirty (30) days.
			6. Suspension of staff appointment or clinical privileges for thirty (30) days or more.
		2. **Recommendations or Actions Not Entitling Practitioner to Right to Hearing.** There shall be no right to a hearing as the result of any recommended or taken action that is not reportable to the state or National Practitioner Data Bank, including, but not limited to, the following:
			1. Issuance of letter of warning, admonition or reprimand.
			2. Imposition of probation, supervision or observation which supervision or observation does not restrict the clinical privileges of the Medical Staff member or the delivery of professional services to patients.
			3. Recommendation that a Medical Staff member be directed to obtain additional training or continuing education.
			4. Denial, termination, or reduction of temporary privileges.
			5. Automatic relinquishment or voluntary resignation of appointment or privileges.
			6. Automatic termination or suspension of privileges in Section VII.
			7. The restriction or suspension of clinical privileges for less than thirty (30) days while an investigation is pending.
			8. The denial or refusal to accept an application for initial appointment or reappointment to the medical staff (a) where the application is incomplete; or (b) where the application reflects that the applicant does not meet the minimum objective requirements for appointment or reappointment.
			9. Any change in medical staff category resulting from the failure of a Member to meet the minimum objective criteria for a specific category.
			10. Ineligibility to request membership or privileges because a relevant specialty is covered under an exclusive provider agreement.
	1. **Notice of Adverse Recommendation or Action.**

When an adverse recommendation or action has been taken against a Practitioner pursuant to Section 7.I. I of these Bylaws, the Practitioner shall promptly be given special written notice of such action within five (5) days of the action. Such notice shall be sent by the Medical Director by hand or by certified or registered mail. Such notice shall include the following:

* + 1. Advise the Practitioner that a professional review action has been proposed to be taken against him.
		2. State the reasons for the proposed action.
		3. Notify the Practitioner of the right to a hearing and that a hearing must be requested within thirty (30) days of receipt of the notice.
		4. State that the recommendation, if finally adopted, will be reported as required to the appropriate state licensing authority or other applicable state agencies and the National Practitioner Data Bank.
		5. Provide a summary of the Practitioner's rights at such a hearing under these Bylaws.
		6. State that upon receipt of a hearing request, the Practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action.
		7. State that failure to request a hearing within the time limit set forth in the Bylaws shall constitute a waiver of all hearing and appeal rights under the Bylaws and acceptance of the recommendation contained in the notice.

If the Medical Director is the subject of the adverse recommendation or action, or is determined by the Governing Board, in its sole discretion, to be otherwise unable to conduct the investigation for reasons, including, but not limited to, the inability to objectively perform an investigation, an interim Medical Director may be appointed by the Medical Executive Committee to carry out the responsibilities in Article VIL

# Request for Hearing.

A Practitioner shall have thirty (30) days following his receipt of a notice to submit a written request for a hearing to the Medical Director. The request for a hearing shall contain a statement, signed by the Practitioner, that the Practitioner shall maintain the confidentiality of all documents provided to him during the fair hearing process and shall not disclose or use the documents for any purpose outside of the fair hearing process.

# Waiver by Failure to Request A Hearing.

A Practitioner who fails to request a hearing within the time and in the manner specified in Section

7.3 waives any hearing and appeal rights and accepts the recommended action. Such recommended action shall thereupon become effective immediately upon final Governing Board action.

# Number of Hearings.

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing or appellate review with respect to a single adverse recommendation or action.

# Notice of Time and Place of Hearing.

Upon receipt of a timely request for hearing, the Medical Director shall deliver such request to the Governing Board and the Medical Executive Committee. Within thirty (30) days of the receipt of the hearing request, the Medical Director or his designee shall schedule the hearing. The hearing date shall not be less than thirty (30) nor more than ninety (90) days from the date of receipt of the request for hearing unless the parties have agreed in writing to a different hearing date. Notwithstanding the foregoing, a hearing for a Practitioner under suspension then in effect shall, at the Practitioner's request, be held as soon as arrangement for it reasonably may be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

The Medical Director or his designee shall give written notice, certified mail return receipt requested, to the Practitioner requesting the hearing. This notice shall include the time, place and date of the hearing; a proposed list of witnesses as known at that time who will give testimony or evidence in support of the recommended action at the hearing; the names of the hearing panel members and presiding officer or hearing officer, if known; and a statement of the specific reasons for the recommendation. This statement, and the list of supporting evidence, may be amended or added to at any time, including 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 individual and the individual's counsel have sufficient time to study this additional information and rebut it.

# Appointment of Hearing Committee and Presiding Officer.

* + 1. **Appointment of Hearing Committee.** When a hearing is requested, the Medical Director shall appoint a Hearing Committee that shall be composed of not less than three (3) members of the Medical Staff who are in good standing. The Medical Director may, in his sole discretion, also appoint one or more Practitioners who are not members of the Medical Staff to a Hearing Committee. An individual appointed to the hearing panel shall not be a member of the Governing Board, a partner or associate of the affected Practitioner, in direct economic competition with the affected Practitioner, or have actively participated in the consideration of the matter involved at any previous level. Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. The Hearing Committee shall be entitled to legal counsel or other representation in all hearings and proceedings.
		2. **Objection to Hearing Committee Composition.** Upon receipt of notice provided in Section 7.6, the Practitioner shall have five (5) days to object in writing to the participation of any members of the Hearing Committee. Such written objection shall be delivered by hand or by certified or registered mail to the Medical Director or his designee. Any objection the composition of the Hearing Committee must be based on good cause. The Medical Director or his designee shall, in his sole discretion, determine whether new Hearing Committee members should be appointed to replace the members to whom the Practitioner objected. While the individual who is the subject of the hearing may object to a panel member, he or she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the Medical Director. If no objection is made in writing within five (5) days, the Practitioner shall be deemed to have waived any objection to the Hearing Committee's composition.
		3. **Presiding Officer.** A member of the Hearing Committee shall be appointed the Chair of the Hearing Committee by the Medical Director and shall act as the Presiding Officer. The Chair of the Hearing Committee shall be entitled to one (I) vote. In lieu of the Chair of the Hearing Committee serving as the Presiding Officer, the Medical Director or his designee may appoint an attorney to serve as the Presiding Officer. The Presiding Officer shall act to maintain decorum and to

assure that all participants in the hearing have a reasonable opportunity to present relevant 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. The Presiding Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence. The Presiding Officer shall be available to the Hearing Committee to advise them on any procedural or legal matters and to assist the Hearing Committee in the drafting of its report and recommendation but shall not be entitled to vote on any recommendations.

# Pre-Hearing and Hearing Procedure

* + 1. **Pre-Hearing Exchange of Information.** There is no right to formal "discovery" in connection with the hearing. The Presiding Officer shall rule on any dispute regarding discovery after a consideration of all factors, which shall include whether the information sought may be introduced to support or defend the charges; the exculpatory or inculpatory nature of the information sought, if any; the burden imposed on the party in possession of the information sought, if access is granted; and any previous request for access to information submitted or resisted by the parties to the same proceeding. The Presiding Officer may impose any safeguards, including denial or limitation of discovery to protect the peer review process and to assure a reasonable and fair hearing.

7.8.1.1 In general and upon specific request, the individual requesting the hearing shall be entitled to copies at the individual's expense of the following:

* + - 1. Copies of, or reasonable access to, all patient medical records supporting the Medical Executive Committee's recommendation.
			2. Reports of experts relied upon by the Medical Executive Committee.
			3. Redacted relevant committee or service minutes, subject to denial or limitation to protect the peer review process or other privilege, to the extent permitted by law.
			4. Any other documents relied upon by the Medical Executive Committee or the Governing Board.

No information regarding other practitioners shall be requested, provided or considered. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges also shall be excluded.

The exchange of any information is subject to a stipulation signed by

both parties 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. Failure to provide this information at least thirty (30) days prior to the hearing shall constitute good cause for a continuance.

* + - 1. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, the parties shall exchange copies of all proposed exhibits, including copies of any expert reports or other documents upon which the party will rely at the hearing. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
			2. Within fifteen (15) days after receipt of the notice of hearing, the Practitioner shall provide a list of witnesses he may call at the hearing. The Practitioner shall deliver such notice by hand or by certified or registered mail to the Center Representative, who shall promptly forward a copy of such notice to the Hearing Committee. The Practitioner's list of witnesses may be amended at any time for good cause shown. The Hearing Committee shall, in its sole discretion, determine whether good cause has been shown.
			3. The affected Practitioner shall not contact any Center employee appearing on the Center's witness list concerning the subject matter of the hearing unless the Center gives permission after consultation with the proposed witness.
		1. **Pre-Hearing Conference.** The Presiding Officer may require the individual and the Center's representative or the parties' respective counsel to participate in a pre-hearing conference for the purpose of resolving procedural questions, including any objections to exhibits or witnesses, and determining the time to be allotted to each witness's testimony and cross-examination.
		2. **Personal Appearance.** The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause, as determined by the Hearing Committee in its sole discretion, to appear at such hearing shall be deemed to have waived his rights to a hearing and any appellate review and to have voluntarily accepted the recommendations or actions pending, which shall then be forwarded to the Governing Body for final action.
		3. **Record of Hearing.** The hearing proceedings shall be taken and transcribed by a court reporter. The Center shall be responsible for the cost of such reporter, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense.
		4. **Oath of Witness.** The Presiding Officer may, in his discretion, order all testimony at the hearing to be under oath administered by a person authorized to administer oaths.
		5. **Rights of Parties.** During a hearing, each of the parties shall have the right to:
			1. Call and examine witnesses.
			2. Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law.
			3. Cross-examine any witness on any matter relevant to the issues.
			4. Be represented by counsel or other representative who may call, examine, and cross-examine witnesses and present the case, provided that notice of the name of representative has been provided to the other party at least ten

(10) days prior to the date of the hearing

* + - 1. To present and rebut any relevant evidence.
			2. Obtain a copy of the record upon payment of any reasonable charges associated with the preparation thereof and upon signing a stipulation agreeing to maintain the record confidentially.
			3. Present a written statement prior to or at the close of the hearing.

If the Practitioner who requested the hearing does not testify on his behalf, he may be called and examined as if under cross-examination.

* + 1. **Admissibility of Evidence.** The hearing need not be conducted strictly according to technical rules of evidence relating to the admissibility or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs, as determined by the Presiding Officer, shall be admitted, regardless of the admissibility of such evidence in a court of law. Hearsay evidence shall not be excluded merely because it may constitute hearsay.
		2. **Official Notice.** In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee. The Hearing Committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection

with applications for appointment or reappointment to the Medical Staff and for clinical privileges.

* + 1. **Burden of Proof.** The Practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action is arbitrary, capricious, unfounded, or unsupported by credible evidence.
		2. **Postponements.** Request for postponements of a hearing shall be granted by the Hearing Committee only if it determines in its sole discretion that good cause for postponement exists.
		3. **Presence of Hearing Committee Members.** Each member of the Hearing Committee must be present throughout the hearing and deliberations.
		4. **Recesses and Adjournment.** The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties.
		5. **Order of Presentation.** The Governing Body or the Medical Executive Committee, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the individual who requested the hearing shall present evidence. Notwithstanding the foregoing, the Presiding Officer shall, in his discretion, exercise liberality in accommodating the schedules of witnesses, parties, and representatives and in allowing changes in the order of the proceedings or the representation of evidences.
		6. **Submission of Proposed Findings of Fact and Recommendations.** Within fourteen (14) days of the close of the hearing, and subject to any limitation imposed by the Presiding Officer, each party shall have the right to submit written proposed findings of fact and recommendations.
		7. **Hearing Committee Report.** Within fourteen (14) days, or as soon thereafter as is reasonably practicable under the circumstances, submission of Proposed Findings of Fact and Recommendations, or, if no Proposed Findings of Fact and Recommendation are submitted, final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Center Representative. Within five (5) days of receipt of the Hearing Committee Report, the Center Representative shall send a copy of the Hearing Committee Report to the Practitioner requesting the hearing and to the Governing Board. The Practitioner also shall receive notice of his right to appellate review pursuant to Section 8.10 at such time.
	1. **Appellate Review by Governing Board**
		1. **Request for Appellate Review.** Within ten (10) days after receipt of notice of the Hearing Committee Report, any party to the original hearing may request an appellate review of the recommendation of the hearing committee by an appellate review committee of the Governing Body. The request for appellate review shall be made in writing and delivered to the Center Leader either in person or by certified mail, and shall include a brief statement for the reasons of the appeal and the specific facts or circumstances supporting such appeal.
		2. **Waiver of Appellate Review.** The failure of any party to request an appellate review in a timely manner shall constitute a waiver of the right to appellate review and be deemed an acceptance of the recommendation of the Hearing Committee Report. Under such circumstances, the Hearing Committee Report and Recommendation shall be forwarded to the Governing Body for final action.
		3. **Grounds for Appeal.** The grounds for appeal shall be limited to the following:
			1. There was substantial failure to comply with these Bylaws or to afford due process or a fair hearing.
			2. The recommendation of the hearing panel was arbitrary, capricious, or with prejudice.
			3. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.
		4. **Notice of Appellate Review Meeting.** Within forty-five (45) days after receipt by the Center Leader of a request for appellate review, the Governing Board shall schedule a date for an appellate review meeting. Not less than ten (10) days prior to the date of the appellate review, the Governing Board shall give the parties written notice of the time, place, and date for the meeting. The date shall be not less than ten (10) days nor more than sixty (60) days after the date of receipt by the Center Leader of the request for appellate review. The Chair of the Governing Board for good cause may extend the time for appellate review.
		5. **Nature of Appellate Review.** The Chair of the Governing Board shall appoint a review panel composed of members of the Governing Board to consider the information upon which the recommendation before the Governing Board was made.

The Appellate Review Panel shall limit its review to the record of the hearing before the Hearing Committee, the Hearing Committee Report, and any written briefs submitted by the parties. The Governing Board, may, however, in its sole discretion, accept additional issues or oral or written evidence, subject to the same rights of cross-examination and rebuttal provided for the hearing. Such additional

evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence that was viable to be presented at the hearing.

Each party shall have the right to submit a written statement in support of its position on appeal. Each party or its representative also shall have the right to appear personally and make a time-limited thirty minute oral argument.

The review panel shall recommend final action to the Governing Board. The Governing 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 Governing Board's ultimate legal responsibility to grant appointment and clinical privileges.

Within (30) thirty days after either waiver of appellate rights or receipt of the appellate review panel's recommendation, the Governing Board shall issue a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairperson of Medical Executive Committee, in person or by certified mail, return receipt requested.

Except where the matter is referred for further action and recommendation, the final decision of the Governing Board following the appeal shall be final and effective immediately. However, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Governing Board in accordance with the instructions given by the Governing Board. This further review process and the report back to the Governing Board shall not exceed forty-five (45) days in duration except as the parties may otherwise stipulate.

* + 1. **Restriction on Reapplication.** An Practitioner who has received a final adverse decision concerning appointment, re-appointment, or clinical privileges, or who has resigned or failed to apply for reappointment while under investigation, in order to avoid investigation, or following an adverse recommendation by the Medical Executive Committee, shall not be eligible to reapply for appointment to the medical staff for a period of two (2) years unless the Governing Board expressly provides otherwise. Upon any reapplication, the Applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision, recommendation or resignation no longer exists.
		2. **External Reporting Requirements.** The Center shall submit a report regarding a final adverse action to the appropriate state professional licensure board (i.e., the state agency that issued the individual's license to practice) and all other agencies as required by all applicable federal and/or state law(s).

# ARTICLE VIII COMMITTEES

# General.

The Medical Staff shall have standing and ad hoc committees as designated in the Bylaws or as may be established from time to time. The committees' functions are specified herein or as identified by the Medical Staff. Ad hoc committees may be established at the time of need. The Medical Director is a member of all Medical Staff Committees unless otherwise specified in these Bylaws.

Committee members are expected to attend at least fifty (50) percent of scheduled meetings. All committees will keep accurate and complete minutes of all their meetings and will file copies of the minutes.

# Quality Assurance Performance Improvement (QAPI) Committee.

* + 1. **Committee Composition.** The QAPI Committee shall be a combined Medical Staff, Administrative, Safety, Pharmacy, Risk Management and Infection Control Committee. The QAPI Committee and QAPI Chairperson shall be appointed by the Governing Board. Committee members shall include:
			1. At least two (2) physicians, including the QAPI Chairperson and Medical Director;
			2. Other members of the Medical Staff as appointed by the QAPI Chairperson;
			3. Center Leader;
			4. Pharmacy Consultant;
			5. Infection Control Coordinator;
			6. Quality Coordinator/Risk Manager as applicable to the center;
			7. Business Office representative as applicable to the center;
			8. Representative from each clinical area, i.e. Pre-Op, OR, Procedure Area, PACU as applicable to the center; and
			9. Other staff members as deemed necessary.
		2. **Committee Functions.** Specific functions of the QAPI Committee include:
			1. Develop, implement and oversee a written QAPI program.
			2. Conduct an annual review of the QAPI program and establish annual quality goals and objectives.
			3. Objectively and systematically review the quality of service delivery and related performance measures, including, but not limited to, a consideration of complications, appropriateness of care and patient selection.
			4. Develop processes to identify important problems or concerns to be addressed.
			5. Develop and revise indicators as necessary to evaluate safety and care delivery.
			6. Review data summaries for identified indicators, as well as other sources of information regarding quality of care, patient safety, customer satisfaction, infection control, and health outcomes.
			7. Oversee all patient safety and risk management activities.
			8. Identify opportunities for improvement and assure that appropriate action is taken.
			9. Monitor improvement activity to ensure effectiveness of actions taken.
			10. Develop educational programs based on needs identified through QAPI activities.
			11. Support education regarding the principles of continuous improvement and the Center's QAPI program.
			12. Assure integration of Risk Management and Infection Control activities into the QAPI program.
			13. Monitor the incident reporting system.
			14. Establish and maintain processes to report findings from quality improvement activities through the center and to the Governing Board.
			15. Assure compilation of quality data to be utilized in the reappointment of Medical Staff members.
		3. **Meetings.** The QAPI Committee shall meet quarterly. A quorum shall consist of a simple majority of appointed Committee members. Minutes shall be forwarded to the Medical Executive Committee and Governing Board.
		4. **QAPI Chairperson.** The responsibilities and duties of the QAPI Chairperson are as follows:
			1. Oversee the performance improvement program and all corresponding activities of the Center.
			2. Assist in the development and revision of indicators necessary to adequately evaluate care provided by the Center and that meet or exceed governmental requirements.
			3. Direct the review of data summaries of all identified indicators, as well as information from other sources regarding the quality of care provided by the Center.
			4. Direct the development of educational programs based on the needs identified through committee activities and support department-wide education on continuous process improvement principles.
			5. Oversee the credentialing and re-credentialing process for the Center's Medical Staff.
			6. Oversee and administer the risk management program for the Center.
			7. Oversee and administer medical malpractice issues related to the Center.
			8. Work with the Center's QAPI Committee in fulfillment of the QAPI Committee's responsibilities as contemplated in these Bylaws.

# Medical Executive Committee.

* + 1. **Committee Composition.** The Medical Executive Committee (MEC) shall consist of the Physician members of the QAPI Committee and an Administrative designee as appointed by the Governing Board. The Governing Board shall appoint the Chairperson of the Medical Executive Committee and may appoint additional physicians to the MEC. The Administrative designee shall be a non-voting member of the MEC.
		2. **Committee Functions.** Specific functions of the MEC include:
			1. Review the credentials of all applicants to the Medical Staff, including any recommendation from the Medical Director, regarding appointments, reappointments, and delineation of privileges.
			2. Review periodically or at least every two years information available regarding the performance and current clinical competence of physicians and other providers with clinical privileges and make any recommendations regarding changes in clinical privileges.
			3. Conduct Medical Staff peer review, with input from other physicians as needed to complete a thorough, objective review. Cases may be referred for external peer review by the Medical Director or MEC.
			4. Provide a summary of peer review activities to the Governing Board.
			5. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff Members.
			6. Communicate to the Governing Board regarding recommendations for approval, denial, or any special limitations on staff appointment and scope of clinical privileges of Medical Staff members.

**8.3.3 Meetings.** The MEC shall meet as needed, but at least on a quarterly basis unless the MEC, in consultation with the Governing Board, approves a meeting schedule on a less frequent basis. A quorum shall consist of at least two voting members of the Committee. Minutes shall be maintained and forwarded to the Governing Board.

**ARTICLE IX**

**IMMUNITY FROM LIABILITY/CONFIDENTIALITY**

* 1. **Confidentiality.**

Each member of the Medical Staff agrees to maintain as confidential all information and documents related to patients' condition or treatment, peer review, quality assurance and quality improvement, risk management, utilization review, and other information related to the evaluation of the provision of health care, or actions or conduct of health care providers. This confidentiality provision includes, but is not limited to, information with respect to any practitioner submitted, collected, or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of evaluating and improving the quality and efficiency of patient care to the fullest extent permitted by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. Failure to maintain the confidentiality of confidential information shall be grounds for immediate suspension and/or termination of Medical Staff membership and clinical privileges.

* 1. **Immunity from Liability.**

No representative of the Center, including its Governing Board, Center Leader, administrative employees, Medical Staff, its partners, representatives, agents or employees of its partners, and third parties shall be liable to a Practitioner for damages or other relief for any investigation, decision, opinion, action, statement, or recommendation made within the scope of his or her duties as an official representative of the Center or for providing information, opinion, counsel, or services to a representative or to any health care facility or organization of health professionals concerning said Practitioner. Immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

* 1. **Activities and Information Covered.**

The confidentiality and immunity provided by this Section applies to all acts, information, communications, reports, recommendations, or disclosures made in connection with this or any other health-related institution's or organization's activities, including, but not limited to, the following:

* + 1. Applications for appointment, clinical privileges, or specified services.
		2. Periodic appraisals and applications for reappointment, clinical privileges, temporary privileges, or specified services.
		3. Proceedings for suspension, reduction of clinical privileges or for denial or revocation of appointment or any other disciplinary action.
		4. Hearings and appellate reviews.
		5. Quality assessment and performance improvement activities.
		6. Peer reviews.
		7. Inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, or behavior.
		8. Required reports to the National Practitioner Data Bank and state licensure boards or other applicable state agencies.
		9. Utilization reviews.
		10. Claims reviews and risk management and liability prevention activities.
		11. Other Center or committee functions and activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

# Adoption.

**ARTICLEX AMENDMENTS AND ADOPTION**

These Bylaws, once adopted at any meeting of the Center's Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Governing Board.

# Amendments

These Bylaws may be amended at any regular or special meeting of the Medical Staff. A proposed amendment shall be reviewed by the MEC prior to a vote by the full Medical Staff. To be adopted, an amendment shall require two thirds approval vote by the active Medical Staff present at the meeting. Amendments so made shall be effective when approved by the Governing Board.