



Trinity Health
Of New England

Saint Francis Hospital
and Medical Center

**The Saint Francis Hospital & Medical Center Bylaws
Updated & Ratified
December, 2017**

**Anne Massucco, MD, Medical Staff President
John Rodis, MD, Hospital President
Anthony Giorgio, Hospital Board Chairman**

Saint Francis Hospital & Medical Center Medical Staff Bylaws & Governance Documents

Saint Francis Hospital & Medical Center, a nonprofit member organization of Trinity Health, operates an acute care hospital. Applicable law and regulation require that the practitioners authorized to practice at the Hospital be organized into a medical staff that is accountable to the Hospital's governing body for the quality of medical care provided to Hospital patients.

The Saint Francis Hospital & Medical Center oversees, and strives to improve, the quality of patient care in the Hospital, while working cooperatively with the Chief Executive Officer and the Board to fulfill the Hospital's commitments to its patients. The practitioners authorized to practice in the Hospital are organized into a Medical Staff in conformity with the following Bylaws that describe the structure and governance of the Medical Staff.

Collectively referred to as the "Bylaws" the documents below govern medical staff rules and regulations, formal bylaws, collegial resolution and investigations, corrective actions, credentialing, and organization, as well as peer review activities. The document supersedes previous bylaws and peer review documents dated 2014 and 2015, and are subject to further clarification by existing and new policies as they are updated. This iteration was voted upon and ratified on 12/20/17.

These documents were updated with input from Greeley, Inc. consultation, the ad-hoc Medical Executive Committee Bylaws Review Subcommittee, and with input from Saint Francis Chief Counsel. Overlap with the Trinity Health bylaws template will be an ongoing process.

Contents:

Section Title

- A. Medical Staff Rules & Regulations
- B. Medical Staff Bylaws: Governance
- C. Medical Staff Bylaws: Medical Staff Collegial Resolution, Investigations, Corrective Action, Hearing and Appeal Plan
- D. Medical Staff Bylaws: Medical Staff Credentialing Guide
- E. Medical Staff Bylaws: Medical Staff Organization & Functions Manual
- F. Medical Staff Bylaws: Medical Staff Peer Review Manual

Signatures

Ratified 12/21/17

Adopted by:

_____ President of the Medical Staff (Anne Massucco, MD)	_____ Date
_____ President of the Hospital (John Rodis, MD)	_____ Date
_____ Board Chairperson (Anthony Giorgio)	_____ Date

**Saint Francis Hospital & Medical Center
Medical Staff GOVERNANCE DOCUMENTS**

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MEDICAL STAFF DOCUMENTS

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PART A: SAINT FRANCIS HOSPITAL & MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I: INTRODUCTION

A.1.1 DEFINITIONS:

“**ADVANCE DIRECTIVE**” means a document or documentation allowing an individual to give directions about future medical care, or to designate another person to make medical decisions if the individual loses decision-making capacity. Advance directives often include a “Declaration of a Desire for a Natural Death”, “Do-Not-Resuscitate Orders”, and similar documents expressing the individual’s preferences as specified in the Patient Self-Determination Act.

“**ADVANCED PRACTICE PROFESSIONAL**” means physician assistants, advanced practice registered nurses, or nurse midwives who are authorized to care for patients under the supervision of a member of the Medical Staff.

“**ATTENDING PHYSICIAN**” means the physician or member of the Medical Staff responsible for care of the patient. This responsibility may be shared by members of a group of practitioners.

“**CLINICAL PRIVILEGES**” means the authorization granted to a practitioner to render patient care and includes unrestricted access to those Hospital resources (including equipment, facilities, and Hospital personnel) that are necessary to effectively exercise those privileges.

“**EMERGENCY**” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

“**FAMILY**” means those persons who play a significant role in the individual’s life. This may include persons who are not legally related to the individual.

“**LIFE-SUSTAINING PROCEDURE**” means a medical procedure or intervention which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

“**HEALTH CARE AGENT**” means the person designated in a legal document who has power of attorney to make health care decisions on behalf of an individual who is incapacitated.

“**INVASIVE PROCEDURE**” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

“**MEMBER OF THE MEDICAL STAFF**” also referred to herein as “**MEMBER**” means an allopathic or osteopathic physician, dentist, or podiatrist holding a current license and practicing within the scope of that license as a member of the Medical Staff.

“**PATIENT**” means any individual undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

“**PHYSICIAN**” means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as

recognized by the Connecticut Board of Medical Examiners and who holds a current valid license to practice medicine and surgery in state of Connecticut.

“**PRACTITIONER**” means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or advance practice professional that has been granted clinical privileges.

“**REPRESENTATIVE OF AN ATTENDING PHYSICIAN**” also referred to herein as “**REPRESENTATIVE**” means a member of the Medical Staff who is covering for the Attending Physician, or a resident physician or advance practice professional acting under the supervision of an attending physician.

“**UNABLE TO CONSENT**” means unable to appreciate the nature and implications of the patient’s condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does not include minors unless they are married or have been determined judicially to be emancipated [Adult Health Care Consent Act].

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

A.1.2 APPLICABILITY: These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all members of the Medical Staff and other individuals exercising clinical privileges.

A.1.3 CONFLICT WITH HOSPITAL POLICY: Hospital policies concerning the delivery of health care may not conflict with the Medical Staff Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

A.1.4 DEPARTMENTAL RULES AND REGULATIONS: Members of the Medical Staff shall refer to the departmental Rules and Regulation for specific items pertaining to their respective departments. Where departmental Rules and Regulations appear to conflict with the Medical Staff Rules and Regulations, the Medical Staff Rules and Regulations shall take precedence.

A.1.5 AMENDMENT: These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.

ADOPTION: This article supersedes and replaces any and all other Medical Staff Rules and Regulations pertaining to the subject matter thereof.

ARTICLE II: ADMISSION AND DISCHARGE

A.2.1 ADMISSIONS: Members of the Medical Staff who are in good standing and who have admitting privileges may admit patients to the Hospital. The Admitting Office shall be contacted and a provisional diagnosis shall be given for all patients who are being admitted.
[Prioritization of Patients (MA 2.003)]

A.2.2 UNASSIGNED EMERGENCY PATIENTS: A patient who does not request a specific physician or member of the Medical Staff shall be assigned to an appropriate member for admission based upon the on-call schedule for the relevant department, clinical service, or clinical section. In general, patients with multi-system injuries due to trauma shall be admitted to the Trauma Service

A.2.3 TRANSFERS: The member of the Medical Staff who admits the patient shall be responsible for the total care of the patient unless there is an agreement between two (2) members to transfer the care of the patient to the other member. An order shall be entered into the medical record by the member who admitted the patient, or his representative, transferring the care of the patient to the member who has agreed to accept the transfer and assume care of the patient. An acceptance note shall be documented in the medical record.

[Transfer Policy (Medical Affairs)]

A.2.4 PROMPT ASSESSMENT OF EMERGENCY CONDITIONS: Patients experiencing an emergency condition shall undergo a prompt medical screening examination by a credentialed practitioner. All patients are entitled to a screening evaluation as outlined in the Hospital's EMTALA policies.

[Emergency Medical Screening and Stabilization/EMTALA (ED 2.002)]

A.2.5 DETERMINATION OF FALSE LABOR: If the patient is determined to be in false labor after the screening evaluation, then a physician shall certify the diagnosis within twenty- four (24) hours and document this certification in the medical record.

A.2.6 DISCHARGE ORDERS AND INSTRUCTIONS: Patients shall be discharged from the Hospital only upon the order of a credentialed practitioner. The attending physician, or his representative, is responsible for a clear set of discharge instructions that shall be communicated to the patient, or his health care agent, and to the next caregiver. A priority discharge summary shall be completed prior to the transfer of the patient to another institution.

A.2.7 DISCHARGE PLANNING: It is the responsibility of the attending physician, or his representative, to plan the discharge in a timely manner. Patients and their families shall be notified on the day prior to discharge of the scheduled discharge time so that transportation and appropriate services can be arranged. All home care and outpatient requirements shall be communicated to the Case Manager so that coordination of services can be accomplished.

[Discharge Planning (Case Management)]

A.2.8 DISCHARGE AND READMISSION THE SAME DAY: If a patient is discharged and readmitted within twenty-four (24) hours with the same problem and primary diagnosis, the attending physician, or his representative, may use the previous History and Physical but shall complete an update in the Progress Notes that addresses the changes in both the patient's condition and the physical examination, and shall also explain the reason for readmission.

A.2.9 THERAPEUTIC PATIENT LEAVE OF ABSENCE: A patient may leave the Hospital when authorized by the attending physician, or his representative, for therapeutic reasons as long as an order has been placed in the CPOE system and the "Policy on Patient Passes to Leave the Hospital" has been followed.

[Patient Passes to Leave the Hospital (Risk Management)]

A.2.10 DISCHARGE AGAINST MEDICAL ADVICE: A patient may leave the Hospital against medical advice as long as the "Against Medical Advice Discharge Policy" (CLIN.0109) has been followed. If the attending physician, or his representative, feels that the patient is a danger to himself or to others, a psychiatric consultation shall be obtained as quickly as possible to determine if the patient needs to be committed or held against his wishes.

[Against Medical Advice Discharge Policy (Risk Management)]

ARTICLE III: MEDICAL RECORDS/HEALTH INFORMATION

A.3.1 GENERAL REQUIREMENTS: The attending physician, or his representative, shall be responsible for the preparation of a complete medical record for each patient. The final obligation for completion of the medical record rests with the member of the Medical Staff who discharges the patient unless it is clearly stated in the record that this responsibility rests with another member. The reason for the transfer of responsibility shall be clearly stated and the accepting member shall be identified. No medical record may be filed until it is complete or the Medical Records Committee has ordered the record to be filed.

[Analysis of Inpatient and Ambulatory Discharged Records (HIM)]

A.3.2 AUTHENTICATION OF ENTRIES: The author of any entry in the medical record shall sign, date and time all entries. The individual making the entry shall ensure that this information is legible, and it is encouraged that they leave contact information, preferably a beeper number or a phone number.

A.3.3 CLARITY, LEGIBILITY, COMPLETENESS: All entries in the medical record shall be clear, legible and complete so that other Hospital personnel and medical professionals are able to understand the entry and the author's intentions.

[Medical Record Documentation: Legibility (HIM)]

A.3.4 ABBREVIATIONS: Prohibited abbreviations have been determined by the Patient Safety Committee, and they shall not be used in the medical record. A list of the prohibited abbreviations is available in the Health Information Management department and should be available on clinical wards, and is available on sharepoint under the Prohibited Abbreviations Policy (CLIN.0144).

In general, the use of abbreviations is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

A.3.5 CORRECTIONS OF ERRORS: Corrections to any written medical record shall be made with a single line through the entry; the author shall sign, date and time this correction. When a dictated entry requires correction, the author shall dictate an addendum to the initial report. When an electronic entry requires correction, a provider may add an addendum to the existing electronic note or include a strikethrough text in the existing note.

A.3.6 ADMISSION HISTORY AND PHYSICAL EXAMINATION: A complete History and Physical Examination (H&P) shall be performed and documented by the attending physician, or his representative, on all patients admitted to the Hospital. The requirements for both the initial and updated H&P may be found in the Medical Staff Bylaws in Part III: The Credentials Manual, Paragraph 6.4. An H&P shall be completed on all patients no more than thirty (30) days prior to admission or within twenty-four (24) hours after the patient has been admitted. Any H&P completed thirty (30) days prior to admission shall be updated within twenty-four (24) hours of admission or prior to any surgical or invasive procedure. An interval, when required in the electronic health record, may be entered instead of a separate update. An H&P that is performed thirty (30) days prior to admission may be completed by physicians who are not members of the Medical Staff; however, the updated H&P shall be completed by a member of the Medical Staff, or his representative. Any H&P documentation completed by primary care or other non-medical staff physician must be updated by the admitting physician, who assumes accountability for its contents.

[Bylaws Part II, Section B.2.6.7]

A.3.7 PREOPERATIVE DOCUMENTATION: Except in an emergency, a current History and Physical Examination (H&P) shall be completed for all patients prior to undergoing any surgical or invasive procedure. Per the Medical Staff Bylaws (Part III, Paragraph 6.4) and Paragraph 3.6 (see above), any H&P completed thirty (30) days prior to admission shall be updated prior to the surgery or the procedure. All required documentation, to include applicable laboratory, radiological and cardiac testing

and a properly executed consent form, shall be available before the patient can undergo any surgical or invasive procedure. [Bylaws Part II, Section B.2.6.7]

A.3.8 PROGRESS NOTES: A daily progress note shall be completed on each patient by a member of the Medical Staff or his representative. The attending physician shall write progress notes with a frequency that reflects appropriate involvement for that particular patient.

A.3.9 OPERATIVE REPORTS: A brief operative note with all required data shall be entered in the medical record upon completion of any surgical or invasive procedure. A complete operative report shall be dictated or entered electronically within twenty-four (24) hours of the completion of any surgical or invasive procedure or the member of the Medical Staff may risk suspension in accordance with Hospital policy. Providers who complete an electronically entered operative note immediately following the procedure do not require an additional brief operative note, provided the electronic entry is comprehensive and immediately available.

[Operative Reports (HIM)]

A.3.10 CONSULTATIVE REPORTS: In general, consultative reports shall be placed in the medical record within twenty-four (24) hours of the request. These consultations may be dictated or entered electronically. If the consultative report is dictated, there shall be a notation in the medical record that the report has been completed and is in the electronic health record. Urgent consultant findings should be communicated to the requesting provider(s) expeditiously.

A.3.11 OBSTETRICAL RECORDS: A dictated discharge summary is not required for a normal newborn or for the normal delivery of a term pregnancy provided that there were no complications and the infant was not in the Neonatal Intensive Care Unit.

A.3.12 DISCHARGE SUMMARIES: The member of the Medical Staff who discharges the patient shall be responsible for the discharge summary. A dictated discharge summary shall be completed prior to the transfer of a patient to another facility. For patients going home, the discharge summary shall be completed within thirty (30) days after discharge or the member may risk suspension in accordance with Hospital policy. Members are encouraged to complete the discharge summary prior to or at the time of discharge. If the discharge summary is not clear regarding the final diagnoses, a query may be sent to the member from the HIM Department requesting clarification. Members shall submit the reply to the query to HIM as soon as possible. A medical record is not complete until the discharge summary has been completed.

A.3.13 DIAGNOSTIC REPORTS: All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the CPOE system.

A.3.14 ADVANCED PRACTICE PROFESSIONALS: Certain responsibilities of members of the Medical Staff regarding the care of the patient and completion of the medical record may be delegated to a member of the Advanced Practice Professional Staff, in accordance with the Medical Staff Bylaws (Part III, Paragraph 6.1) and the Advanced Practice Professional Policy.

[Advanced Practice Professionals (APP) Policy (Medical Affairs) (Draft) [Medical Staff Bylaws Part III, Paragraph 6.1]

A.3.15 ACCESS AND CONFIDENTIALITY: Pursuant to state and federal law and all Hospital and HIPAA policies, all medical records are the property of the Hospital and may not be used for purposes other than patient care, research and education, peer review and risk management, and other valid Hospital and Medical Staff functions. Proper authorization shall be obtained prior to the release of any confidential information from the medical record in accordance with Hospital policies and state and federal regulations. Access to confidential information by members of the Medical Staff is permissible

only when the person is involved in the care of the patient or engaged in authorized activities, such as peer review, credentialing, research, education, and risk management. Sharing or misuse of passwords to the CPOE system is prohibited and may result in suspension.
[Confidentiality of Patient Information (HIPAA 1.002)]

A.3.16 MEDICAL RECORD COMPLETION: Medical records shall be completed upon discharge of the patient from the Hospital; records not completed within thirty (30) days of discharge shall be considered delinquent. The attending physician shall be responsible for the completion of the medical record. If the medical record is not completed within twenty- one (21) days of the discharge date, the member of the Medical Staff responsible for the deficiencies will receive a written notice that the record(s) must be completed within seven days or his privileges to admit patients and to schedule surgical procedures will be suspended on the twenty-eighth (28) day.

If the record(s) is not completed in this time period, a certified letter and fax will be sent to the member(s) on the twenty-eighth (28) day after discharge notifying him of the suspension of his admitting and surgical scheduling privileges. The member(s) will still have access to the CPOE system until the thirtieth (30) day after discharge. If the member(s) fails to complete the record(s) by the thirtieth (30) day, then all Hospital privileges will be suspended, to include access to the CPOE system, and he will be notified of this suspension by certified letter, fax and phone. A copy of the certified letter of suspension will be sent to his departmental chair/clinical service or section chief. The member(s) must contact the Director of HIM, or his representative, in order to regain access to the CPOE system and complete his record(s). Any member suspended four (4) or more times per year will be reported to the appropriate Medical Staff Quality Review Committee and to the Medical Executive Committee (MEC) for possible disciplinary action.

A.3.17 ELECTRONIC RECORDS AND SIGNATURES: Signatures in the medical record may be written or electronic; an electronic signature is equivalent to a written signature and signifies concurrence with the order or report.

A.3.18 FORMS: All forms in the medical records, both printed and electronic, shall be approved by the Forms Management Committee and the Medical Records Committee and be assigned a form number prior to use in the medical record. Modification of current forms, which often result from changes in state and federal regulations, shall be handled expeditiously by both the Forms Management Committee and Medical Records Committee.

ARTICLE IV: STANDARDS OF PRACTICE

A.4.1 ATTENDING PHYSICIAN: The attending physician is the member of the Medical Staff who accepts the responsibility for the admission and care of the patient. This responsibility may be shared by members of a group, and some responsibilities may be delegated to members of the Advanced Practice Professionals Staff. The attending physician, or his representative, shall be responsible for the completion of the admission History and Physical Examination (H&P), which shall include appropriate diagnostic strategies and a plan of treatment. The attending physician, or his representative, shall be responsible for ensuring appropriate communication to the patient and the patient's family regarding the treatment plan and realistic goals of care. The attending physician, or his representative, shall also be responsible for the completion of the discharge summary and the medical record. If the responsibility for the care of the patient is shared by members of a group, the attending of record is the member who discharges the patient unless otherwise clearly designated in the discharge summary.

A.4.2 COVERAGE AND CALL SCHEDULES: All departmental chairs/clinical service or section chiefs shall have designated coverage for their departments, clinical services or sections in the form of on-call schedules. These schedules shall be prepared and communicated in a timely manner to the appropriate departments and personnel, such as the Hospital telecommunication office

and the practitioner's answering service, so that the practitioner on-call may be contacted when their services are required. Any changes to these on-call schedules shall be communicated in a timely manner to the appropriate departments and personnel so that there is no delay in contacting the covering practitioner.

A.4.3 RESPONDING TO CALLS AND PAGES: Members of the Medical Staff shall respond to pages and calls in a timely manner; in general, all pages and calls shall be returned within fifteen (15) minutes unless there are extenuating circumstances. All STAT pages shall be returned immediately. If a member of the Medical Staff is personally unable to respond to a call or page in a timely manner due to an activity, such as surgery or involvement in a code, it is his responsibility to ensure that a qualified colleague is available to respond to any calls.

A.4.4 ORDERS: All orders shall be entered into the computer system, or written in the medical record in the event of computer downtime, by the attending physician, or his representative. All orders shall be dated and timed and contain all required elements of information, such as dose, frequency, route for medication orders, so that the person carrying out the order has complete understanding of the order. Verbal orders shall be utilized only when it is impractical for the practitioner to enter the order into the computer system, or written medical record during computer downtime. These orders may be entered into the electronic medical record system by appropriate Hospital personnel, i.e. registered nurse, dietician, pharmacist, or therapist (Occupational, Physical, Speech, or Respiratory). Verbal orders shall be countersigned by a member of the Medical Staff within twenty-four (24) hours. The utilization of verbal orders shall be kept to an absolute minimum.

[Medical Orders Policy (PCS 2.029)]

A.4.5 CONSULTATIONS: Except in emergency situations, consultations with an appropriate and qualified member of the Medical Staff shall be obtained when there is doubt regarding the best diagnostic and therapeutic measures to be utilized or when the proposed procedure may interrupt a known pregnancy. The attending physician, or his representative, shall arrange the consultation and specify the level of involvement of the consultant. The consultant, or his representative, shall perform the consultation in the required timeframes:

STAT Consultations shall be completed within four (4) hours;

Routine consultations shall be completed within twenty-four (24) hours.

For STAT consultations, direct communication between the attending physician, or his representative, and the consultant is required. Direct verbal communication between the attending physician, or his representative, and the consultant is strongly encouraged for all consultations in order to accomplish proper coordination of care.

A.4.6 SURGICAL AND INVASIVE PROCEDURES: All members of the Medical Staff shall have the appropriate clinical privileges for the surgical and invasive procedure that they plan to perform and shall adhere to all Hospital and departmental policies regarding these procedures. After the procedure, the member performing the procedure shall decide and clearly document on whose service the patient shall be placed once agreement has been reached with the accepting member.

A.4.7 TISSUE SPECIMENS: All tissue specimens and foreign bodies removed at the time of surgery or invasive procedure, except those specified on the tissue specimen exclusion list, shall be sent to the Department of Pathology for examination in order to arrive at a pathological diagnosis. All specimens shall be handled in accordance with Hospital policies. Unless there are extenuating circumstances, the report of this examination shall be available within seventy-two (72) hours. In the event that a therapeutic intervention is planned for a patient that is based on pathological report from another institution, the physician who is planning the therapeutic intervention shall be responsible for the review of the specimen or the report prior to commencement of the therapeutic intervention. [Handling and Care of Surgical Specimens (Surgical Services)]

A.4.8 SITE IDENTIFICATION FOR SURGERY OR PROCEDURE: In accordance with Universal Protocol, the member of the Medical Staff shall ensure that appropriate site markings and a valid Time Out have been accomplished prior to starting a surgical or invasive procedure. These preoperative tasks shall conform to current Hospital policies.
[Surgical Site Identification (Surgery 2.024)] [Universal Protocol Policy (Medical Affairs)]

A.4.9 DEATH: Members of the Medical Staff, or their representatives, shall complete all required documents in the event of the death of their patient in the Hospital in accordance with Hospital policies.
[Death Pronouncement Policy (Medical Affairs)] [Guidelines for Managing Patient Death (PCS)] [Brain Death Policy (Medical Affairs)]
[Procedure for Processing Expired Patients (HIM)]

A.4.10 AUTOPSY: Members of the Medical Staff, or their representatives, shall request permission for autopsy for all deaths that occur in the Hospital unless the family or patient has previously declined permission.
[Autopsy Consent Policy (PCS 2.018)]

A.4.11 SUPERVISION OF DEPENDENT PRACTITIONERS: Individuals who are credentialed by the Medical Staff and appointed to the Advanced Practice Professional Staff may participate in the management of patients under the supervision of a designated member of the Medical Staff. Specific activities of the Advanced Practice Professional Staff shall be delineated by the departmental chair in accordance with Hospital policies and their specific collaborative agreements.
[Advanced Practice Professionals (APP) Policy (Medical Affairs)]

A.4.12 INFECTION CONTROL: The attending physician and his representatives shall comply with Hospital policies pertaining to infection control. Standard precautions shall be utilized in all patients where contact with blood or body fluids is anticipated. The attending physician or his representative, nurse, or Hospital epidemiologist shall determine the need for additional precautions. Orders for such precautions shall be entered into the CPOE system, and a note shall be placed in the medical record stating the reason for these precautions. The Hospital epidemiologist shall have the final determination regarding the initiation and/or discontinuation of these precautions.
[Infection Control Policy (IC 1.4)]

ARTICLE V: PATIENT RIGHTS

A.5.1 PATIENT RIGHTS: All patients who receive care at the Hospital shall be provided with a copy of the “Patient’s Bill of Rights” and the “Notice of Privacy Practices” that outlines their patient rights. All health care providers have the responsibility to keep the patient and their families informed with respect to the ongoing course of treatment to include such issues as diagnoses, medications, treatment options, risks and benefits, and unanticipated outcomes. All members of the Medical Staff and their representatives shall be aware of these patient rights and shall comply with Hospital policies pertaining to patient rights.
[Policy on Patient’s Rights and Responsibilities (RM 2.001)]
[Notice of Privacy Practices (HIPAA 1.004)]
[Patients’ Right-to-Know (Risk Management)]

A.5.2 INFORMED CONSENT: Except in emergency situations, the responsible member of the Medical Staff shall ensure that proper informed consent is obtained prior to any surgery, procedure, or treatment for which it is appropriate. A list of “Procedures Requiring Consent” will be maintained as an appendix to these Rules and Regulations. A properly executed consent form, which contains all required

elements of information, shall be maintained in the patient's medical record. Members of the Medical Staff and their representatives shall comply with all Hospital policies regarding informed consent and the consent process.

[Consent Policy (Risk Management)]

A.5.3 ADVANCE DIRECTIVES: Patients are encouraged to have "Advanced Directives" so that their physicians and health care agents can make decisions regarding their care in accordance with their wishes if they are unable to participate in this decision-making. All members of the Medical Staff shall comply with the patient's "Advanced Directives" and with the Hospital's Advance Directives Policy. If the member is unable to comply with the patient's wishes or "Advanced Directives", then they shall assist the patient or health agent in finding another physician to assume the care of the patient.

[Advance Directives Policy (Risk Management)]

[Transfer and Discharge of Patients with DNR Order (PCS)]

A.5.4 WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEASURES: There are situations where allowing natural death to occur is appropriate and would entail withdrawing or withholding certain treatments. All members of the Medical Staff, or their representatives, shall comply with the Hospital's Policy for Withdrawing or Withholding Life-Sustaining Measures. Before life-sustaining treatment can be withheld or withdrawn, there shall be documentation in the medical record of the agreement between the attending physician and the patient, or his health care agent, regarding the consensus on care and the next steps to be taken. Once there is documentation of the agreement to withhold or withdraw life-sustaining treatment, the attending physician, or his representative, shall enter the appropriate orders into the CPOE system.

[Life-Sustaining Measures: Policy for Withholding and Withdrawing (MEC)]

A.5.5 RESTRAINTS AND SECLUSION: Treatment and healing occur optimally in the absence of physical restraints. Only when necessary and/or when all other therapeutic modalities have been attempted shall the attending physician, or his representative, place an order for restraints in the CPOE system. In emergent situations, it may not be possible to attempt all alternative modalities. Members of the Medical Staff shall comply with all Hospital policies pertaining to restraints and seclusion.

[Restraint and Seclusion Policy (PCS 2.042)]

A.5.6 RESEARCH AND HUMAN SUBJECTS: The health, welfare, and safety of human subjects shall be paramount in the performance of all research studies. Members of the Medical Staff shall obtain approval from the Institutional Review Board (IRB) prior to the initiation of any research studies, the results of which may be published or presented. All patient rights shall be observed and proper informed consent shall be obtained. The IRB has the right to terminate any research study due to deviation from the protocol, lack of compliance and/or unexpected risk to human subjects.

[Investigational Drugs (Pharmacy)] [IRB Policy
Manual (Research)] [Consent Policy (Risk
Management)]

ARTICLE VI: RULES OF CONDUCT

A.6.1 GENERAL: Members of the Medical Staff and their representatives shall conduct themselves in a professional manner in all interactions with patients, families and Hospital personnel and shall comply with the Hospital's Code of Conduct and the Medical Staff's Disruptive Physician Policy.

[Medical Staff Policy on Professional Conduct (Medical Affairs)]

[Employee Behavior Policy (HR 24-8)]

A.6.2 STAFF DUES: Medical Staff dues shall be determined by the Medical Executive Committee and approved at the Annual Meeting of the Medical Staff. Members of the Medical Staff shall receive bills for

their dues each year in January and shall pay these dues within ninety (90) days. The member may have his privileges suspended for non-payment of the dues in accordance with medical staff policies/credentials (Part II, Section 2.1.5) policy.

A.6.3 DISRUPTIVE BEHAVIOR: Quality patient care can only be delivered in a dignified environment of professional and collegial behavior. Therefore, all members of the Medical Staff, and their representatives, shall treat others with respect, courtesy and dignity, and shall conduct themselves in a professional and cooperative manner. Inappropriate and unprofessional behavior shall not be tolerated and shall be handled in accordance with Hospital policies and the Medical Staff Bylaws. Disruptive behavior may also result in the member being referred to the Physician Health Committee. [Medical Staff Policy on Professional Conduct (Medical Affairs)] (Draft) [Sexual Harassment (HR 22-9)]

A.6.4 IMPAIRED PRACTITIONERS: When there is a concern that a member of the Medical Staff is impaired in a manner that would endanger patient care, that member shall be referred to the Physician Health Committee and/or to the appropriate agency that deals with these issues, e.g. HAVEN.

A.6.5 SMOKING POLICY: The Hospital is a smoke-free environment. Members of the Medical Staff shall comply with this rule and all other Hospital policies regarding smoking. [Non-Smoking Policy (HR 31-6)]

PART B: SAINT FRANCIS HOSPITAL & MEDICAL CENTER
MEDICAL STAFF BYLAWS

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SECTION B1. MEDICAL STAFF PURPOSE & AUTHORITY

B.1.1 Purpose

B.1.1.1 The purpose of this medical staff is to collaborate with the hospital administration and Board; striving for excellence in patient care and community health through patient advocacy, effective quality monitoring, peer review, credentialing and governance of the medical staff.

B.1.2 Authority

B.1.2.1 Subject to the authority and approval of the board the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the hospital. Henceforth, whenever the term “the hospital” is used, it shall mean St. Francis Hospital and Medical Center; and whenever the term “the Board” is used, it shall mean the Board of Directors of St. Francis Hospital and Medical Center.

SECTION 2. MEDICAL STAFF MEMBERSHIP

B.2.1 Nature of Medical Staff Membership

B.2.1.1 Membership on the medical staff of the hospital is a privilege that shall be extended only to professionally competent physicians, (M.D. or D.O.) podiatrists and dentists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the medical staff and the hospital.1 Telemedicine physicians, locum tenens physicians, clinical psychologists, moonlighting postgraduates (with state licensure), and Advance Practice Professionals are eligible for privileges but are not eligible for Medical Staff Membership.

B.2.2 Qualifications for Membership

B.2.2.1 The qualifications for medical staff membership are delineated in Part III of these bylaws (Credentials Procedures).

B.2.3 Nondiscrimination

B.2.3.1 The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability, sexual orientation, gender identity or unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

B.2.4 Conditions and Duration of Appointment

B.2.4.1 The Board shall make initial appointment and reappointment to the medical staff. The Board shall act on appointment and reappointment only after the medical staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC), with the exception of temporary and disaster privileges. Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) calendar months.

B.2.5 Medical Staff Membership and Clinical Privileges

B.2.5.1 Requests for medical staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria recommended by the MEC and approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures) of these bylaws.

B.2.6 Medical Staff Members Responsibilities

B.2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

B.2.6.2 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as identified in part IV of these bylaws as requested by the MEC.

B.2.6.3 Each staff member must submit to a health evaluation as requested by the MEC when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.

B.2.6.4 Each staff member must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital policies as endorsed by the MEC.

B.2.6.5 Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board. Each staff member shall notify the MEC and Department Chair or Clinical Service Chief in a timely manner of any and all malpractice claims filed in writing against the medical staff member.

B.2.6.6 Each staff member agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the medical staff member and his/ her credentials.

B.2.6.7 Each staff member shall prepare and complete in timely fashion, according to medical staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

(a) The History and Physical Examination (H & P) shall be performed and recorded by a doctor of medicine (MD), a doctor of Osteopathy (DO), a podiatrist (DPM), a dentist (DMD, DDS), or an oral and maxillofacial surgeon (DMD). All or part of the H & P may be delegated to other practitioners in accordance with State law and hospital policy, but the MD, DO, DPM, DMD or DDS, as applicable, must sign the H & P and update the note, and must assume full responsibility for the H & P. Provisions for Hospital-Based Physician Assistants and Nurse Practitioners are acceptable, as they represent designees of privileged or community providers.

(b) A medical history and appropriate physical examination must be entered in the medical record no more than thirty (30) days before or twenty-four (24) hours after a hospital inpatient or observation admission. If an H & P Examination has been performed and documented within thirty (30) days of the patient's admission to the Hospital, a legible copy of that H & P examination may be used in the patient's hospital medical record provided that an "Updated History and Physical Examination" is entered in the medical record no more than 24 hours after admission or prior to surgery. Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to all invasive procedures performed in the Hospital's surgical suites.

B.2.6.8 Each staff member will use confidential information only as permitted in accordance with state and federal laws (including HIPAA), and hospital policies and rules, for all activities including, but not limited to, treatment, payment, administrative, research, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information,

and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

B.2.6.9 Each staff member must participate in any type of competency evaluation when determined necessary by the MEC in order to properly delineate that member's clinical privileges.

B.2.6.10 Each staff member shall disclose to the appropriate leader, consistent with the medical staff conflict of interest policy any ownership or financial interest that may conflict with, or provide personal benefit to that member, or have the appearance of conflicting with, the interests of the medical staff or hospital.

B.2.6.11 Members of the Medical and Dental Staff shall conform to the Ethical and Religious Directives for Catholic Health Care Services as adopted and amended from time to time by the United States Conference of Catholic Bishops, with respect to their practice in or at the Hospital, and shall not engage in activity prohibited by the Directives in or at the Hospital. Members shall affirm their agreement to conform to the Directives as part of the process for the appointment and reappointment to the Medical and Dental Staff.

B.2.6.12 Each staff member, consistent with his granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty leadership, to assist in meeting the patient care needs of the community.

B.2.7 Medical Staff Member Rights

B.2.7.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC. In the event such practitioner is unable to resolve a matter of concern after working with his department chair, clinical service chief or other appropriate medical staff leader(s), that practitioner may, upon written notice to the president of the medical staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

B.2.7.2 Each staff member in the Active category has the right to initiate a recall election of a medical staff officer by presenting a petition signed by twenty percent (20%) of the members of the Active category and following the procedure outlined in Section 4.7 of Part I of these bylaws, regarding removal and resignation from office.

B.2.7.3 Each staff member in the Active category has the right to request, in writing, a general medical staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty percent (20 %) of the members of the Active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted. If the recommendation of the MEC varies from the position of the general medical staff, the issue will be referred to the conflict resolution process outlined in these bylaws.

B.2.7.4 The officers of the medical staff and other members of the MEC have a right to a meeting with the administrative and/or board officers to discuss any issue impacting the medical staff, hospital or community at a mutually agreed upon date, time and location.

B.2.7.5 Each staff member in the Active category may challenge any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by twenty percent (20 %) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.2.1 will be followed.

B.2.7.6 Each staff member in the Active category may call for a department or a clinical service meeting by presenting a petition signed by twenty (20 %) of the members of the department or clinical service. Upon presentation of such a petition the department chair or clinical service chief will schedule a

department or clinical service meeting as appropriate.

B.2.7.7 The above sections 2.7.1 – 2.7.6 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

B.2.7.8 Any staff member has a right to a hearing/appeal pursuant to the conditions and procedures described in the medical staff's hearing and appeal plan (Part II of these bylaws).

SECTION B.3. CATEGORIES OF THE MEDICAL STAFF

B.3.1 The Active Category

B.3.1.1 Qualifications: Members of this category must have successfully completed the credentialing process, and in most cases the privileging process. The majority of members in the category shall maintain active privileges at the hospital. Some members of this category may admit all their patients through the hospitalists and not seek privileges, but they may desire to remain active in medical staff matters and run for a medical staff office or the MEC.

The MEC may waive certain requirements for practitioners with 10 years of service in the active category or for those who have supported the hospital's patient care mission.

In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital policies that are endorsed by the MEC, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

B.3.1.2 Prerogatives: Members of this category may:

B.3.1.2.1 Attend general medical staff, department or clinical service meetings of which s/he is a member and may attend any medical staff or hospital education programs;

B.3.1.2.2 Vote on all matters presented by the general medical staff, department or clinical service and committee(s) to which the member is assigned;

B.3.1.2.3 Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

B.3.1.3 Responsibilities: Members of this category shall:

B.3.1.3.1 Comply with any applicable medical staff or hospital policies or procedures that are endorsed by the MEC including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities.

3.1.3.2 Supervise the professional training programs for Medical Staff and the professional conduct of house officers and non-physician personnel, other than nurses, engaged in the delivery of patient care.

1. Members of the Medical Staff may participate in formal teaching programs and provide training opportunities for interns, residents and fellows (herein collectively referred to as

(“Residents”) through the hospital’s teaching programs, and during these training opportunities, the Residents are actively engaged in patient care activities under the supervision of participating members of the Medical Staff.

2. In any claim, suit, or proceeding arising out of the care of a patient of the Hospital, as between the Hospital and the Attending Physician, the Hospital shall assume all liability for the actions or inactions of the Resident(s) in the proportion, if any, that the conduct of the Resident(s) is determined to be negligent and the cause of a patient’s injuries and/or damages under applicable law (“Resident Liability”). The Hospital shall satisfy any financial obligation arising out of any such Resident Liability.

3. With regard to any such claim, suit, or proceeding, the Hospital shall not bear the portion of the liability or damages, if any, which is determined to result from the attending physician’s own negligence in providing medical care to the patient or in supervising the Resident in accordance with applicable standards of care. This provision does not apply with respect to Attending Physicians whose medical liability insurance is provided by Saint Francis Hospital and Medical Center.

4. These provisions are intended for the benefit of only the Hospital and the Attending Physician, and are not intended to confer any right or benefit on any other person or party.

5. These provisions shall apply retroactively to pending claims, suits or proceedings.

B.3.2 The Courtesy Category

B.3.2.1 Qualifications: Members of this category are practitioners who do not have the volume of patients to constitute active staff status and who admit patients infrequently to the hospital. They shall have active staff privileges at another hospital. They shall complete the credentialing and privileging process.

B.3.2.2 Prerogatives: Members of the courtesy category may:

B.3.2.2.1 Attend general medical staff, department or clinical service meetings of which s/he is a member and may attend any medical staff or hospital education programs;

B.3.2.2.2 Not vote on matters presented by the general medical staff, department, or clinical service and committee(s) to which the member is assigned;

B.3.2.2.3 Not hold office and sit on or be chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

B.3.2.3 Responsibilities: Members of the courtesy category shall have the same responsibilities as active category members.

B.3.3 The Consultant Category

B.3.3.1 Qualifications: Members of this category are practitioners who are considered to have expertise in their respective specialties that allows them to give unique and valuable advice to members of the staff and the hospital. They shall have active privileges at another hospital. They shall complete the credentialing process, but they shall complete the privileging process only if they plan to actively treat patients, rather than just give advice.

B.3.3.2 Prerogatives: Members of the consulting category may:

B.3.3.2.1 Attend general medical staff, department or clinical service meetings of which s/he is a member and may attend any medical staff or hospital educational programs.

B.3.3.2.2 Not vote on matters presented by the general medical staff, department or clinical service and committee(s) to which the member is assigned;

B.3.3.2.3 Not hold office and sit on or be chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

B.3.3.3 Responsibilities: Members of the consulting category shall have the same responsibilities as active category members where applicable; it is recognized that a number of responsibilities will not apply.

B.3.4 The Community Physician Category

The Community Physician Category is restricted to those individuals recommended by the MEC. Appointment to this category is meant for those physicians who refer patients to the hospital and require access to the computerized medical record. These community physicians maintain an active practice in the state but have no intention of obtaining privileges at this institution, nor do they intend to become active in medical staff matters. They may participate in educational (CME) activities but cannot vote on medical staff matters or hold office. There shall be no requirement for them to be board certified in their specialty.

B.3.5 The Emeritus Category

The Emeritus Category is restricted to those individuals recommended by the MEC. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Emeritus Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend general medical staff, department or clinical service meetings, participate in continuing medical education activities, and may be voting members of medical staff committees. They shall not hold clinical privileges, hold office or be eligible to vote at general medical staff, department or clinical service meetings.

SECTION B4. OFFICERS, MEC AT-LARGE, VOLUNTARY DEPARTMENT CHAIRS AND VOLUNTARY CLINICAL SERVICE CHIEFS OF THE MEDICAL STAFF

B.4.1 Officers of the Medical Staff

B.4.1.1 President of Medical Staff

B.4.1.2 Vice-President of Medical Staff

B.4.1.3 Secretary/Treasurer

B.4.1.4 Assistant Secretary/Treasurer

B.4.2 Qualifications of Officers, MEC at-large members, Voluntary Department Chairs and Voluntary Clinical Service Chiefs:

B.4.2.1 To be eligible to be elected as an officer, MEC at-large member, Voluntary Department Chair or Voluntary Clinical Service Chief of the medical staff, candidates must have previously served in a

significant leadership position on a medical staff, indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have a history of attendance at continuing education relating to medical staff leadership and/or be willing to do so during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and should have excellent administrative and communication skills. The medical staff Nomination Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

B.4.2.2 Officers may not simultaneously hold leadership positions on another hospital medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in automatic removal from office unless the MEC determines that continuation in office will serve the interests of the hospital. The Nomination Committee shall have discretion to determine what constitutes a “leadership position” at another hospital.

B.4.3 Duties of Officers:

B.4.3.1 Duties of the President.

The President shall:

B.4.3.1.1 The president of the medical staff is the primary elected officer of the medical staff and is the medical staff’s advocate and representative in its relationships to the Board and the administration of the hospital. The president of the medical staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations and policies. Specific responsibilities and authority are to:

B.4.3.1.2 Call and preside at all general and special meetings of the medical staff;

B.4.3.1.3 Serve as chair of the MEC (with vote), and as ex officio member of all other medical staff committees (without vote), and to participate as invited by the hospital president or the Board on hospital or Board committees;

B.4.3.1.4 Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;

B.4.3.1.5 Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions ; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

B.4.3.1.6 Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

B.4.3.1.7 Report to the Board the MEC’s recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or Advanced Practice Professionals who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

B.4.3.1.8 Continuously evaluate and periodically report to the hospital, MEC, and the Board

regarding the effectiveness of the credentialing and privileging processes;

B.4.3.1.9 Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

B.4.3.1.10 Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

B.4.3.1.11 Attend Board meetings and Board committee meetings as invited by the Board;

B.4.3.1.12 Ensure that the decisions of the Board are communicated and carried out within the medical staff;

B.4.3.1.13 Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

B.4.3.2 Duties of the Vice President.

The Vice President shall:

B.4.3.2.1 Succeed to the Presidency in the event of a vacancy in that office and be eligible for election and reelection as described below.

B.4.3.2.2 Act, upon designation by the President, in place of the President in instances of the President's illness, absence from the community or other situations in which the President is temporarily incapacitated.

B.4.3.2.3 Serve as a voting member of the MEC.

B.4.3.3 Duties of the Secretary-Treasurer.

The Secretary-Treasurer shall:

B.4.3.3.1 Issue notices of General Medical Staff and MEC meetings, in conjunction with the President of the Medical Staff.

B.4.3.3.2 Approve the recorded minutes of General Medical Staff and MEC meetings and have them approved at subsequent meetings. The Secretary-Treasurer will receive appropriate secretarial assistance, furnished by Hospital administration.

B.4.3.3.3 Collect authorized Staff dues and properly disburse authorized monies from the Staff treasury.

B.4.3.3.4 Present a Treasurer's Report at the annual meeting.

B.4.3.3.5 Serve as a voting member of the MEC.

B.4.3.3.6 Be bonded in an amount to be fixed by the MEC.

B.4.3.3.7 Train, and be assisted by, the Assistant Secretary-Treasurer.

B.4.3.4 Duties of the Assistant Secretary-Treasurer.

The Assistant Secretary-Treasurer shall:

B.4.3.4.1 Assist, and be trained by, the Secretary-Treasurer.

B.4.3.4.2 Succeed to the office of Secretary-Treasurer in the event of a vacancy and be eligible for reelection as described below.

B.4.3.4.3 Succeed to the office of Secretary-Treasurer when the term of the Secretary-Treasurer expires, and be eligible for reelection as described below.

B.4.3.4.4 Serve as a voting member of the MEC.

B.4.4 Selection of Medical Staff Officers and MEC At-Large Members:

B.4.4.1 Nominations: Only members of the Active Staff may be nominated to serve as officers of the medical staff or MEC at-large members. Nominations shall take place as follows:

B.4.4.1.1 Every other year or as needed, the MEC shall appoint a nominations committee chaired by the immediate past president of the medical staff and comprised of two (2) other MEC members and four (4) active medical staff members at-large, to fill MEC at-large vacancies.

When a vacancy exists, the Medical Staff must receive notice identifying the vacancy to allow for interested parties to submit candidacy, who must submit a biographical statement of interest to the chair within two weeks of the notice.

Following the announcement of vacancy, the committee shall offer a slate of at least one nominee (but no more than three (3)) for each at-large position of the Medical Executive Committee. This slate may be comprised of interested parties and/or eligible members identified by the Nominations Committee.

The slate of nominees shall be created two weeks (2) after the vacancy announcement, and presented to the MEC at least thirty days (30) days prior to the annual staff meeting, and shall be delivered or mailed to members of the active medical staff at least fourteen (14) days prior to the election.

B.4.4.1.2 Nominations may also be made by any Member of the Active Staff by submitting to the Chairman of the Nominations Committee a petition signed by at least 10% of the Active medical staff members eligible to vote, which bears the candidates written/documented consent. Such petitions shall be delivered to the Chairman of the Nominations Committee as soon as possible, but at least 20 days prior to the date of the election. Nominations made in this manner shall be delivered or mailed to Members of the Active Staff at least 10 days prior to the meeting. The slate of nominations will be included on the ballot as provided by the nomination committee unless an additional nomination by an Active Medical Staff member of an eligible staff member which meets the criteria above is submitted, at which time that nominee will be added to the ballot.

B.4.4.1.3 Officers and MEC at-large members shall be elected at least one month prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote or hold office. The medical staff services professional, in consultation with the President of the Medical Staff, and subject to approval of the MEC, will determine the mechanisms by which votes may be cast, subject to the approval of the MEC. Mechanisms that may be considered include written mail-in ballots, electronic voting via computer, fax, or other technology for transmitting the member's voting choices. The nominee receiving the greatest number of votes will be elected. In the event of a tie vote, the MEC will vote to determine the winner. All votes are subject to simple majority only.

For roles of the Nominating Committee, refer also to E.18.1 and B.6.2.1.3

B.4.5 Terms of Office

B.4.5.1 The President and Vice President shall be elected for a two (2) year term. The President and the Vice President are not eligible to hold consecutive terms. The President and Vice President are eligible to be elected to an elected position when they have not held an officer position for a two (2) year period.

B.4.5.2 All MEC at-large members shall be elected for a two (2) year term. To the extent reasonably possible, MEC at-large-Members shall serve staggered terms to enhance continuity of leadership within the MEC. MEC at-large members may be reelected for additional terms not to exceed a total of six years.

B.4.5.3 The Secretary-Treasurer and the Assistant Secretary-Treasurer shall be elected for a two (2) year term and may be reelected for additional terms not to exceed a total of four (4) years. The timeframe noted in this term limitation will start with the terms subsequent to amendment of this bylaws change, inclusive of the most recent term.

B.4.6 Vacancies

B.4.6.1 In General: A vacancy shall occur upon the death, disability, resignation or removal of an officer, or upon the officer's loss of membership on the Staff.

B.4.6.2 President: A vacancy in the office of President shall be filled by the Vice President as provided in 4.3.2.1 of this Article.

B.4.6.3 Vice President: A vacancy in the office of Vice President shall be filled by election at the next annual meeting of the Staff, if fewer than three months remain in the term. If longer than three months remain, a special election may be held within the MEC to identify the replacement Vice President.

B.4.6.4 Secretary-Treasurer: A vacancy in the office of Secretary-Treasurer shall be filled by the Assistant Secretary-Treasurer as provided in 4.3.4.2, of this Article. If necessary, the President shall appoint an MEC member to assume the duties of Assistant Secretary-Treasurer until the next annual meeting of the Staff.

B.4.6.5 Simultaneous Vacancy of President and Vice President: If the offices of both President and Vice President are vacant, the MEC shall appoint an individual to temporarily assume the office of the President, and within 30 days shall convene a special meeting of the general medical staff for the purpose of electing a new President and Vice President. Individuals so elected may be reelected to two full terms following the partial ones.

B.4.7 Removal of Officers or MEC At-Large Members

B.4.7.1 The medical staff may remove any officer or MEC at-large member by petition of 20% of the active staff members and a subsequent affirmative two thirds (2/3) majority vote of the active medical staff. The MEC may remove any officer or MEC at-large member by 2/3 majority vote and subsequent approval by the Saint Francis Board of Directors.

B.4.7.2 Automatic removal shall be for failure to conduct those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, or for conduct or statements damaging to patient care, or if the officer triggers an automatic or precautionary suspension of clinical privileges which lasts for more than thirty days. The existence of such failures will be determined by the MEC.

B.4.8 Compensation

B.4.8.1 The Officers of the Staff shall be eligible for compensation for time spent in discharge of duties of the office. The President shall be furnished with an office at the Hospital and with secretarial assistance as required.

SECTION B5. MEDICAL STAFF ORGANIZATION: DEPARTMENTS, CLINICAL SERVICES AND CLINICAL SECTIONS

B.5.1 Organization of the Medical Staff

B.5.1.1 The medical staff shall be organized as a departmentalized staff. The medical staff may create sections within a department or clinical services in order to facilitate medical staff activities. A list of departments, sections and clinical services organized by the medical staff and formally recognized by the MEC is listed in Part IV of the bylaws (Organization and Functions).

The MEC, with approval of the Board, may designate new medical staff departments, sections or clinical services or dissolve current departments, sections or clinical services as it determines will best meet the medical staff needs for performing effective peer review, performance improvement, credentialing/privileging, and promoting communication and patient safety.

The MEC may recognize any group of at least three (3) practitioners who wish to organize themselves into a department section or a clinical service. Any section or clinical service, if organized, shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report to document a specific position is required only when the section is making a formal report to the department or when a clinical service is making a formal report to the MEC. The Department Chair and the section chief will decide if the report is placed on the department agenda and whether the section chief will attend the department meeting to present the report and participate in the vote of the department on that specific issue. The President of the Medical Staff and the clinical service chief will decide if the report is placed on the MEC agenda and whether the Clinical Service Chief (or designee) will attend the MEC meeting to present the report and participate in the vote of the MEC on that specific issue. Sections and Clinical services are completely optional and shall exist to perform any of the following activities:

- B.5.1.1.1 Continuing education/discussion of patient care;
- B.5.1.1.2 Review and resolution of peer review issues referred by the medical staff quality review committee;
- B.5.1.1.3 Conduct grand rounds;
- B.5.1.1.4 Discussion and enforcement of policies and procedures;
- B.5.1.1.5 Discussion of equipment needs;
- B.5.1.1.6 Development of recommendations for a department, another section or clinical service or MEC;
- B.5.1.1.7 Participation in the development of criteria for clinical privileges when requested by the credentials committee or MEC;
- B.5.1.1.8 Discussion of a specific issue at the request of a medical staff committee or the MEC.

B.5.2 Qualifications, Selection, Term, and Removal of Department Chair and Clinical Service

Chiefs

B.5.2.1 Permanent department chairs and permanent clinical service chiefs are hired by the institution and removed in accordance with institutional Human Resources policies. Voluntary department chairs and voluntary clinical service chiefs shall serve a term of two (2) years commencing on January 1, and may be elected to serve successive terms. All chairs and chiefs must be members of the active staff with relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. To be eligible for election as a voluntary department chair or voluntary clinical service chief, individuals must meet the selection criteria listed in section 4.2.1 of these bylaws.

B.5.2.2 Voluntary department chairs and voluntary clinical service chiefs will be elected by majority vote of the active members of the department or clinical service, subject to ratification by the MEC. Each department or clinical service that does not have a permanent chair shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC.

B.5.2.3 Voluntary department chairs or voluntary clinical service chiefs may be removed from office by the MEC upon receipt of a recommendation of a 2/3 majority of the members of the department or clinical service, or, in the absence of such recommendation, the MEC may remove a chair or chief on its own by a 2/3 majority vote if any of the following occurs:

B.5.2.3.1 The voluntary department chair or voluntary clinical service chief ceases to be a member in good standing of the medical staff;

B.5.2.3.2 The voluntary department chair or voluntary clinical service chief suffers an involuntary loss or significant limitation of practice privileges;

B.5.2.3.3 The voluntary department chair or voluntary clinical service chief fails, in the opinion of the MEC, to demonstrate to the satisfaction of the MEC or the Board that he or she is effectively carrying out the responsibilities of the position.

B.5.2.4 If removal is required, a new election will be held according to the established departmental or clinical service procedures.

B.5.2.5 Permanent department chairs and permanent clinical service chiefs are responsible for fulfilling the duties and responsibilities contained in their position description and employment contract in addition to the responsibilities assigned in Part IV of these bylaws (Organization and Functions Manual). Voluntary department chairs and voluntary clinical service chiefs shall carry out the responsibilities assigned in Part IV of these bylaws (Organization and Functions Manual).

B.5.3 Responsibilities of Department Chairs

B.5.3.1 To oversee all clinically-related activities of the department;

B.5.3.2 To oversee all administratively-related activities of the department, unless otherwise provided by the hospital;

B.5.3.3 To provide ongoing surveillance of the performance of all individuals in the medical staff department who have been granted clinical privileges;

B.5.3.4 To recommend to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff department;

B.5.3.5 To recommend clinical privileges for each member of the department and other licensed independent practitioners practicing with privileges within the scope of the department;

- B.5.3.6 To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff department or the hospital;
- B.5.3.7 To integrate the department into the primary functions of the hospital;
- B.5.3.8 To coordinate and integrate interdepartmental and intradepartmental services and communication;
- B.5.3.9 To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;
- B.5.3.10 To recommend to the Hospital President sufficient numbers of qualified and competent persons to provide patient care and service;
- B.5.3.11 To provide input to the Hospital President regarding the qualifications and competence of department or service personnel who are not LIPs but provide patient care, treatment, and services;
- B.5.3.12 To continually assess and improve of the quality of care, treatment, and services;
- B.5.3.13 To maintain quality control programs as appropriate;
- B.5.3.14 To orient and continuously educate all persons in the department or service; and
- B.5.3.15 To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff department to provide patient care services.

B.5.4 Assignment to Department or Clinical Service

B.5.4.1 The MEC will, after consideration of the recommendations of the appropriate permanent or voluntary department chair or permanent or voluntary clinical service chief, recommend department or clinical service assignments for all members in accordance with their qualifications. Each member will be assigned to one primary department or clinical service. Clinical privileges are independent of department or clinical service assignment.

SECTION 6. MEDICAL STAFF COMMITTEES

B.6.1 Designation and Substitution

B.6.1.1 There shall be a MEC and such other standing and special committees as established by the MEC and enumerated in Part IV of the bylaws (Organization and Functions). Those functions requiring participation of, rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established by the President of the Medical Staff in consultation with the MEC and collaboration with the hospital president to perform such functions. The president of the medical staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

B.6.1.2 Medical staff members may be appointed to hospital committees by the President of the Medical Staff. Actions taken by hospital committees that affect the standard operating procedures, quality efforts, and patient care needs (including those where clarification may be required) must have those actions approved by the MEC prior to going into effect.

B.6.2 Medical Executive Committee (MEC)

B.6.2.1 Committee Membership:

- B.6.2.1.1 Composition: The MEC shall be a standing committee consisting of the following officers:
- A. President, Vice President, Secretary/Treasurer, Assistant Secretary/Treasurer
 - B. All officers are voting members; the President of the Medical Staff, although having the right to vote, will usually refrain from voting except in those instances necessary to break a tie.
 - C. The MEC chair will be the president of the medical staff.
 - D. Other Voting Members
 - a. Chair of the Credentials Committee
 - b. Chair of the Quality Oversight Committee
 - c. Department Chairs in: Medicine, Surgery, Obstetrics-Gynecology, Emergency Medicine, Anesthesiology, Radiology
 - d. At Large Members (5 elected from active Medical Staff)
 - e. The immediate past president will serve on the MEC with voting rights for two years following their term as president.
 - E. Non-Voting Members
 - a. The hospital president or designee
 - b. CMO
 - c. CQO
 - d. CNO
 - e. A representative of the APP staff shall be invited by the president of the medical staff as an ad-hoc member

B.6.2.1.2 Resignation or removal from MEC: A voting member of the MEC may be removed from his position for failure to conduct those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, or for conduct or statements damaging to patient care, or if the identified MEC member triggers an automatic or precautionary suspension of clinical privileges which lasts for more than thirty days. When the chair of either the credentials or quality oversight committees or a designated department chair resigns or is removed from these positions, his replacement will serve on the MEC. An at-large member of the MEC may be removed by a majority affirmative vote of MEC members. When a member of the MEC who was elected at-large resigns or removed, the MEC will arrange for an at-large election for a replacement is to serve out the remainder of the vacated seat's term. Such election will follow procedures established by the MEC and must take place within sixty (60) days of the resignation or removal of an MEC member.

B.6.2.1.3 Selection of candidates for MEC election:

The Nominating Committee for the MEC shall select appropriate MEC Officer (President, Vice President, Secretary/Treasurer, Assistant Secretary/Treasurer) candidates, who must meet the qualifications set forth in Section 4.2 of Part 1 of the Medical Staff Bylaws; the Chair of the Nominating Committee, in conjunction with the MEC, will maintain the authority to identify the slate of officers running for election.

The Nominating Committee for the MEC shall also select appropriate candidates for an MEC at-large vacancy based on the qualification set forth in Section 4.2 of Part 1 of the Medical Staff Bylaws. The Nominating Committee shall consist of the Immediate Past President of the Medical Staff, as well as two (2) MEC members and three (3) non-MEC members chosen by the MEC. All members of the medical staff will be solicited to apply for any vacant position via an open request distributed by electronic mail. No more than three candidates shall be selected and appear on the ballot for each vacancy. Elections for the MEC shall be arranged by the Medical Staff Office and shall be held by written ballot.

B.6.2.2 Duties: The duties of the MEC shall be to:

B.6.2.2.1 Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;

- B.6.2.2.2 Coordinate the implementation of policies adopted by the Board;
- B.6.2.2.3 Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department/clinical service assignments, clinical privileges, and corrective action;
- B.6.2.2.4 Account to the Board and to the staff for the overall quality and efficiency of professional patient care services provided in the hospital by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
- B.6.2.2.5 Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;
- B.6.2.2.6 Make recommendations to the Board on medical administrative and hospital management matters;
- B.6.2.2.7 Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
- B.6.2.2.8 Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
- B.6.2.2.9 Represent and act on behalf of the staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws;
- B.6.2.2.10 Formulate and recommend to the Board medical staff rules, policies, and procedures;
- B.6.2.2.11 Request evaluations of practitioners privileged through the medical staff process in instances in which there is question about an applicant or member's ability to perform privileges requested or currently granted;
- B.6.2.2.12 Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
- B.6.2.2.13 Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the hospital by entities outside the hospital;
- B.6.2.2.14 Oversee that portion of the corporate compliance plan that pertains to the medical staff;
- B.6.2.2.15 Hold medical staff leaders, committees, clinical services, departments and department sections accountable for fulfillment of their duties and responsibilities;
- B.6.2.2.16 Make recommendations to the medical staff for changes or amendments to the medical staff bylaws.

B.6.2.3 Meetings: The MEC shall meet at least six (6) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

SECTION B.7. MEDICAL STAFF MEETINGS

B.7.1 General Medical Staff Meetings

B.7.1.1 An annual meeting and other general meetings of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.

B.7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

B.7.1.3 Special Meetings of the General Medical Staff

B.7.1.3.1 The president of the medical staff may call a special meeting of the general medical staff at any time. Such request or resolution shall state the purpose of the meeting. The president of the medical staff shall designate the time and place of any special meeting of the general medical staff.

B.7.1.3.2 Written or electronic notice stating the time, place, and purposes of any special meeting of the general medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

B.7.2 Regular Meetings of Medical Staff Committees, Clinical Services, Sections and Departments

B.7.2.1 Committees, Clinical Services, Sections and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall meet at least annually.

B.7.3 Special Meetings of Committees, Clinical Services, Sections and Departments

B.7.3.1 A special meeting of any Committee, Clinical Service, Section or Department may be called by the chair or chief or by the President of the Medical Staff.

B.7.4 Quorum

B.7.4.1 Annual and General Medical Staff meetings: those present or those eligible medical staff members voting on an issue.

B.7.4.2 MEC, Credentials Committee, Medical Staff Quality Oversight Committee, and the Surgical, Medical and Women's and Children's Quality Review Committees: A quorum will exist when 50% of the voting members are present.

B.7.4.3 Department, Clinical Service or Section meetings or medical staff committees other than those listed in 7.4.2 above: Those present or those eligible medical staff members voting on an issue.

B.7.5 Attendance Requirements

B.7.5.1 Members of the medical staff are encouraged to attend meetings of the medical staff.

B.7.5.1.1 MEC, Credentials Committee, Medical Staff Quality Oversight Committee

meetings and the Surgical, Medical and Women's and Children's Quality Review Committees: Members of these committees are expected to attend at least seventy-five percent (75%) of the meetings held.

B.7.5.1.2 Special meeting attendance requirements: Whenever there is suspected or actual non-compliance with medical staff or hospital policies or suspected deviation from standard clinical or professional practice, the president of the medical staff or the applicable department or committee chair, clinical service or department section chief may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting, including the date, time, place, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after receiving notice, unless excused by the MEC upon showing good cause, will result in an automatic termination of clinical privileges and membership from the medical staff. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced meeting.

B.7.5.1.3 Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

B.7.6 Manner of Action

The recommendation of a simple majority of its members present at a meeting at which a quorum is present shall be the action of a meeting, except as otherwise stipulated in these bylaws. Only items published on the agenda sent to the members in preparation for the meeting may be voted on at that department or general staff meeting. Such approved recommendation(s) will then be forwarded to the MEC for action. Urgent matters requiring departmental or staff discussions may be added to meeting agendas, but must be identified as 'ad hoc' when forwarded to the MEC.

SECTION B.8: CONFLICT RESOLUTION

B.8.1 The chair of the Board or the president of the medical staff may call for a meeting at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

B.8.2 Conflict Resolution between the Board and the MEC

B.8.2.1 Unless otherwise set forth in the Medical Staff Bylaws or Hospital Articles of Incorporation or Bylaws, the Medical Staff, in partnership with the Board of St. Francis Hospital, establishes the following process for addressing conflicting recommendations made by the Board and the Medical Staff

B.8.2.1.1 The Medical Staff, in partnership with the Board will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the hospital, the communities we serve, and the members of the Medical Staff.

B.8.2.1.2 When the Board plans to act or is considering acting in a manner contrary to a recommendation by the MEC, the Medical Staff Officers shall meet with the Board, or a designated committee of the Board and management and seek to resolve the conflict through informal discussions.

B.8.2.1.3 If these informal discussions fail to resolve the conflict, the Medical Staff President or the chairperson of the Board may request initiation of a formal conflict resolution process.

B.8.2.1.4 The formal conflict resolution process will begin with a meeting of the Joint Conference

Committee within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.

B.8.2.1.5 The Joint Conference Committee shall be comprised of MEC representatives and/or designees, Board members and/or designees, and the hospital president or designee.

B.8.2.1.6 If the Joint Conference Committee cannot produce a resolution to the conflict acceptable to the MEC and the Board within thirty (30) days of this initial meeting, the Medical Staff and the Board shall enter into mediation facilitated by an outside party.

B.8.2.1.7 The MEC and Board shall agree upon the selection of the third party mediator.

B.8.2.1.8 The MEC and Board shall make best efforts to collaborate together and with the third party mediator to resolve the conflict. The Board and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approvals of the MEC and the Board which are set forth in the Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital.

B.8.2.1.9 If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

B.8.2.1.10 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed. Actions taken which are not susceptible to change will not be changed.

B.8.2.1.11 In addition to the formal conflict resolution process herein described, the chairperson of the Board or the president of the medical staff may call for a meeting of the Joint Conference Committee at any time and for any reason in order to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to medical staff leaders, the governing board or management.

B.8.2.1.12 It is the duty of all practitioners to disclose potential conflicts of interest to the committee or body at which an issue (that is the reason for the potential conflict of interest) is being discussed. If the conflict of interest is not disclosed by the affected practitioner, any other individual may raise the issue of conflict of interest. The practitioner must recuse themselves from participation in, deliberation on or involvement in the decision-making regarding the conflicted issue. If the practitioner does not recuse himself, they shall be temporarily excused while the committee/body discusses the conflict of interest to determine whether the affected practitioner may participate in, deliberate on, or be involved in the decision-making on that issue. The determination of the committee/body shall be final regarding the conflicted issue.

B.8.3 Conflict Resolution between the MEC and the General Medical Staff

B.8.3.1 Unless otherwise set forth in the Medical Staff Bylaws or Hospital Articles of Incorporation or Bylaws, the MEC, in partnership with the General Medical Staff of St. Francis Hospital, establishes the following process for addressing conflicting recommendations made by the MEC and the General Medical Staff to help ensure consistent recommendations to the Board regarding medical staff issues

B.8.3.1.1 The MEC, in partnership with the General Medical Staff will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the hospital, the communities we serve, and the members of the Medical Staff.

B.8.3.1.2 When the MEC plans to act or is considering acting in a manner contrary to the position of the General Medical Staff, the Medical Staff Officers shall meet with the General Medical Staff or a representative group thereof and seek to resolve the conflict through informal discussions.

B.8.3.1.3 If these informal discussions fail to resolve the conflict, the Medical Staff President shall initiate a formal conflict resolution process.

B.8.3.1.4 The formal conflict resolution process will begin with a “representatives” meeting of an equal number of representatives from the MEC and the General Medical Staff within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.

B.8.3.1.5 If the MEC and General Medical Staff representatives meeting cannot produce a resolution to the conflict acceptable to the MEC and the General Medical Staff within thirty (30) days of this Representatives meeting, the MEC and the General Medical Staff shall enter into mediation facilitated by an outside party.

B.8.3.1.6 The MEC and the General Medical Staff shall agree upon the selection of the third party mediator.

B.8.3.1.7 The MEC and the General Medical Staff shall make best efforts to collaborate together and with the third party mediator to resolve the conflict. The General Medical Staff and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approvals of the MEC and the General Medical Staff.

B.8.3.1.8 If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and the General Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the General Medical Staff shall have the authority to act on the issue that gave rise to the conflict. An affirmative 2/3 majority vote of the active medical staff is required to confirm the position of the General Medical Staff.

B.8.3.1.9 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed.

B.8.3.1.10 In addition to the formal conflict resolution process herein described, the president of the medical staff may call for a meeting of the General Medical Staff at any time and for any reason in order to seek direct input from the General Medical Staff members, clarify any issue, or relay information directly to medical staff members, the Board or management. Active medical staff members may also exercise individual member rights as indicated in Section 2.7 of Part I of these bylaws.

SECTION B.9. REVIEW, REVISION, ADOPTION, AND AMENDMENT

B.9.1 Medical Staff Responsibility

B.9.1.1 The medical staff shall have the responsibility to formulate, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed, which shall be effective when approved by the Board. The medical staff therefore has the responsibility to review

existing bylaws every three years. The MEC must exercise this responsibility through its elected and appointed leaders, and may assign a bylaws review and revision committee.

B.9.2 Methods of Adoption and Amendment to these bylaws

B.9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty percent (20%) of the members of the active category. Each active member of the medical staff will be eligible to vote on the proposed amendment to these bylaws via printed or secure electronic ballot in a manner determined by the MEC. All active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. To be adopted, such changes must receive a 2/3 majority of the votes cast by active members of the medical staff eligible to vote (may not be eligible if conflict of interest). Amendments so adopted shall be effective when approved by the Board.

B.9.2.2 The Board or medical staff shall not have the authority to unilaterally adopt or amend the medical staff bylaws.

B.9.3 Methods of Adoption and Amendment to any medical staff rules, regulations and policies.

B.9.3.1 The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and Policies Manual may be utilized to organize these additional documents.

B.9.3.2 Proposed amendments to the rules, regulations and policy manual may be originated by the MEC.

B.9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, any of these documents may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board.

B.9.3.4 In addition to the process described in 9.3.3 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by ten percent (10%) of the members of the active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

B.9.3.5 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party at least ten (10) days prior to vote and encourages feedback to the originating party.

B.9.3.6 If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the MEC immediately informs the medical staff. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

B.9.3.7 In cases of a documented need for an urgent amendment to policies and procedures necessary for the efficient and effective operations of the organization, the CMO and President of the Medical Staff may together provisionally adopt the urgent amendment prior to going to approval of the full MEC. The adopted urgent amendment to policies and procedures shall then go forward to the MEC at their next meeting for formal approval, and is subject to the MEC's standing authority.

B.9.4 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee’s judgment, technical or legal modifications or clarifications, reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital President.

SECTION B.10: CONFIDENTIALITY, IMMUNITY, AND RELEASES

10.1 Confidentiality of information

To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

10.2 Immunity from liability:

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his duties as an official representative of the hospital or medical staff or for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

10.3 Covered activities:

The confidentiality and immunity provided by these bylaws apply to all information or disclosures performed or made in connection with this or any other healthcare facility’s or organization’s activities concerning, but not limited to:

- x applications for appointment/affiliation, clinical privileges, or specified services;
- x periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- x corrective or disciplinary actions;
- x hearings and appellate reviews;
- x quality assessment and performance improvement/peer review activities;
- x utilization review and improvement activities;
- x claims reviews;

- x risk management and liability prevention activities;
- x other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 Releases:

Each practitioner shall provide all materials, documents, releases and authorizations to access information, and any other relevant materials, as discussed in these bylaws or as requested by the hospital, President of the Medical Staff, or the MEC related to processes in these bylaws. Failure to comply with this subsection shall result in any application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn.

SAINT FRANCIS HOSPITAL & MEDICAL CENTER

PART C: COLLEGIAL RESOLUTION, INVESTIGATIONS, CORRECTIVE ACTION, HEARING AND APPEAL PLAN

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SECTION C1. COLLEGIAL RESOLUTION; INVESTIGATIONS

C.1.1 Collegial Resolution

Ongoing and Focused Professional Practice Evaluations. All ongoing and focused professional practice evaluations shall be conducted in accordance with the medical staff's peer review procedures. Matters that cannot be appropriately resolved through collegial intervention or through the peer review process shall be referred to the MEC.

Collegial, Educational and/or Informal Proceedings: These bylaws encourage the use of progressive steps by medical staff leaders and hospital management, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management are part of the hospital's ongoing and focused performance improvement, and professional and peer review activities.

Collegial intervention efforts involving reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps may include but are not limited to the following:

- (a) educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, on-call obligations, and the timely and adequate completion of medical records;
- (b) following up on any questions or concerns raised about the clinical practice and/or conduct of staff members and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- (c) sharing summary comparative quality, utilization, and other relevant information in order to assist individuals to conform their practices to appropriate norms.

The affected individual shall be provided an opportunity to respond in writing to any written communications, and the response shall be maintained in the individual's file along with the original communication.

Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. Collegial efforts shall be considered to be confidential peer review activities, but shall not in and of themselves give rise to any hearing rights.

When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. This includes circumstances where information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be:

- a. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
- b. Unethical;
- c. Contrary to the medical staff bylaws, associated manuals, rules and regulations, or medical staff or hospital code of conduct or policies;
- d. Below applicable professional standards of behavior or clinical management.

C.1.2 Investigations

Following efforts at collegial intervention, if it appears that the practitioner's performance places patients

in danger or the quality of care is compromised, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether a recommendation to restrict or revoke membership and/or privileges should be made to the Board. Before issuing such a recommendation the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

C.1.2.1 Initiation

A request for an investigation must be submitted by a **medical staff officer, committee chair, department chair, clinical service chief, Hospital President, CMO or hospital board chair** to the MEC and supported by reference to the specific activities or conduct of concern. If the MEC initiates the request, it shall make an appropriate record of its reasons.

C.1.2.2 Investigation

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff.

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant necessary and such use is approved by the MEC and the hospital President. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The practitioner of concern shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. This meeting (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws, nor shall the procedural rules with respect to hearings or appeals apply. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. The person being investigated may consult privately with his own counsel or consultants, on his own time, at his own cost, and will be responsible for complying with all confidentiality laws with respect to such consultations. Despite the status of any investigation, at all times the MEC 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.

C.1.2.2.1 An external peer review consultant should be considered when:

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

C.1.2.2.2 In the event the Board believes that an investigation is necessary, it may direct the MEC to proceed with an investigation.

C.1.2.3 MEC Action

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

- a. Determining no corrective action is taken, and the conclusion of the report of the investigation will be included in the member's file;
- b. Issuing letters of the report of findings and corrective action, although nothing herein shall be deemed to preclude appropriate committee/department chairs or section/service chiefs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;
- c. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
- d. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;
- e. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- f. Recommending suspension, revocation, or probation of medical staff membership;
- g. Taking other actions deemed appropriate under the circumstances.

C.1.2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, that recommendation shall be transmitted in writing to the Board. The MEC will comply with all state and federal reporting requirements. The recommendation of the MEC shall become final unless the member requests a hearing, in which case the final decision shall be determined as set forth in the Hearing and Appeal Plan.

SECTION C2. CORRECTIVE ACTION

C.2.1 Automatic relinquishment/Voluntary resignation

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

C.2.1.1 Licensure

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

b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective upon review and concurrence of the MEC.

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

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

C.2.1.2 Controlled substances

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

b. **Probation:** Whenever a practitioner's DEA certificate or Connecticut Controlled Substance Registration is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

C.2.1.3 Medical record completion requirements: A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

C.2.1.4 Professional liability insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the

medical staff office immediately of any change in professional liability insurance carrier or coverage.

C.2.1.5 Medical Staff dues/special assessments: Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

C.2.1.6 Felony conviction: A practitioner who has been convicted of, or pled "guilty" or "no contest" or its equivalent to a felony related to the provision of healthcare such as controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence or abuse (sexual, child, elder or domestic) or an activity involving a charge of moral turpitude (wrongful or depraved conduct) in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary. When charges are filed against a practitioner, the MEC will review the circumstances to determine if immediate suspension is warranted.

C.2.1.7 Failure to satisfy the special appearance requirement: A practitioner who fails without good cause to appear at a meeting where his special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored upon compliance with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

C.2.1.8 Failure to participate in an evaluation: A practitioner who fails to participate in an evaluation of his qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored upon compliance with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

C.2.1.9 Failure to become board certified as defined in Sections D.2.2.5 – D2.2.8 of Part D of these bylaws Credentialing Procedures

C.2.1.10 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release and/or provide documents when requested by the president of the medical staff or designee in order to evaluate the competency and credentialing/privileging qualifications of the practitioner to assure patient safety shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

C.2.1.11 MEC Deliberation: As soon as practicable after action is taken or warranted as described in Sections 2.1.1 through Section 2.1.10, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure set forth in the Section 1.3 above.

C.2.2 Precautionary Restriction of Privileges or Suspension

C.2.2.1 Criteria for Initiation: Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders and/or the hospital President determines that there is a need to carefully consider any event,

concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution, or to impair the reputation of the medical staff or hospital, then any two of the following, hospital President or designee, president of the medical staff or designee, or the MEC, may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A revocation, suspension, restriction of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

Such precautionary suspension or restriction of privileges shall be deemed an interim precautionary step in the professional review activity related to any ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

Unless otherwise stated, such precautionary restriction of privileges or suspension shall become effective immediately upon imposition and the person or body responsible for initiation shall promptly give written notice to the practitioner, the MEC, the hospital President, and the Board. The restriction of privileges or suspension may be limited to 30 days duration and shall remain in effect for the period stated or, if none, unless and until lifted or modified by the Board.

Unless otherwise indicated by the terms of the precautionary restriction of privileges or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the president of the medical staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

C.2.2.2 MEC action: Within a reasonable time period, not to exceed fourteen (14) days after such precautionary restriction or suspension has been imposed, the MEC shall review and consider the action and make a recommendation to the Board as to whether the restriction of privileges or suspension should be lifted or modified. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may make a recommendation to the Board to modify, continue, or terminate the precautionary restriction of privileges or suspension, but in any event it shall furnish the practitioner with notice of its decision.

After considering the matters resulting in the precautionary suspension or restriction of privileges and the individual's response, if any, the MEC shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation.

There is no right to a hearing based on the imposition or continuation of a precautionary restriction of privileges or suspension.

C.2.3 Disciplinary time out

The MEC may, with approval of the Hospital President, institute one or more disciplinary time outs for a practitioner for a period not to exceed fourteen (14) consecutive calendar days. During a disciplinary time out the practitioner may not exercise any clinical privileges except in an emergency situation or to address an imminent delivery. A disciplinary time out may be instituted only if all of the following circumstances are true:

- a. When the action that has given rise to the suspension relates to one of the following policies of the medical staff: completion of medical records, practitioner behavior (or disruptive practitioner policy) or requirements for on-call coverage;

b. When the action(s) have been reviewed by the MEC and only when the MEC has determined that one or more of the above policies have been violated;

c. When the practitioner has received at least two written warnings within the last twelve (12) months regarding the conduct in question. Such warnings must state the conduct or behavior that is questioned and specify or refer to the applicable policy, and state the consequence of repeat violation of the policy;

d. When the affected practitioner has been offered an opportunity to meet with the MEC prior to the imposition of the disciplinary time out. Failure on the part of the practitioner to accept the MEC offer of a meeting will constitute a violation of the medical staff bylaws regarding special meetings and will not prevent the MEC from issuing the disciplinary time out.

In the event of a disciplinary time out, the practitioner's patients shall be promptly assigned to another medical staff member by the president of the medical staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. The president of the medical staff or designee will determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the disciplinary time out.

SECTION C3. INITIATION AND NOTICE OF HEARING

C.3.1 Initiation of Hearing

Any practitioner eligible for medical staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

a. Denial of medical staff appointment or reappointment;

b. Revocation of medical staff appointment;

c. Denial or restriction of requested clinical privileges;

d. Involuntary reduction or revocation of clinical privileges of greater than fourteen (14) days;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed;

f. Suspension of staff appointment or clinical privileges for greater than fourteen (14) days, but only if such suspension is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

C.3.2 Hearings will not be triggered by the following actions:

1. Issuance of a letter of guidance, warning, or reprimand.

2. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on

privileges.

3. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege.
4. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee.
5. Requirement to appear for a special meeting under the provisions of these bylaws.
6. Automatic relinquishment or voluntary resignation of appointment or privileges.
7. Imposition of a precautionary suspension or disciplinary time out.
8. Denial of a request for leave of absence, or for an extension of a leave.
9. Determination that an application is incomplete or untimely.
10. Determination that an application will not be processed due to misstatement or omission.
11. Decision not to expedite an application.
12. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct.
13. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.
14. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement.
15. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted or if exhaustion of due process rights is pending.
16. Termination of any contract with or employment by hospital.
17. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation.
18. Any recommendation voluntarily accepted by the member.
19. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period.
20. Change in assigned staff category.
21. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request.
22. Removal or limitations of on-call obligations.
23. Any requirement to complete an educational assessment.
24. Retrospective chart review.

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

26. Grant of conditional appointment or appointment for a limited duration.

27. Appointment or reappointment for duration of less than 24 months.

C.3.3 Notice of Recommendation

When a recommendation is made, which, according to these bylaws, entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days after receipt of the recommendation by the HOSPITAL PRESIDENT) be given written notice by the HOSPITAL PRESIDENT delivered either in person or by certified mail, return receipt requested. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation.
- c. Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank;
- d. A copy of Section 5.5 of Part II of these bylaws outlining procedural rights with regard to the hearing.

C.3.4 Request for Hearing

Such individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the HOSPITAL PRESIDENT. In the event the affected individual does not request a hearing within the time and in the manner required by these bylaws, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made, and such recommended action shall thereupon become effective immediately upon final Board action.

C.3.5 Notice of Hearing and Statement of Reasons

The hospital President shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Board), at the hearing;
- c. The names of the hearing panel members and presiding officer or hearing officer, if known;
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and the individual's counsel have sufficient time to study this additional information and rebut it.
- e. The hearing shall begin as soon as practicable, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

C.3.6 Witness List

At least fifteen (15) calendar days before the hearing, the individual requesting the hearing shall provide to the presiding officer a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf. The list of witnesses who will testify in support of the recommendation of the MEC or the Board will include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

C4. HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER

C.4.1 Hearing Panel:

- a. When a hearing is requested, the hospital president, acting for the Board and after considering the recommendations of the president of the medical staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a hearing panel that shall be composed of not fewer than three individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the hearing panel chair or the presiding officer.
- c. The hospital president or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the hospital president, who shall determine whether a replacement panel member should be identified. While the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the hospital president.

C.4.2 Hearing panel chairperson or presiding officer

C.4.2.1 In lieu of a hearing panel chair, the hospital president, acting for the Board and after considering the recommendations of the president of the medical staff (or those of the chair of the Quality and Medical Affairs Committee of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in the fair hearing process. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

C.4.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the hospital president to serve as the presiding officer and shall be entitled to one vote.

C.4.2.3 The presiding officer (or hearing panel chair) shall do the following:

- a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;
- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel;
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

C.4.3 Hearing Officer

- a. As an alternative to the hearing panel described in Section 4.1 of this manual, the HOSPITAL PRESIDENT, acting for the Board and after considering the recommendations of the president of the medical staff (or those of the chair of the Quality and Medical Affairs Committee of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.
- b. The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

SECTION C5. PRE-HEARING AND HEARING PROCEDURE

C.5.1 Provision of Relevant Information

C.5.1.1 There is no right to formal “discovery” in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discovery and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and assure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the practitioner’s expense;
- b. Reports of experts relied upon by the MEC or the Board;
- c. Copies of redacted relevant committee minutes;

- d. Copies of any other documents relied upon by the MEC or the 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 shall be excluded.

Materials containing protected health information shall be provided to the individual's counsel and experts only if such counsel and experts shall have executed a business associate agreement or other appropriate documentation to ensure the privacy of such information.

C.5.1.2 Prior to the hearing, on dates set by the presiding officer, hearing panel chair or hearing officer, or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing in advance of the hearing. The presiding officer, hearing panel chair or hearing officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

C.5.1.3 Prior to the hearing, on dates set by the presiding officer, hearing panel chair or hearing officer, the individual requesting the hearing shall, upon specific request, provide the MEC (or the Board) copies of any expert reports or other documents upon which the individual will rely at the hearing.

C.5.1.4 Unless the parties agree otherwise, there shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his counsel.

C.5.2 Pre-Hearing Conference

The presiding officer, hearing panel chair or hearing officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer, hearing panel chair or hearing officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination.

C.5.3 Failure to Appear

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

C.5.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The presiding officer, hearing panel chair or hearing officer may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Connecticut.

C.5.5 Rights of Both Sides

C.5.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

- a. To call and examine witnesses to the extent available;
- b. To introduce exhibits;
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may call, examine, cross-examine witnesses and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
- e. To submit a written statement at the close of the hearing.

C.5.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.

C.5.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

C.5.6 Admissibility of Evidence

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

C.5.7 Burden of Proof

It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital code of conduct and policies.

C.5.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed, following the close of the hearing.

C.5.9 Official Notice

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

C.5.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer, hearing panel chair or hearing officer, or the hospital president on a showing of good cause.

C.5.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the president of the medical staff or hospital president.

C.5.12 Order of Presentation

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

C.5.13 Basis of Recommendation

If the hearing officer or hearing panel finds that the action of the MEC (or Board) is reasonable, and supported and sustained by the evidence, the panel or officer shall recommend in favor of the MEC (or Board) action.

C.5.14 Adjournment and Conclusion

The presiding officer, hearing panel chair or hearing officer may adjourn the hearing and reconvene the same as s/he deems to be appropriate. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

C.5.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after the close of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, based on a majority opinion, signed by the officer or hearing officer, which shall contain a concise statement of the reasons for the recommendation.

C.5.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the hospital President who shall forward it, along with all supporting documentation, to the Board for further action as appropriate. The hospital President shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

SECTION 6. APPEAL TO THE HOSPITAL BOARD

C.6.1 Time for Appeal

Within ten (10) calendar days after notice of the hearing panel's recommendation, the practitioner subject to the hearing, the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the hospital President or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days as provided herein, the parties shall be deemed to have accepted the recommendations.

C.6.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or
- b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or
- c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record in accordance with the burden of proof set forth in sect. 5.7.

C.6.3 Time, Place and Notice

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

C.6.4 Nature of Appellate Review

- a. The chair of the Quality and Medical Affairs Committee of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.
- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.
- d. The Board may affirm, modify or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

C.6.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receipt of the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the credentials committee and MEC, in person or by certified mail, return receipt requested.

C.6.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke,

suspend, restrict or terminate the medical staff appointment and/or clinical privileges of a current member, that individual may not apply within five (5) years for medical staff appointment or for those clinical privileges at this hospital unless the Board decides otherwise.

C.6.7 Fair hearing and appeal for those with privileges without medical staff membership and who are not physicians or dentists

Psychologists and APPs are not entitled to the hearing and appeals procedures set forth in the medical staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his exercise of clinical privileges, the practitioner and his supervising physician shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The practitioner and the supervising physician must request such a meeting in writing to the hospital President within 10 working days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the medical staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board. The practitioner and the supervising physician may request an appeal in writing to the hospital President within 10 days of receipt of the findings of the review body. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within 10 days of the final decision of the Board.

PART D: SAINT FRANCIS HOSPITAL & MEDICAL CENTER

CREDENTIALING PROCEDURES

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SECTION D1. MEDICAL STAFF CREDENTIALS COMMITTEE

(overseen by chair of credentials committee)

D.1.1 Composition

Membership of the medical staff credentials committee shall consist of at least five (5) members of the active medical staff who are experienced leaders. The president of the medical staff, with input from the department chairs, clinical service chiefs and with the confirmation of the MEC, will appoint the chair and other members. The chair must have served on the credentials committee for at least one year prior to being appointed as chair. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms not to exceed a total of twelve (12) years. Any member, including the chair, may be relieved of his committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite ex officio members as required.

D.1.2 Meetings

The medical staff credentials committee shall meet at least six (6) times per year and more frequently as required or on the request of the credentials chair.

D.1.3 Responsibilities

D.1.3.1. To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category;

D.1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;

D.1.3.3 To recommend eligibility criteria for the granting of medical staff membership and privileges;

D.1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

D.1.3.5 To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders;

D.1.3.6 To perform such other functions as requested by the MEC.

D.1.4 Confidentiality

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

D.1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff officers and the CMO or designee may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the hospital President or designee.

D.1.4.2 Individual practitioners may review their credentials file under the following circumstances: Upon request which is authorized by the credentials chair, department chair, clinical service chief or the CMO. Review of such files will be conducted in the presence of the medical staff service professional,

medical staff officer, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only correspondence from the practitioner or sent to the practitioner may be copied. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

SECTION D2. QUALIFICATIONS FOR MEMBERSHIP AND PRIVILEGES

D.2.1 No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

D.2.2 The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges:

D.2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, or applicable recognized course of training in a clinical profession eligible to hold privileges;

D.2.2.2 Have a current unrestricted state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Connecticut;

D.2.2.3 Have a record that is free from current Medicare/Medicaid exclusions and not be on the OIG List of Excluded Individuals/Entities;

D.2.2.4 A new applicant must have a record that is free of felony convictions related to the provision of healthcare such as controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, or abuse (sexual, child, elder or domestic) within the last three (3) years, or any occurrences that would raise questions of undesirable conduct which could injure the reputation of the medical staff or hospital. After initial appointment, Section 2.1.6 of Part II of these bylaws applies to members with felony convictions.

D.2.2.5 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within (5) five years of completing formal training or as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association;

D.2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

D.2.2.7 Oral maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

D.2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board qualified to begin practice, or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Medicine. Further qualifications for practice in the hospital will be in accordance with Connecticut Statute first, then hospital policy, and subsequently dictated by the Podiatry Section

leadership.

D.2.2.9 A new applicant must possess a current, valid, unrestricted drug enforcement administration (DEA) number and state of Connecticut controlled substance registration number. After initial appointment, Section 2.1.2 of Part II of these bylaws applies to members whose right to prescribe medications has been suspended, revoked, or limited.

D.2.2.10 Have appropriate written and verbal communication skills;

D.2.2.11 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

- a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities;
- b. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.

The following qualifications must also be met by all applicants requesting clinical privileges:

D.2.2.12 Demonstrate his background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

D.2.2.13 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his responsibilities of medical staff membership and the specific privileges requested by and granted to the applicant;

D.2.2.14 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

D.2.2.15 Demonstrate recent clinical performance within the last twenty four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

D.2.2.16 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan;

D.2.2.17 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

D.2.3 Exceptions:

D.2.3.1 All practitioners who are current medical staff members and/or hold privileges as of **12-31-08** and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

D.2.3.2 Only the Board may create additional exceptions to the above Section 2.2 after consultation with the MEC.

SECTION 3. INITIAL APPOINTMENT PROCEDURE

D.3.1 Completion of Application

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

A completed application includes, at a minimum:

- a. a completed, signed, dated application form
- b. a completed privilege delineation form if requesting privileges
- c. copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency
- d. all applicable fees
- e. a current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card
- f. receipt of all references; References shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested.
- g. relevant practitioner-specific data as compared to aggregate data, when available
- h. morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

D.3.1.2 The burden is on the applicant to provide all required information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

D.3.1.3 It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a written communication requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request, the application will be deemed to have been voluntarily withdrawn.

D.3.1.4 Upon receipt of a completed application the **medical staff office professional and the credentials chair in consultation with the department chair or the appropriate clinical service chief**, will determine if the requirements of Part III, Section 2.2 are met. In the event the requirements of Part III, Section 2.2 are not met, the potential applicant will be notified that s/he is ineligible to apply for

membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of section 2.2 are met, the application will be accepted for further processing.

D.3.1.5 Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:

- a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past ten (10) years;
- b. Documentation of the applicant's past clinical work experience;
- c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration.
- d. Information from the OIG list of Excluded Individuals/Entities, and FACIS (Fraud and Abuse Control Information System),
- e. Information from professional training programs including residency and fellowship programs;
- f. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested.
- g. Other information about adverse credentialing and privileging decisions;
- h. Two or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism and physical, mental and emotional ability to perform requested privileges.
- i. Information from a criminal background check will be done on all initial applicants for membership and/or privileges;
- j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;
- k. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application.

D.3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

D.3.2 Applicant's Attestation, Authorization and Acknowledgement

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

D.3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

D.3.2.2 Consents to appear for any requested interviews in regard to his application.

D.3.2.3 Authorizes the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on his professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

D.3.2.4 Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:

- a. professional qualifications and competence to carry out the clinical privileges requested;
- b. physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
- c. professional and ethical qualifications;
- d. professional liability actions including currently pending claims involving the applicant;
- e. any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

D.3.2.5 Releases from liability, promises not to sue and grants immunity to the hospital, its medical staff, and its representatives for acts performed and statements made in connection with evaluation of the application and his credentials and qualifications to the fullest extent permitted by the law.

D.3.2.6 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning his background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

D.3.2.7 Authorizes the hospital medical staff and administrative representatives to release credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities concerned with this provider's performance and releases representatives of the hospital from liability for so doing.

D.3.2.8 Acknowledges that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff and agrees to abide by their provisions.

a. Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

D.3.2.9 Agrees to provide accurate answers to the following questions, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during the period of the applicant's medical staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

b. Has your license to practice or registration in any state ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?

c. Have you ever been asked to surrender your professional license?

d. Have you ever been suspended, sanctioned, excluded or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?

e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

f. Has your DEA certificate ever been relinquished, limited, denied, suspended, or revoked?

g. Is your DEA certificate currently being challenged?

h. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?

i. Has your employment, medical staff membership, or clinical privileges ever been reduced, suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily?

j. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's Board made a decision?

k. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

l. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?

m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?

If you are not currently board certified please answer n. through q. below (if board certified skip to r below):

n. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

o. If not certified, have you applied for the certification exam?

- p. Have you ever been accepted to take the certification exam?
- q. If yes, what dates are you scheduled to take the certification exam?
- r. Have any professional liability claims or suits ever been filed against you or are any presently pending?
- s. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).
- t. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?
- u. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?
- v. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?
- w. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?

D.3.3 Application Evaluation

D.3.3.1 Expedited Credentialing: An expedited review and approval process may be used for initial appointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. The department chair or the appropriate clinical service chief will make an initial determination of whether the applicant is a category 1 or a category 2. Applicants in Category 1 will be granted medical staff membership and/or privileges after review and action by the following: department chair, clinical service chief, CMO, credentials chair acting on behalf of the credentials committee, the MEC (quorum is defined as 3 voting members) and a Board committee consisting of at least two individuals.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. The department chair, clinical service chief (who may seek input from the appropriate department or clinical service), credentials committee, MEC, and the Board, review and act on applications in Category 2. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

- a. The application is deemed to be incomplete;
- b. The final recommendation of the MEC is adverse or with limitation;
- c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary

actions or legal sanctions;

- e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years **or** one final adverse judgment in a professional liability action in excess of \$1,000,000;
- f. Applicant changed medical schools or residency programs or has gaps in training or practice;
- g. Applicant has changed practice locations more than three times in the past ten (10) years;
- h. Applicant has practiced or been licensed in three (3) or more states;
- i. Applicant has one or more reference responses that raise concerns or questions;
- j. Discrepancy is found between information received from the applicant and references or verified information;
- k. Applicant has an adverse National Practitioner Data Bank report except as noted in (e) above;
- l. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- m. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- n. Applicant has potentially relevant physical, mental and/or emotional health problems;
- o. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

D.3.3.2 Applicant Interview

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

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

D.3.3.3 Department Chair / Clinical Service Chief Action

3.3.3.1 All completed applications are presented to the appropriate department chair or clinical service chief for review and recommendation or report. The department chair or clinical service chief reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The department chair or the clinical service chief, in consultation with the medical staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The department chair or clinical service chief may obtain input if necessary from an appropriate subject matter expert or from members of

the department or clinical service. If a department chair or clinical service chief believes a conflict of interest exists that might preclude his ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

3.3.3.2 The department chair forwards to the medical staff credentials committee the following:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges;
- d. Comments supporting the recommendations in 3.3.3.2 a, b and c above.

D.3.3.3.3 The clinical service chief forwards a report to the credentials committee indicating Category 1 or 2 status, information on whether to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges and any circumstances requiring monitoring and evaluation of clinical performance after initial grant of clinical privileges consistent with the focused professional practice evaluation policy.

D.3.3.4 Medical Staff Credentials Committee Action

D.3.3.4.1 If the application is designated Category 1, it is presented to the credentials chair or designee for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the medical staff credentials committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the medical staff credentials committee reviews the application and forwards the following to the MEC:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges;
- d. Comments supporting the recommendations in 3.3.4.1 a, b and c above.

D.3.3.5 MEC Action

3.3.5.1 If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements (3 voting members of the MEC) established for expedited credentialing. The president of the medical staff has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges;
- d. Comments supporting the recommendations in 3.3.5.1 a, b and c above.

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

D.3.3.6 Board Action:

D.3.3.6.1 If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

D.3.3.6.2 If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:

- a. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months.
- b. If the board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).
- c. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

D.3.3.7 Notice of final decision: Notice of the Board's final decision shall be given, through the hospital president to the MEC and to the chair of each department or clinical service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment and any special conditions attached to the appointment.

D.3.3.8 Time periods for processing: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

D.3.3.8.1 These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided

therein govern the continued processing of the application.

SECTION D4. PROFESSIONAL PRACTICE EVALUATION

All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The credentials committee, after receiving a recommendation from the department chair or the appropriate clinical service chief and with the approval of the MEC will define circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

The medical staff will also engage in ongoing professional practice evaluation (OPPE) in order to identify professional practice trends that impact on quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. The OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to a FPPE when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

SECTION D5. REAPPOINTMENT

D.5.1 Criteria for reappointment

It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The practitioner must also be determined by the MEC to be a provider of effective care that is consistent with the hospital standards of ongoing quality and the hospital performance improvement program and provide the information enumerated in Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the department chair or clinical service chief in the evaluation of current competency of the department chair or clinical service chief, and recommend appropriate action to the credentials committee.

In the event a practitioner finds no need to utilize the facilities or resources of the institution for purposes of patient care through either admission, performance of a procedure, consultation, or referral, during a two year period s/he may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of current appointment or privileges. This provision applies to individuals who have been granted a leave of absence, moved their practice location, established a relationship with another institution or otherwise find no need to utilize the clinical resources of the institution. Exceptions to this provision may be made by the Board upon recommendation of the MEC.

D.5.2 Information collection and verification

D.5.2.1 From appointee: Approximately six (6) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office notifies the

practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the medical staff office:

- a. A completed reapplication form, which includes complete information to update his file on items listed in his original application, any required new, additional, or clarifying information, and any required fees or dues;
- b. Information concerning continuing training and education internal and external to the hospital during the preceding period;
- c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

D.5.2.2 From internal and/or external sources: The medical staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in Sections 3.1.5 and 3.2.9, items a.-w.

D.5.2.3 The following information is also collected and verified:

- a. A summary of clinical activity at this hospital for each appointee due for reappointment;
- b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided any clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
- c. Documentation of any required hours and appropriateness of continuing medical education activity commensurate with the privileges being requested
- d. Service on medical staff, department, clinical service and hospital committees;
- e. timely and accurate completion of medical records;
- f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff.
- g. Any significant gaps in employment or practice since the previous appointment or reappointment
- h. Verification of current licensure;
- i. National Practitioner Data Bank query;
- j. when sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental and emotional ability to perform requested privileges will be requested;

D.5.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application, unless a two hundred and fifty (\$250.00) dollar late fee is paid at the time of the late reapplication submission. Upon payment the medical staff office will endeavor to process the reapplication prior to expiration. In any case the appointment will automatically expire when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

D.5.3 Evaluation of Application for Reappointment of Membership and/or Privileges

D.5.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1

above.

D.5.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an “adverse recommendation” by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms “applicant” and “appointment” as used in these sections shall be read respectively, as “staff appointee” and “reappointment”.

SECTION D6. CLINICAL PRIVILEGES

D.6.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency and disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), physicians serving short locum tenens positions, telemedicine physicians, Ph.D. or Psy.D. psychologists, L.Ac Licensed Acupuncturists, or others deemed appropriate by the MEC and Board.

D.6.2 Requests

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

D.6.3 Basis for privileges determination

D.6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

D.6.3.2 Privileges for which no criteria have been established:

- a. In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:
 1. Review the community, patient and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
 2. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
 3. Meet with management to ensure that the new privilege is consistent with the hospital’s mission, values, strategic, operating, capital, information and staffing plans;
 4. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee and appropriate clinical service/specialty or subject matter experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein.

B. For the development of criteria, the medical staff service professional (with a designated member of the Medical Staff who is a subject matter expert) will compile information relevant to the privileges requested which may include (but need not be limited to) product information, utilization guidelines, published peer-reviewed articles or position papers from specialty providers or organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate; existing documented procedural success in reasonably high-fidelity research or outside clinical implementation of standard protocols may also serve as foundational material for the new privilege.

b. Criteria to be established for the privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Precepting or proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the VPMA, under the direction (as required) by the service line leadership; See 6.9.1 and Section 7.

c. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the credentials committee who has no vested interest in the issue.

D.6.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the staff's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

D.6.3.4 The procedure to be used in determining if a procedure, modality of care or treatment requires different competency criteria to be developed by the MEC prior to being eligible to request and be granted the privilege by the Board is as follows:

6.3.4.1 When the department chair or the clinical service chief, or two (2) or more members of the credentials committee determine that two (2) or more of the following criteria are significantly different than the current privilege; new/additional competency criteria will be developed by the credentials committee: skill, knowledge, technique, equipment, risk, judgment or ability to manage complications the procedure, modality of care or treatment.

D.6.3.5 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

D.6.4 Special conditions for dental privileges

Requests for clinical privileges for dentists and oral and maxillofacial surgeons are processed in the same manner as all other privilege requests. Dentists and oral and maxillofacial surgeons may be granted the privilege of performing a history and physical examination (H&P) on their own patients upon submission of documentation of appropriate training on H & Ps during their residency program. It is anticipated that most H & Ps for dental and oral and maxillofacial surgery patients will be performed by patient's primary care practitioner.

D.6.5 Special conditions for licensed independent practitioners not qualified for medical staff appointment but practicing pursuant to clinical privileges per hospital policy

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Advanced practice professionals in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care.

D.6.6 Special conditions for podiatric privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. Podiatrists may be granted the privilege of performing a history and physical examination (H & P) on their own patients upon submission of documentation of appropriate training on H & Ps during their residency program. It is anticipated that most H & Ps for podiatry patients will be performed by the patient's primary care practitioner.

D.6.7 Special conditions for residents or fellows in training

Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the CMO, DIO, and Designated Site Directors, the graduate medical education committee, or program director in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The post-graduate education program director or committee must communicate annually with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

D.6.8 Telemedicine Privileges

Practitioners providing only telemedicine services will not be appointed as a member to the medical staff but must be granted privileges at this hospital and must meet the same qualifications and must be processed in the same manner as any other applicant or medical staff appointee. This hospital may use credentialing information from the telemedicine entity/organization if they are a Joint Commission-accredited organization. This information will then be updated with current verifications and then processed in the usual manner.

D.6.9 Temporary Privileges

Temporary privileges may be granted by the hospital President, or designee, acting on behalf of the Board and based on the recommendation of the president of the medical staff or designee, provided there is verification of current licensure and current competence. Temporary privileges may be granted only in two

(2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

D.6.9.1 Important Patient Care, Treatment or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days, while the full credentials information is verified and approved. For the purposes of granting temporary privileges, an important patient care, treatment or service need is defined as including the following:

- a. A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted, (i.e., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner);
- b. A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care, treatment or service from the institution if the temporary privileges under consideration are not granted (i.e., the institution will not be able to provide adequate emergency room coverage in the providers specialty, or the Board has granted privileges involving new technology to a physician on your staff provided the physician is precepted or proctored for a specific number of initial cases and the precepting or proctoring physician, who is not seeking medical staff membership, requires temporary privileges to serve as a preceptor);
- c. A circumstance in which a group of patients in the community will be placed at risk of not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted, (i.e., a physician who has a large practice in the community for which adequate coverage of hospital care for those patients cannot be arranged).

D.6.9.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital: current licensure; education training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in section 3 of this manual.

D.6.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

D.6.9.4 Termination of temporary privileges: The hospital President, acting on behalf of the Board and after consultation with the president of the medical staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the hospital President or his designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

D.6.9.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated or suspended unless based on a determination of clinical incompetence or unprofessional conduct.

D.6.9.6 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of department/clinical service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

D.6.9.7 Disaster Privileges:

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the Hospital President and such other individuals as identified in the institution's Disaster Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected LIP's who must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

1. A current picture hospital ID card that clearly identifies professional designation;
2. A current license to practice;
3. Primary source verification of the license;
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR- VHP), the State of Connecticut Emergency Credentialing Program (ECP), or other recognized state or federal organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
6. Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

Debriefing of emergency/disaster credentialed providers will occur within 72 hours to discuss performance, management of time, and review by assigned, existing clinical leader in their assigned geographic or serviced-based area.

c. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. .

d. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

e. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

SECTION D7. PRECEPTORSHIP & PROCTORSHIP

D.7.1 A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship either with a current member in good standing of the medical staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of sections 7.1 and 7.2.

D.7.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the department chair, clinical service chief and/or credentials committee and MEC. At a minimum, the preceptorship program description must include the following:

D.7.2.1 The scope and intensity of required preceptorship activities;

D.7.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

D.7.2.3 Privileges for new procedures, or privileges *reestablished* after an absence of more than six months must include proctoring as appropriate, determined by the specialty subject matter experts, service line chief or chair, and appropriately privileged provider already performing that procedure, should they already exist. Proctoring shall occur within a duration determined by the subject matter experts to properly employ the FPPE process, per the FPPE policy.

SECTION D8. REAPPLICATION AFTER MODIFICATIONS OF MEMBERSHIP STATUS OR PRIVILEGES AND EXHAUSTION OF REMEDIES

D.8.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstration that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

D.8.2 Request for modification of appointment status or privileges

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

D.8.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his staff appointment and/or clinical privileges must provide written notice to the appropriate department chair, clinical service chief or president of the medical staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

D.8.4 Exhaustion of administrative remedies

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

D.8.5 Reporting requirements

The hospital President or his designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of [appointment] and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

SECTION D9. LEAVES OF ABSENCE

Leaves of absence are to be addressed in the hospital medical staff leave of absence policy.

SECTION D10. PRACTITIONERS PROVIDING CONTRACTED SERVICES

D.10.1 When the hospital contracts for patient care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a Joint Commission accredited organization, the hospital will:

- a. Specify in a contract that the entity providing these services by contract (the contracting entity) will ensure that all services provided under this contract by individuals who are LIPs will be within the scope of those individual's privileges at the contracting entity; or
- b. Verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

D.10.2 When the hospital contracts for care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a Joint Commission accredited organization, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

D.10.3 Exclusivity policy

The MEC will advise and give input to the administration and to the Board regarding the need for and medical staff preference to providing a clinical service or program through an exclusive contract. The MEC

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

D.10.4 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his appointment category as any other applicant or staff appointee.

D.10.5 The terms of the medical staff bylaws will govern disciplinary action taken by or recommended by the MEC.

D.10.6 Effect of contract or employment expiration or termination

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

SECTION D11. MEDICAL ADMINISTRATIVE OFFICERS

D.11.1 A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

D.11.2 Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his clinical responsibilities and discharge staff obligations appropriate to his staff category in the same manner applicable to all other staff members.

D.11.3 Effect of removal from office or adverse change in appointment status or clinical privileges

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

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

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

D.11.4 Gender and Terminology

The use of any particular gender pronoun or reference herein is solely for ease of expression and each

gender identified shall be deemed to include, where applicable, all others.

**MEDICAL STAFF BYLAWS
PART E: ORGANIZATION AND FUNCTIONS MANUAL**

MEDICAL STAFF BYLAWS PART E: ORGANIZATION AND FUNCTIONS MANUAL

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E.1.0 ORGANIZATION AND FUNCTIONS OF THE STAFF

E.1.1 Organization of the Medical Staff

E.1.2 The medical staff shall be organized as a departmentalized **medical** staff including the following departments and sections:

Anesthesiology

Dentistry

- Oral and Maxillofacial Surgery*
- General Dentistry*

Emergency Medicine

- Medical Toxicology

Family Medicine

- Sports Medicine

Medicine

- Allergy and Immunology
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Geriatric Medicine
- Hematology and Oncology
- Hospitalist Medicine
- Infectious Disease
- Internal Medicine
- Nephrology
- Occupational Medicine
- Pulmonary and Critical Care Medicine
- Rheumatology

Obstetrics and Gynecology

- Gynecological Oncology
- Maternal Fetal Medicine
- Urogynecology

Orthopedics

Pathology and Laboratory Medicine

Psychiatry

Radiology

- Interventional radiology
- Diagnostic radiology
- Neuroradiology

Surgery

- Acute Care Surgery
- Bariatric Surgery

- Cardiothoracic Surgery*
- Colon and Rectal Surgery
- General Surgery
- Minimally Invasive Surgery
- Neurosurgery
- Otolaryngology
- Plastic and Reconstructive Surgery
- Podiatric Surgery
- Surgical Critical Care
- Surgical Oncology
- Trauma Surgery
- Urology
- Vascular Surgery*

*Surgical specialties, while remaining in their own divisions of the medical staff, report through the department of surgery & surgery service line, and to the surgery service line chairman unless otherwise indicated. Cardiovascular surgery and vascular surgery otherwise report through the Cardiovascular Service Line.

E.1.3 A permanent or voluntary department chair shall head each department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC. Permanent department chairs are responsible for fulfilling the duties and responsibilities contained in their position description and employment contract. Voluntary department chairs shall carry out the responsibilities assigned in Part IV, Section 1.24 of these bylaws the Organization and Functions.

E.1.4 A permanent or voluntary clinical section chief shall head each clinical section with responsibility for the supervision and satisfactory discharge of assigned duties under the direction of the department chair.

E.1.5 The MEC has also authorized the following of clinical services that may perform duties as specified in Part I, Section 5.1 of these bylaws:

- Neurology
- Ophthalmology
- Radiation Therapy
- Rehabilitation Medicine
- **Pediatrics** (Adolescent Medicine, Developmental and Behavioral Pediatrics, and Neonatology)

E.1.6 A permanent or voluntary clinical service chief shall head each clinical service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

E.1.7 Responsibilities for Medical Staff Functions

E.1.7.1 The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Organization and Function Section 1.8 with the ultimate responsibility lying with the MEC. The medical staff officers, department chairs, section chiefs, clinical service chiefs, hospital and medical staff committee chairs, are responsible for working collaboratively to develop a process for communication of medical staff function activities by providing periodic reports as appropriate to the department /section/service/committee and to elevate issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

E.1.7.2 Additionally, the president of the medical staff shall appoint, in collaboration with the CEO, designated physicians to serve on hospital committees to help fulfill medical staff functions.

E.1.8 Description of Medical Staff Functions

The responsible party is listed in parentheses following each activity outlined below:

E.1.9 Governance, direction, coordination, and action:

E.1.9.1 Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC);

E.1.9.2 Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care provided by members of the medical staff at the hospital (president of the medical staff and MEC);

E.1.9.3 Take reasonable steps to ensure professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted (president of the medical staff and MEC with input from the appropriate department or clinical service chief);

E.1.9.4 Make recommendations on medical, administrative, and hospital clinical and operational matters that impact patient care (president of the medical staff and MEC);

E.1.9.5 Inform the medical staff of the accreditation and state licensure status of the hospital (President of the medical staff, VPMA and MEC);

E.1.9.6 Act on all matters of medical staff business, and fulfill any state and federal reporting requirements (MEC, VPMA);

E.1.9.7 Oversee, develop, and plan continuing medical education (CME) programs and activities that are designed to keep the staff informed of significant new developments that are related to the findings of performance improvement activities (Medical Staff CME committee);

E.1.9.8 Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution (MEC, hospital ethics committee or subject matter expert);

E.1.9.10 Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that they act within approved guidelines established by the medical staff and governing body (graduate medical education committee, VPMA, MEC);

E.1.9.11 Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board (Medical Staff Officers, VPMA and MEC)

E.1.10 Medical Care Evaluation/Performance Improvement/Patient Safety Activities (See Medical Staff Peer Review Manual)

E.1.11 Communicate findings, conclusions, recommendations, and actions to improve the performance of physicians to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement. (See Peer Review Manual)

E.1.12 The medical staff shall also participate in hospital performance improvement and patient safety programs to: (See Peer Review Manual)

E.1.13 Credentials review (see Part III Credentials Procedures)

E.1.14 Information Management (MEC, Hospital Medical Record Committee)

E.1.14.1 Review and evaluate medical records to determine that they:

E.1.14.2 Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken;

E.1.14.3 Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

E.1.14.4 Develop, review, enforce, and maintain surveillance of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein. (MEC, Hospital Medical Record Committee)

E.1.15 Emergency Preparedness (MEC, Hospital Safety Committee): Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

E.1.16 Organizational Planning (president of the medical staff, MEC, VPMA, department chairs and clinical service chiefs)

E.1.16.1 Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

E.1.16.2 Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources;

E.1.16.3 Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

E.1.17 Bylaws review (MEC)

E.1.17.1 Conduct periodic review of the medical staff bylaw, rules, regulations and policies;

E.1.17.2 Submit written recommendations to the MEC, to the general medical staff and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

E.18.1 Nominating (MEC appointed Nominating Committee See Part I, Section 4.4.1.1)

Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; the Chair of the Nominating Committee, in conjunction with the MEC, will maintain the authority to identify the slate of officers running for election.

E.1.18.2 In identifying nominees, consult with members of the medical staff, the MEC, administration and Board concerning the qualifications and acceptability of prospective nominees.

E.1.19 Infection Control Oversight (MEC, See Hospital Infection Control Committee Charter)

E.1.20 Drug and Therapeutics functions (MEC, See Hospital Drug Therapy Management)

Committee (DTM) Charter)

E.1.21 Responsibilities of department chairs:

E.1.21.1 To oversee all clinically-related activities of the department;

E.1.21.2 To oversee all administratively-related activities of the department otherwise provided for by the hospital;

E.1.21.3 To provide ongoing surveillance of the performance of all individuals in the medical staff department who have been granted clinical privileges;

E.1.21.5 To recommend to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff department;

E.1.21.6 To recommend clinical privileges for each member of the department and other licensed independent practitioners practicing with privileges within the scope of the department;

E.1.21.7 To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff department or the hospital;

E.1.21.8 To integrate the department into the primary functions of the hospital;

E.1.21.9 To coordinate and integrate interdepartmental and intradepartmental services and communication;

E.1.21.10 To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services;

E.1.21.11 To recommend to the hospital administrator the sufficient numbers of qualified and competent persons to provide patient care and service;

E.1.21.12 To provide input to the hospital administrator regarding the qualifications and competence of department or service personnel who are not LIPs but provide patient care, treatment, and services;

E.1.21.13 To provide continuous assessment and improvement of the quality of care, treatment, and services;

E.1.21.14 To maintain quality control programs as appropriate;

E.1.21.15 To orient and continuously educate all persons in the department or service;

E.1.21.16 To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff department to provide patient care services.

E.2.0 MEDICAL STAFF COMMITTEES

E.2.1 General language governing committees

The following shall be the standing committees of the medical staff. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The president of the medical staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease upon

the accomplishment of the purpose of the committee or upon a date set by the president of the medical staff when establishing the committee. The president of the medical staff and the Hospital President, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the president of the medical staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical staff members may be appointed to hospital committees by the President of the Medical Staff. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

E.2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

E.2.3 Credentials Committee

Description of the credentials committee is in Part III: Credentials Procedures; Section 1.

E.2.4 Medical Staff Quality Oversight Committee (MSQOC) (See MSQOC Charter in Peer Review Manual)

E.2.5 Surgical, Medical and Women's and Children's Quality Review Committees (See Quality Review Committee Charters in Peer Review Manual)

E.2.6 Continuing Medical Education (CME)

E.2.6.1 Composition: The CME advisory committee shall be multidisciplinary with required members to be consistent with the recommendations of the ACGME and the **Connecticut State Medical Society**. The director of medical education will be a member of the committee.

E.2.6.2 Responsibilities: The committee provides program leadership with duties as described by the Connecticut State Medical Society CME Committee and reports to the MEC. This Committee shall review the Hospital's medical education program to determine that all requirements for relevant accreditation are being satisfied. It shall also make such other recommendations to the MEC in relation to the education program as it deems appropriate.

E.2.7 Practitioner Health Committee

E.2.7.1 Composition: The practitioner health committee shall consist of at least three (3) members of the active medical staff and shall include a member of the MEC, a member of one of the medical staff quality review committees and, if possible a physician with a previous history of impairment whose impairment has been successfully treated. The VPMA shall be an ex-officio member without vote.

E.2.7.2 Responsibilities: The Responsibilities of the Practitioner Health Committee are:

E.2.7.2.1 Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence including alcoholism or because of mental, physical or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

E.2.7.2.2 Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

E.2.7.2.3 Notify the impaired practitioner's department chair/clinical service chief and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the practitioners' health committee does not alter the primary responsibility of the department chair or clinical service chief for the practitioner's clinical performance;

E.2.7.2.4 Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible;

E.2.9.2.5 Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

MEDICAL STAFF GOVERNANCE DOCUMENTS
PART F: MEDICAL STAFF PEER REVIEW MANUAL

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Peer Review Manual

SECTION 1: Medical Staff Peer Review Policy

Purpose:

To ensure that the hospital, through the activities of its medical staff, assesses the Ongoing Professional Practice Evaluation of individuals granted clinical privileges and uses the results of such assessments to improve care and, when necessary, perform Focused Professional Practice Evaluation.

Goals:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges.
2. Create a culture with a positive approach to peer review by recognizing physician excellence as well as identifying improvement opportunities.
3. Perform focused professional practice evaluation when potential physician improvement opportunities are identified.
4. Promote efficient use of physician and quality staff resources.
5. Provide accurate and timely performance data for physician feedback, Ongoing and Focused Professional Practice Evaluation and reappointment.
6. Assure the process for peer review is clearly defined, fair, defensible, timely, and useful.

Definitions:

Peer Review

“Peer Review” is the evaluation of an individual practitioner’s professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Consistent with Chapter 368a of the Connecticut General Statutes, Peer Review shall also mean the procedure for evaluation by health care professionals of the quality and efficacy of services ordered or performed by other health care professionals, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, and claims review.

Peer review is conducted using multiple sources of information including: 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff, and 3) clinical standards and use of rates in comparison with established benchmarks or norms.

The individual’s evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six Joint Commission General Competencies described below:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.
- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
- **Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
- **Systems Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

These competencies are further elaborated in the Medical Staff Expectations for Physicians (Attachment A).

Peer

A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

Peer Review Body

The peer review body designated to perform the initial review by the Medical Executive Committee (MEC) or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer review performed by or on behalf of the hospital. The initial peer review body will be the Multi-specialty Quality Committee (MSQC) as described in the MSQC Charter (Attachment B) unless otherwise designated for specific circumstances by the MEC. Peer Review may be carried out by any committee that has been established under the medical staff by-laws, when engaged in peer review as directed by the MEC, or activities of any board or committee reviewing professional qualifications of staff or prospective staff.

Ongoing Professional Practice Evaluation (OPPE)

The routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

Focused Professional Practice Evaluation (FPPE)

The establishment of current competency for new medical staff members, new privileges and/or concerns from OPPE. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

Conflict of Interest

A member of the medical staff requested to perform peer review may have a conflict of interest if he/she may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review or is a first degree relative. Relative conflicts of interest are either due to a provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating in the case review. When a potential conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the Peer Review Process (Attachment C).

Policy:

1. All peer review information is privileged and confidential in accordance with medical staff and hospital by-laws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

2. The individual practitioner will receive provider-specific feedback on a routine basis.

3. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in secure, locked files in the credentialing and Quality departments. Provider-specific peer review information consists of information related to:

- Performance data for all dimensions of performance measured for that individual physician,
- The individual physician's role in sentinel events, significant incidents or near misses,
- Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.

5. Only the final determinations of the MSQC/MSQOC and any subsequent actions are considered part of an individual provider's quality file. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes and the physician reviewers and requests for information from the involved physicians and any written responses to the committee.

6. Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based on their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The Chief Medical Officer and/or Chief Quality Officer will assure that only authorized individuals have access to individual provider quality files and that the files are reviewed under the supervision of the Coordinator of Medical Staff Services or designee. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

- The specific provider;
- The President of the Medical Staff for purposes of considering corrective action;
- Medical staff department chairs (for members of their departments only) to conduct OPPE;
- Members of the Medical Executive Committee, credentials committee, and medical staff services professionals for purposes of considering reappointment or corrective action.
- Chief Medical Officer, Chief Quality Officer, Quality Director and quality staff supporting the peer review process;
- Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. Joint Commission or state/federal regulatory bodies; and
- The hospital CEO when information is needed for the CEO's involvement in the process of immediate formal corrective action for purposes of summary suspension as defined by the Medical Staff By-laws.

7. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or by-laws, the MEC, the Board, or by mutual agreement between the President of the Medical Staff and the Chief Medical Officer for purposes of deliberations regarding corrective action on specific cases.

Circumstances requiring peer review:

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedures for conducting peer review for individual cases and for aggregate performance measures is described in Attachments B and C.

In the event a decision is made by the Board of Directors to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the Medical Executive

Committee or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the Medical Staff By-laws.

Circumstances requiring external peer review:

Either the MSQOC, MSQC, MEC, or the Board of Directors will make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEC, MSQC, or the Board of Directors. Circumstances requiring external peer review may include but are not necessarily limited to:

- Litigation- when dealing with the potential for lawsuit.
- Ambiguity- when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
- Lack of internal expertise- when no one the medical staff as adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or governing board.
- Miscellaneous issues- when the medical staff needs an expert witness for a fair hearing, for evaluation of all of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the medical executive committee or governing board may require external peer review in any circumstance deemed appropriate by either of these bodies.

Participants in the review process:

Participants in the review process will be selected according to the medical staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in the timeframe outlined in Attachment C.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MSQC, the MSQOC, or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

Medical Review Committee

Medical Review Committee shall include any committee of the hospital established pursuant to this or any part of the medical staff by-laws, or any entity permitted pursuant to state law, engaging in peer review to gather and review information relating to the care and treatment of patients for the purposes of any of the following: evaluating and improving the quality of health care rendered; reducing morbidity and mortality; or establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. Medical Review Committee shall also mean any hospital board or committee reviewing the professional qualifications or activities of its medical staff or applicants for admission to the medical staff.

Individual Case Review

Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The rating system for determining results of individual case reviews is described in the Case Review Rating Form (Attachment D).

Rate and Rule Indicator Data Evaluation

The evaluation of aggregate physician performance measures via either rate or rule indicators will be

conducted on an ongoing basis by the MSQC/MSQOC or its designee as described in Attachment B.

Selection of Physician Performance Measures

Measures of physician performance will be selected to reflect six General Competencies and will utilize multiple sources of data described in the Medical Staff Indicator List in Attachment E.

Thresholds for Focused Professional Practice Evaluation

If the results of Ongoing Professional Practice Evaluation indicate a potential issue with physician performance, the MSQC/MSQOC may initiate a focused evaluation to determine if there is a problem with current competency of the physician for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or rule or rate indicators. The thresholds for Focused Professional Practice Evaluation are described in the acceptable targets for the medical staff indicators in Attachment E. However, a single egregious case may initiate a focused review by the MSQC/MSQOC.

Oversight and Reporting

Direct oversight of the peer review process is delegated by the MEC to the MSQOC. The responsibilities of the MSQOC related to peer review are described in the MSQOC Charter (Attachment B). The MSQOC will report to the Board of Directors through the MEC at least quarterly.

Statutory Authority

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and Chapter 368a of the Connecticut General Statutes. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled with language consistent with the following:

CONFIDENTIAL PEER REVIEW PROTECTED MATERIAL: This material is confidential and has been prepared in accordance with Connecticut General Statutes Section 19a-17b for the purpose of evaluating and improving the quality and efficiency of health care rendered and/or reducing morbidity or mortality.

Statement of Confidentiality

The proceedings of a medical review committee conducting peer review shall be, at minimum, subject to all the confidentiality and immunity provisions as provided in Chapter 368a of the Connecticut General Statutes. There shall be no disclosure of peer review information that would cause the peer review protections of the state law to be jeopardized.

Peer Review Determinations are subject to categorical change to adopt new recommendations and adapt to changing Peer Review standards. This includes modification of committee determinations from standard “Appropriate,” “Controversial,” and “Inappropriate” to MEC approved terminology.

SECTION 2: Attachment A

Medical Staff Expectations and Expectation Implementation Policy: Expectations of Attending Physicians Granted Privileges at Saint Francis Hospital and Medical Center

This document describes the expectations that physicians have of each other as members of our medical staff based on the ACGME/Joint Commission physician General Competencies framework. The expectations described below reflect current medical staff by-laws, policies and procedures, and organizational policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our medical staff’s culture and vision.

Medical staff leaders will work to improve individual and aggregate medical staff performance through providing appropriate measurement of these expectations that provides positive and constructive feedback so each physician has the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital.

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff standards of care as defined by comparative outcome data, medical literature and results of peer review activities.
2. Plan and provide appropriate patient management based on clinical patient information, patient preferences, current indications, available scientific evidence and sound clinical judgment.
3. Assure that each patient is evaluated by a physician as defined in the by-laws, rules and regulations and document findings in the medical record at that time.
4. Demonstrate caring and respectful behaviors when interacting with patients and their families.
5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards.
6. Counsel and educate patients and their families.
7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.
8. If applicable, supervise residents, students, and allied health professionals to assure patients receive the highest quality of care.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment.
2. Maintain ongoing medical education as appropriate for each specialty and regulatory bodies.
3. Demonstrate appropriate technical skills and medical knowledge using medical simulation technology where appropriate.

Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self-improvement of patient care.

2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.
3. Use hospital information technology to manage information and access on-line medical information.
4. Facilitate the learning of students, trainees, and other health care professionals.

Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams as evidenced by the following:

1. Communicate effectively with physicians, other care givers, patients and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies.
2. Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and direct physician-to-physician contact for urgent or emergent requests.
3. Maintain medical records consistent with the medical staff by-laws, rules and regulations, and policies.
4. Work effectively with others as a member or leader of a health care team or other professional group.
5. Maintain patient satisfaction with physician care.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude towards their profession and society as evidenced by the following:

1. Act in a professional, respectful manner at all times and adhere to the Medical Staff Standards of Professional Conduct.
2. Respond promptly to requests for patient care needs.
3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers.
4. Participate in emergency call as defined in the by-laws, rules and regulations.
5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.
6. Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
7. Make positive contributions to the medical staff by participating actively in medical staff functions, serving when requested and by responding in a timely manner when input is requested.

Systems Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals and improve quality.
2. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care.
3. Ensure timely and continuous care of patients by clear identification of covering physicians and by availability through appropriate and timely electronic communication systems.
4. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.
5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.
6. Advocate for quality patient care and assist patients in dealing with system complexities.

SECTION 3: Attachment B¹

Multi-specialty Quality Committee (MSQC) Charters

Goals

Establishment of multi-specialty committee for improving physician performance on an individual and aggregate level to accomplish the following:

1. Improve patient outcomes by pursuing and maintaining excellences in physician performance;
2. Create a culture with positive approach to physician peer review;
3. Promote efficient use of physician and quality staff resources;
4. Assist in providing accurate and timely performance data for physician feedback and reappointment;
5. Support medical staff educational goals to improve patient care.

Scope

The MSQC will be responsible for evaluating and improving physician performance from the specialty areas under its scope under the oversight of the Medical Staff Quality Oversight Committee (MSQOC) for the six Competencies as described in the Peer Review Policy and Medical Staff By-Laws.

Medicine:

The following specialty areas are under the scope of the Medicine MSQC:

- Internal Medicine
- Family Medicine
- Cardiology
- Gastroenterology
- Hospital Medicine
- Emergency Medicine
- Critical Care Medicine/Pulmonary
- Infectious Disease
- Neurology
- Rheumatology
- Nephrology
- Dermatology
- Radiology
- Oncology/Hematology
- Radiation Oncology
- Psychiatry
- Geriatric Medicine
- Endocrinology
- Physiatry

Surgery:

The following specialty areas are under the scope of the Surgery MSQC:

- General Surgery
- Orthopedic Surgery
- Cardiothoracic Surgery
- Vascular Surgery
- Urology
- Ophthalmology
- Otolaryngology
- Plastic Surgery

- Neurosurgery
- Trauma/Critical Care
- Pediatric Surgery
- Oral Maxillofacial Surgery
- Dentistry
- Bariatric Surgery
- Minimally Invasive Surgery
- Colorectal Surgery
- Anesthesiology

Women & Children

The following specialty areas are under the scope of the Women & Children MSQC:

- Obstetrics/Gynecology
- Neonatology
- Perinatal
- Maternal Fetal Medicine
- Pediatrics
- Family Medicine

The following areas are considered outside the Committee's scope:

- Individual physician behavior incidents will be the responsibility of the respective department chair or MEC.
- Routine concurrent aspects of physician resource will be managed through the utilization review process. Patterns and trends data will be initially addressed by the MSQC.
- Policies requiring medical staff approval for Blood Use will be referred to the MEC for approval. The MSQC will perform peer review relating to the use of blood or blood products.
- Formulary and medication policy issues requiring medical staff approval will be addressed by the Drug Therapy Management Committee and referred to the MEC for approval. The MSQC will perform peer review relating to the use of medications related to physician care.
- Health Information Management systems issues will be addressed and the issues related to physician compliance related to documentation criteria and record completion will be addressed by the Medical Records Committee. Physician performance indicators for HIM issues will be determined by the MEC.
- Credentialing and privileging is the responsibility of the Medical Staff Department Chair and the Credentials Committee.

Responsibilities

Evaluation of Individual Cases

- Initial review of all cases for sufficient complexity of management or seriousness of outcome requiring physician peer review based on cases identified by review indicators, ongoing departmental audits or through referrals to the Quality staff for the specific clinical conditions as defined in the scope of the committee.
- Obtain reviews and recommendations from specialist on the medical staff or other MSQCs when required.
- Communicate with the physician involved with the case to obtain input prior to making determinations when opportunities for improvement may exist.
- Make recommendations regarding individual or Hospital System PI opportunities for improvement based on individual case review.

Evaluation of Rate and Rule Indicators

- Perform regular review of adverse outliers from aggregated results of rule indicators and adverse patterns, trends, and outlier status for rate indicators relevant to all dimensions of physician performance for the specific clinical conditions as defined within the scope of the committee. The purpose of this review is to determine if additional analysis or focus studies are needed. This function may be delegated to an individual member of the committee or to a subcommittee.
- Identify individual or Hospital PI opportunities for improvement and determine if additional analysis or focus studies are needed.

Oversight of Other Medical Staff Physician Performance Evaluation Committees

The vast majority of initial review of cases, along with rule and rate indicator results, will be performed by the appropriate MSQC. All medical staff departments that wish to meet for purpose of M&M review for educational purposes may also do so if they wish. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures are followed.

However, some medical staff departments or committees will continue to perform specific functions either as a quality control mechanism or to review of specific processes as outcomes as appropriate for departmental performance improvement and education. The MSQOC will have oversight of the process used to perform this review and the indicators selected by the specialty. For rule and rate indicators determined by the MEC as reportable to the medical staff, the department will report the results to the MSQOC. The department or the group will refer to the quality office any case meeting medical staff review indicator criteria for initiation of the case review process by the appropriate MSQC. The following areas will perform this function as described below:

- **Pathology:** The Pathology Department will perform review of surgical pathology or cytology slides interpreted by pathologists. Cases resulting in significant change in treatment, or significant adverse outcomes potentially related to physician care, as defined by review indicators due to misinterpretations or missed findings will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.
- **Radiology:** The Radiology Department (including Diagnostic Imaging, Interventional Radiology) will perform review of radiologic images interpreted by radiologists. Cases resulting in significant change in treatment, or significant adverse outcomes potentially related to physician care, as defined by review indicators due to misinterpretations or missed findings will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.
- **Emergency Department:** The Emergency Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.
- **Anesthesia:** The Anesthesia Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.
- **Trauma:** The Trauma Committee will continue to perform its functions under the required ACS standards. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.
- **Hoffman Heart and Vascular Institute:** The Hoffman Heart and Vascular Institute may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process. Periodic reporting to the MEC may occur as determined by the Chief Quality Officer.

Improvement Opportunities

The role of the MSQC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed. This will be accomplished through the following:

- Communicate individual improvement opportunities to the appropriate department chair, who, with the assistance of the MSQC Chair, develops an improvement plan if necessary.
- Communicate system improvement opportunities to the appropriate hospital committee or department chair. The mode of this communication shall be at regularly scheduled meetings with the appropriate committee chair, department chair or chief quality officer.
- Track responses and improvement plans.
- Review the improvement plan on a scheduled basis.
- Report to the MEC regularly regarding actions taken to improve care and any cases where action was not taken when requested or actions are perceived to be inadequate.

Measurement System Management

- Make recommendations to the MSQOC regarding requests to the quality management department for additions or deletions to indicators, criteria or focused studies for evaluating physician performance.
- At least annually review the indicators, screening tools, and referral systems for effectiveness in collaboration with the medical staff department chairs and recommend changes to the MSQOC.
- Make recommendations to the MSQOC regarding the appropriate content for physician performance feedback reports.
- No changes can be made to the charter and policies without approval of the MEC.

Membership

The Medicine MSQC will be comprised of seven to nine (7-9) members with at least one representative member from each of the following specialties: Internal Medicine, Family Medicine, Cardiology, Pulmonary/Critical Care Medicine, General Surgery, and Emergency Medicine.

The Surgery MSQC will be comprised of five to seven (7-9) members with at least one representative member from each of the following specialties: General Surgery, Critical Care, Emergency Medicine, Cardiovascular Surgery, Orthopedics, Anesthesia, Radiology/Interventional Radiology, and other assigned at-large members.

The Women and Children MSQC will be comprised of five to seven (5-7) members with at least one representative member from each of the following specialties: Obstetrics, Neonatology, Maternal Fetal Medicine, Family Medicine, and General Surgery/Gynecology Oncology.

Other members may be appointed at large. Physicians from other specialties may be invited to the meeting as needed.

The MSQOC Chair, a nursing representative, and appropriate Quality support staff are ex-officio members without a vote. At large members of the MEC may attend as guests.

The Committee members will be appointed by the President of the Medical Staff based on the recommendations from the Committee Chair and approved by the MEC. Representative members will serve for a three year term expect for initial committee members. The initial committee will have staggered terms with a third of the members assigned initial terms of one year, a third assigned initial terms of two years, and a third assigned initial terms of three years. Members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year.

The Chair of the MSQC will be appointed by the President of the Medical Staff, and approved by the MEC for a term of one year. To be eligible for appointment as Chair, the member must have served on the

committee at some point in the time for at least one year, except for the first Chair of the committee. The Chair may serve unlimited number of consecutive terms as long as they are eligible to be a committee member. The Chair will be an ex-officio member of the MEC.

Committee members will be expected to attend at least 75% of the committee meetings over a twelve month period to maintain membership. Committee members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities.

Meetings

The Committee will meet at least 10 times per year. A quorum for purposes of making case determinations will be based on the presence of 50% of the voting committee members at a regularly scheduled meeting. A majority will consist of a majority of voting members present.

Reporting

The Committee will report to the MSQOC/Medical Executive Committee at least 10 times per year.

SECTION 3 (CONTINUED): Attachment B²

MSQOC Charter

Goals

To provide oversight for the policies, procedures and results of physician performance as performed by the medical staff quality committees to achieve the following goals:

1. Improve patient outcomes by pursuing and maintaining excellence in physician performance on an individual and aggregate level.
2. Create a culture with a positive approach to physician peer review through assuring the use of consistent and fair processes.
3. Promote efficient use of physician and quality staff resources.
4. Assure that accurate and timely performance data is available for physician feedback, Ongoing and Focused Professional Practice Evaluation and reappointment.
5. Support medical staff educational goals to improve patient care.
6. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the medical staff.

Scope

The MSQOC will be responsible for overseeing the accountability and effectiveness of the individual Multi-specialty Quality Committees (MSQC) and for developing systematic approaches to evaluating and improving physician performance in the General Competencies as described in the Peer Review Policy and Medical Staff Expectations. The MSQOC will also act as a peer review committee for specific cases as described below.

Responsibilities

Case Review

- Recommend to the MEC general policies and procedure for MSQC performance of individual case review and external peer review.
- Review and approve MSQC specific approaches for individual case review to assure that they comply with general policies and regulatory requirements.
- Define standardized tools for case review to be used by all MSQCs performing peer review.
- Provide oversight to assure all MSQCs are conducting and reporting the results of peer review on a systematic and timely basis.
- Review and approve specific review indicator criteria based on the recommendations of all the MSQCs and department chairs.
- Perform peer review of cases referred to the MSQOC for the following reasons:
 - Difficult or complex issues beyond the capabilities of the MSQC
 - Substantial conflict of interest that would preclude effective MSQC review
 - Potential need for external peer review

Aggregate Measures of Physician Performance

- Review and approve system wide and campus specific rate indicators including benchmarks or targets based on the recommendations of the appropriate specialties.
- Recommend prospective evaluations of best practices and use of evidence based medicine to identify opportunities for improvement and the pursuit of excellence.
- Assure regular review is performed of aggregated results of rate indicators for patterns, trends, and outlier status.
- Assure that patterns and trends are addressed by the MSQCs to improve either individual or aggregate physician performance.

Improvement Opportunities

- Addressing improvement opportunities will be the role of the MSQC, the medical staff leaders, and the MEC. The role of the MSQOC is to assure when opportunities for physician improvement are identified, the leadership follows through with the process. This will be accomplished through the MSQC Chair reporting to the MSQOC regularly regarding recommendations to improve care and any situations where further recommendations are made.

Performance Improvement System Management

- Define mechanisms for reporting the results of physician performance evaluation to the MEC and the Board.
- Develop overall strategies and policies for the use of electronic and risk adjusted data in physician performance evaluation.
- In coordination with the Credentials Committee and the MEC, define the appropriate content and format for physician performance feedback reports.
- Determine support needed to implement and sustain the process and make recommendations to the administration and MEC accordingly.
- At least annually review the indicators, screen tools, and referral systems for effectiveness and recommend changes to the MEC.

Oversight of Other Medical Staff Physician Performance Evaluation Committees

Although the vast majority of initial review of individual cases, along with rule and rate indicator results, will be performed by the MSQCs, some medical staff departments or committees will continue to perform some of these functions either as a quality control mechanism or as a multi-disciplinary educational process. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures of the MSQOC are followed. These departments or committees will refer to the Department of Quality any case meeting medical staff review criteria for initiation of the case review process by the appropriate MSQC.

In addition, specific departments or committees will perform the initial review of rate and rule indicator data relative to their area of expertise and may address patterns and trends and report their findings to the MSQOC as indicated below.

- Image Based Specialties (Pathology, Radiology, Cardiac Images, Vascular Intervention): Image Based Specialties will perform routine quality reviews of diagnostic image interpretation by physicians (e.g. surgical pathology or cytology slides, radiologic images) as either rule or rate indicators. Cases with misinterpretations or missed findings resulting in significant change in treatment, or significant adverse outcomes potentially related to physician care, as defined by the review indicators, will be referred to the Quality office to initiate the MSQC peer review process.
- Trauma: The Trauma Committee will continue to perform its functions under the required ACS standards. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the Quality office to initiate the MSQC peer review process.
- Emergency Department: The Emergency Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. For those indicators determined by the MEC as reportable to the medical staff, the department will report the results. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process.
- Anesthesia: The Anesthesia Department may perform review of the processes and outcomes of care provided in the Anesthesia department. For those indicators determined by the MEC as reportable to the medical staff, the department will report the results,. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process.
- Hoffman Heart and Vascular Institute: The Hoffman Heart and Vascular Institute may perform review of the processes and outcomes of care provided in the Hoffman Heart and Vascular Institute. For

those indicators determined by the MEC as reportable to the medical staff, the department will report the results. Cases resulting in significant adverse outcomes potentially related to physician care as, defined in the review indicators, will be referred to the quality office to initiate the MSQC peer review process.

Membership

The MSQOC will be comprised of the Chairs of each MSQC, and four (4) additional appointed members by the President of the Medical Staff to create a balanced representation from the medical staff. The following are ex-officio members without a vote: the President of the Medical Staff, the CMO, the CNO, the Director for Quality Outcomes, and Chief Quality Officer.

MSQC Chair members will serve terms coinciding with their term as MSQC Chair. Appointed members will serve for a three year term expect for initial committee members. The initial committee will have staggered terms with a third of the members assigned initial terms of one year, a third assigned initial terms of two years, and a third assigned initial terms of three years. Appointed members may serve an unlimited number of consecutive terms.

The Chair of the MSQOC will be appointed by the President of the Medical Staff, and approved by the MEC from committee members who have served for more than one year (expect for the first committee chair). The Chair will be a voting member of the MEC.

In addition to the above members, key clinical administrative representatives and support staff mutually agreed upon between the Medical Staff and Administration may attend the MSQOC meetings.

Committee members will be expected to attend at least two thirds of the committee meetings over a twelve month period to maintain membership (no designees allowed). Committee members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities.

Meetings

The MSQOC is a sub-committee of the MEC. The MSQOC will meet at least 10 times per year. The MSQCs will report at least 10 times per year to the MSQOC/MEC. No changes can be made to the MSQOC Charter and policies without approval of the MEC.

A quorum for purposes of making case determinations will be based on the presence of 50% of the voting committee members at a regularly scheduled meeting. A majority will consist of a majority of voting members present.

Section 4: Attachment C

Case Review Process

1. Cases are referred to the Peer Review Coordinator for review by one of the three multi-specialty Committees. Case referrals can come from a variety of sources but typically are referred from the following: Risk Management, Physician, Nursing, Pharmacy, Non-Clinical Staff (ex: Director of Quality, Patient Ombudsman, Environmental Services), and Database review.
2. The Peer Review Coordinator completes a referral form which notes the referral issue, pertinent patient identification and information (name, date of birth, MR#, Acct#, admission and discharge dates), attributed providers, and a preliminary case summary.
3. The Peer Review Coordinator meets with the respective multi-specialty Committee Chair to discuss the case and whether it warrants further formal review.
 - a. If further review is warranted, the case is entered into secure databases; each case is assigned a case number and a reviewer. An "Initial Provider Review Form" is generated with case specific information, put into a sealed envelope, and left in the Peer Review Record Review Room in the appropriate multi-specialty Committee drawer. Each envelope is marked "Peer Review Protected" and has written on the outside the case number, reviewer name, and patient's MR and Account # for the visit(s) under review. Reviewers are notified via email that they have a new assigned case; cases are generally assigned one to three weeks prior to the meeting in which the case is anticipated to be presented. The referral form is filed in the Peer Review Coordinator office.
 - b. If further review is not warranted, the case is entered into secure databases and is not assigned a case number or reviewer. The referral form is filed in the Peer Review Coordinator office.
4. Reviewers thoroughly review the case prior to the next scheduled meeting of their Committee and complete the "Initial Provider Review Form". Reviews are left in the envelope in the Peer Review Record Review Room.
5. Prior to the scheduled Committee meeting, the Peer Review Coordinator collects the reviews and includes them in the meeting folder for discussion at a designated scheduled meeting.
6. The case is presented and discussed at the designated meeting. The Committee may opt to make a temporary final determination on the case given the adequate documentation in the patient's chart. If the Committee has questions for the provider(s), inquiry letter questions are generated. Inquiry letters are written with the Peer Review Coordinator by the Committee Chair.
7. If inquiry letters are to be sent, the providers are notified in writing within one week of the meeting via certified mail of any concerns and requests for additional information. Providers are expected to respond in writing within two weeks of receipt of the letter so that the case can be re-discussed at following month's scheduled meeting.
8. Following receipt of the inquiry letter, the Peer Review Coordinator makes enough copies for the Committee members to review along with a copy of the original inquiry letter. The case is given a temporary final determination. On rare occasions, a second inquiry letter with further clarifying questions may be sent to the provider.
9. Once a temporary final determination is made, the Peer Review Coordinator includes the case for discussion at the next scheduled Oversight Committee meeting. At this meeting, the Committee Chair presents an overview of the case and the basis for the final determination. In most cases the final

determination stands, however the Oversight Committee Chair reserves the right to send the case back to the multi-specialty Committee for further review and consideration. If this occurs case is re-discussed and further inquiry letters may be sent to providers.

10. Once the Oversight Committee has agreed with the temporary final determination, the case is assigned the temporary final determination as the “final” determination. This is documented in the secure databases and providers are sent a certified letter noting the final determination and any other findings such as documentation issues, system issues, etc.

11. All copies of correspondence (initial inquiry, follow up inquiry if there is one, responses, and final determinations) regarding the case are sent to the Director/Chair of the department which the provider practices under and also to the Medical Staff Office for inclusion into their Quality folder.

12. The Oversight Committee Chair presents the cases at the following scheduled Medical Executive Committee meeting.

The entire process for case referral, discussion, and final determination is expected per the by-laws to occur within a continuous 90 day (3 month) time period. In rare cases the review and discussion of a case is longer due to longer inquiry letter response time, meeting cancelation, or other extenuating circumstances.

SECTION 5: Attachment D--Case Review Rating Form

Case Number:

Provider(s) under review :

Is the patient's H&P Complete and Accurate: Yes No

If there is more than one admission being reviewed, is the patient's return visit H&P complete and accurate? Yes No

If no, what are the issues noted with the H&P:

Was there a deviation from generally accepted performance standards (GAPS)? Yes No

Consideration of performance expectations should include internal and external sources such as internal policies & procedures, nationally recognized best practices & standards of care, and professional practice standards.

Is this considered a known complication? Yes No

If yes: 1. Was the procedure, treatment, or test appropriate and warranted based on nationally recognized standards of care? Yes No

2. Was the complication a known risk, was it anticipated before the procedure, and was the standard of care applied to mitigate the risk? Yes No

3. Was the complication identified in a timely manner (i.e. at the time of the occurrence)? Y/N
No

4. Was the complication treated according to the standard of care an in a timely manner? Y/N
No

If the answer to any question above is no, the event is considered a safety event.

Please circle below what you would consider as the level of harm to the patient according to review and discussion of the case.

SSE1: Death

SSE2: Severe Permanent Harm -Resulting in critical, life-changing harm with no expected change in clinical status; includes events resulting in permanent loss of organ, limb or vital physiologic or neurologic function.

SSE3: Moderate Permanent Harm- Resulting in significant harm with no expected change in clinical condition yet not sufficiently severe to impact activities of daily living or business function; includes events of permanent reduction in physiologic reserve, disfigurement, and impaired or aided sense of function.

SSE4: Severe Temporary Harm - Resulting in critical, potentially life-threatening harm yet lasting a limited time with no permanent residual; requires prolonged transfer to a higher level of care/monitoring, transfer to a higher level of care for a life-threatening condition, or additional major surgery or procedure.

SSE5: Moderate Temporary Harm - Significant harm lasting for a limited time; requires a higher level of care/monitoring or an additional minor procedure.

PSE1: Minimal Permanent Harm - Minor harm with no expected change in clinical status; requires little or no intervention.

PSE2: Minimal Temporary Harm - Minor harm lasting for a limited time only; requires little or no intervention.

PSE3: No Detectable Harm - Deviation that reaches the patient yet without ability to determine the existence of fact of harm, yet harm may exist; includes events where the onset of harm may occur later in time.

PSE4: No Harm - Deviation that reaches the patient yet results in no harm with sufficient info available to determine no harm occurred.

NME1: Unplanned Barrier Catch- Deviation passes through all error detection barriers and does not reach the patient because it is caught by chance or barrier not designed in the system.

NME2: Last Strong Barrier Catch- Deviation passes through early error detection barriers and is caught by a last strong error detection barrier designed into the system.

NME3: Early Barrier Catch- Deviation caught by an early error detection barrier designed into the system.

If the event is a considered a deviation in GAPS or a safety event, please list the actions below which led to the deviation or safety event.

Action	Individual (i.e.: Attending, Resident, RN, PA, etc)	Notes
Example 1: Resident failed to escalate the patient's issue with the Attending.	Resident	Resident tried to manage the patient without Attending intervention which led to deterioration in the patient's condition and further aggressive medical treatment.
Example 2: Patient's ID bracelet was not bar code scanned prior to drug administration.	Nursing	Lorazepam IV was administered to the wrong patient which resulted in 12 hr sedation and multiple rescue drugs.

Patient Outcome/Level of Harm (select one):

1. No Adverse Outcome
2. Minor Adverse Outcome (complete recovery expected)
3. Major Adverse Outcome (complete recovery NOT expected)
4. Catastrophic Adverse Outcome (e.g. death)
5. Unknown to reviewer

Effect on Patient Care (select one):

1. Care not affected
2. Increased level of monitoring/observation (e.g. vital sign checks)
3. Additional treatment/intervention (e.g. IV fluids)
4. Life sustaining treatment/intervention (e.g. intubation, pressor support)
5. Unknown to reviewer

Documentation Issues (select all that apply):

1. No issues with documentation.
2. Documentation exemplary.
3. Documentation does not substantiate clinical course and treatment.
4. Documentation not timely to communicate with other caregivers.
5. Documentation Other:

Issues with provider care (select all that apply):

1. No issue with physician care identified
2. Diagnosis
3. Judgment
4. Clinical judgment/Decision-making
5. Technique/Skills
6. Knowledge
7. Communication/Responsiveness
8. Planning
9. Follow-up/Follow-through
10. Policy Compliance
11. Supervision (resident or allied health provider)
12. Other:

Overall Provider Care (select one):

1. Appropriate with no documentation issues
2. Appropriate with documentation issues
3. Controversial
4. Inappropriate
5. Exemplary Documentation
6. Exemplary Overall Provider Care

Basis for overall care rating:

Inquiry questions for the provider:

- 1.
- 2.
- 3.
- 4.

CONFIDENTIAL PEER REVIEW PROTECTED MATERIAL: This material is confidential and has been prepared in accordance with Connecticut General Statutes Section 19a-17b for the purpose of evaluating and improving the quality and efficiency of health care rendered and/or reducing morbidity or mortality. Full example of safety event breakdown; please note that this is a true event however it did not occur at St. Francis Hospital and Medical Center.

Background: An 18 month old patient fell into a bathtub of scalding water sustaining first and second degree burns over 60% of their body. A central line was placed and the patient was intubated. The patient went to the OR 3 times in the first two weeks of admission for skin grafting and wound debridement. Several wound debridements were also conducted at the bedside using sterile technique. The patient was on a narcotic drip to alleviate pain. After two weeks in the Pediatric ICU (PICU), the patient was transferred to an intermediate care floor. The patient’s vitals and “ins/outs” were continuously monitored. The patient was started on methadone to wean from narcotic use. Within 2 days the patient developed a fever, vomiting, and severe diarrhea; the central line was considered the source of infection, it was removed and the patient was started on antibiotics. The patient’s weight was noted to be 15% lower than that on admission, the patient was actively trying to grab at fluids (water bottles, cups, wet washcloths), and the patient became weak and their eyes were noted to roll back in their head. The patient’s parent questioned these behaviors and was assured that these were “normal” and was denied the opportunity to provide liquids to the patient. Within 12 hours the patient became lethargic, pale, and exhibited sunken, dilated eyes; it was thought that the patient was oversedated with methadone, Narcan was given with good effect. The patient was given fluids; drank 20 ounces of fruit juice. Another dose of Narcan was given and the patient was back to baseline. An order was put in to withhold all narcotics however later in the morning when the Pain Team rounded on the patient they thought the patient should be on a modified dose of methadone in order to prevent withdrawal. Decision was made to give a lower dose of methadone; within 10 minutes of administration the patient coded. Patient was resuscitated however sustained an anoxic brain injury; was moved back to the PICU. The patient was made CMO two days post arrest and expired later in the evening. Cause of death was noted to be severe dehydration and misuse of opiates.

Action	Individual (i.e.: Attending, Resident, RN, PA, etc)	Notes
RNs in the intermediate care unit were recording vitals and ins/outs however not appreciating the information in which they were transcribing.	Nursing	The patient had an imbalance of fluids in/out due to severe diarrhea; the patient exhibited signs of dehydration by trying to grab at liquids. The patient’s downward trend was not noticed.

MDs in the intermediate care unit reviewed vitals and ins/outs however did not appreciate the information.	Physician	MDs reviewed daily vitals and ins/outs however did not adequately review vitals and ins/outs from the prior day(s); they failed to observe that the patient was trending down in weight and becoming dehydrated.
Residents in the intermediate care unit reviewed vitals and ins/outs however did not appreciate the information.	Residents	Residents relied on the Attending (who was also the Director of the PICU and intermediate floor) to make all the medical decisions without their input.
The parent's concern regarding abnormal behavior was not explored; failure to escalate the situation to an Attending.	Nursing	Nursing did not bring the parent's concerns to the MD nor did the nursing staff address the concerns (exploring why eyes rolled back; thirst); assumed that this was normal behavior of the child.
The Pain Team Anesthesiologist overturned the withheld narcotic order without fully discussing the case with the Attending.	Physician	Poor communication between the Anesthesiologist and Attending regarding intent to treat and dosing.

Section 6: Attachment E: Medical Staff Indicators and Targets

Review Indicators

- Unanticipated Death
- Missed/Mis-Diagnosis Resulting in Significant Change in the Patient Treatment Plan
- Unanticipated Cardiac or Respiratory Arrest Outside of the ICU, PACU, OR
- Patient Admitted for Medical Condition with Complication Resulting in Additional Interventions
- Significant Tissue Discrepancy Between Pre and Post of Diagnosis
- Delay in Treatment/Consultation Resulting in Significant Deterioration in Patient Condition
- Risk Management Referral for Significant Clinical Concern Not Otherwise Specified
- Unanticipated Readmission of a Patient within 7 Days of Discharge for Problems Related to the Initial Condition
- Major Perioperative Complication of a Patient Undergoing Anesthesia
- Unplanned Removal of an Organ During Surgical Procedure
- Significant Complication of Surgical Procedure Resulting in Prolonged Inpatient Stay
- Significant Intra or Post Procedural Complications
- Unplanned Readmission within Defined Timeframe of Procedure for Problems Related to Initial Procedure
- Unscheduled Admission Following an Outpatient Procedure Requiring Inpatient Admission to the ICU/Critical Care
- Complications of endoscopy, colonoscopy, or ERCP
- Possible Permanent or Serious Infant Injury
- Mother Transferred to the ICU Post Delivery
- Severe Complications of Invasive/Interventional Cardiac, Peripheral Vascular, or Central Vascular Procedure
- Unplanned Return to the ED within 72 Hours Requiring Hospital Admission to the ICU
- Significant Maternal Complication of Delivery
- Significant Complications Following Percutaneous Non-Vascular Procedures
- Autopsy with Unexpected Findings Potentially Affecting Patient Care
- Newborn <39 Weeks Induced or Delivered by Elective C-Section
- Wrong Procedure/Patient/Side

There are currently no excellence and acceptable targets associated with the above list of indicators. Therefore, a practitioner may have an unlimited number of case review referrals considered in a calendar year and/or designated reporting time period.

Rule Indicators

The following are individually tracked on a rolling 12 month calendar/year and for designated reporting time periods for the on-going professional practitioner evaluation (OPPE).

- Patient Safety Related Events for Patients Undergoing Anesthesia

There is currently no excellence and acceptable target associated with this indicator.

- Documentation Lacking Essential Elements per Regulatory Guidelines

A practitioner may have up to one miss to meet the excellence target or up to four misses to meet the acceptable target.

- Validated Incidents of Practitioner Non-Responsiveness to Nursing Requests

A practitioner may have no misses to meet the excellence target or up to two misses to meet the acceptable

target.

- Validated Incidents of Non-Availability for ED Call by Practitioners on Call List or Covering Practitioner

A practitioner may have no misses to meet the excellence target or up to one miss to meet the acceptable target.

- Validated Incidents of Inappropriate Practitioner Behavior

A practitioner may have no misses to meet the excellence target or up to two misses to meet the acceptable target.

- Validated Incidents of Patient Not Seen and/or Documented Daily by Physician/Practitioner

A practitioner may have no misses to meet the excellence target or up to two misses to meet the acceptable target.

- Non-response to Medical Staff Committee/Department Chair Requests Regarding Patient Care Issues

A practitioner may have no misses to meet the excellence target or up to one miss to meet the acceptable target.

SECTION 7: Attachment F: Validation of Incidents Policy

Purpose

Occurrences regarding physician performance reported may need to be validated either via individual case review or as rule indicator occurrences specifically requiring validation by the medical staff.

Procedure

If the event involves clinical issues evaluated by case review, the case review process itself will provide validation. If the occurrence is measured as a rule indicator that requires validation, the following procedure will be used:

Occurrence Report and Initial Investigation

- The occurrence report must include the name, category, and contact information of the reporting individual or individual's supervisor so that there is preliminary information to validate the event. Events without the necessary information for follow-up will not be further investigated and will be closed as "unable to validate".
- The Chief Medical Officer and/or Chief Quality Officer will contact the individual reporting the occurrence, or appropriate supervisor, and additional individuals who can provide necessary information to validate the occurrence.
- If the event clearly does not appear valid, the Peer Review Coordinator will retain the event in the system but there will be no notification or rule letter sent to the physician.
- If the event appears potentially valid, the Chief Medical Officer and/or Chief Quality Officer will contact the physician to obtain the physician's perspective on the event without disclosing the name of the individual reporting the event.

Physician Leader Validation Decision

- If the occurrence relates to behavior in the medical staff code of conduct, the physician leader (- Department Chair or designee) will make a final determination as to whether the occurrence is valid.
- If the occurrence is related to other performance issues, the Chief Medical Officer and/or Chief Quality Officer or designee will make that determination.

Communication and Tracking

- If the occurrence is not determined to be valid, the occurrence will be retained in the system but no rule indicator letter will be issued to the physician. The physician will receive verbal communication from the the Chief Medical Officer and/or Chief Quality Officer that the occurrence was not validated.
- If the occurrence is validated, the physician will receive a rule indicator letter.
- If an individual event is considered serious in nature, additional follow-up will be performed. At that time, the Chief Medical Officer and/or Chief Quality Officer will determine the next steps to understand why the physician appears to be at variance from his peers.

SECTION 8: Attachment G: Ongoing Physician Performance Evaluation Report (OPPE) Design and Use Policy

While regulatory compliance is not the only reason for providing physicians with performance data, the Joint Commission requirement that aggregate and comparative data be used in the Ongoing Professional Practice Evaluation and in the reappointment process is a driving factor that has led medical staffs across the country to develop meaningful physician data reports. The best approach to using physician performance data is to provide it to physicians on a regular basis as well as have ongoing review by medical staff leaders for patterns and trends to achieve the following goals:

- To create a medical staff culture that accepts performance data feedback in the spirit of continuous improvement.
- To provide physicians with systemic, timely, and periodic feedback, not just at reappointment on all categories of physician performance described in the Medical Staff Expectations.
- To make physicians aware of areas of excellent performance, as well as areas of improvement opportunities.
- To allow physicians the opportunity to self-improve based on the data provided.

Report Design Principles

- Routine feedback reports will be provided to each physician with significant clinical activity on all physician competency categories.
- Indicators will be organized by the physician competence category being measured.
- The data will be presented both numerically and as a summary scorecard to provide physicians with their specific data and the target comparison data for categorical interpretation.
- Historical performance may be shown by color or symbol or by data.
- Data time periods will be used that provide a sufficient volume of data to allow reasonable, if not statistical, data significance (e.g. rolling 2 year periods).
- The physician activity data (i.e. volume data) will be separated from performance data unless the volume level is linked to the retention of individual privileges.
- Support documentation will be provided with the OPPE so the physician will know how each indicator was calculated, the source of the data, and the source of the targets.

Indicator and Target Selection Principles

- Indicators will be selected by the medical staff as described on the MSQC charter and represent a limited number of issues most relevant to physician performance, either generally or for a specific department/section, and may not provide data on all physicians.
- Whenever possible, targets will be based on external benchmarks (normative databases, severity adjusted data, literature).
- The OPPE may contain indicators for feedback purposes only which will not be used in reappointment decisions (e.g. LOS). The MEC will determine which indicators are used for reappointment decisions.

Report Interpretation

- The indicators in the OPPE only provide broad comparisons, not precise measures, of physician competence; the medical staff must recognize data limitations and interpret the data accordingly.
- Physician performance data is a starting point for identifying improvement opportunities, it is not considered definitive unless further evaluation is used to understand differences in performance relative to expectations and discussed with the physician involved.
- When systematic data problems are identified, it is important for the medical staff and the hospital to identify key data error sources and take responsibility to fix them.

- Although indicators will be added to the report over time, the medical staff should have sufficient lead time prior to the use of any new indicators in credentialing and privileging decisions.

Report Distribution and Follow-up

- The OPPE will be distributed semi-annually to all physicians and will be confidential to the individual physician and appropriate medical staff leaders (i.e. Department Chiefs, Credentials Committee, Medical Staff Quality Committee, and Medical Staff Officers).
- Department Chairs will review the semi-annual OPPEs and discuss any areas needing improvement with the physician.
- The Department Chairs will document and communicate their conclusions or the need for further analysis to the Chief Medical Officer, Chief Quality Officer, or their designee.
- At time of reappointment, the most recent OPPE will be included in the reappointment materials sent to the department chiefs for review. The department chiefs will document their interpretation of any indicator that shows the possibility for performance improvement in the reappointment recommendations.
- The OPPE will take several years to refine and the initial OPPE should be considered a starting point, not a finished product. The first year of feedback reports will be considered a pilot test to help physicians understand how to use the report to improve it. There will be no department chief follow-up other than to understand any inaccuracies or problems with the data unless a specific indicator has been used in the past for physician feedback.

SECTION 9: Attachment H—Data Trends Council Charter

Purpose

The purpose of Data Trends Council is to assure that indicator data for the System Performance Improvement Committee and Medical Staff Quality Oversight Committee (MSQOC) and Multi-specialty Quality Committees (MSQCs) at Saint Francis Hospital and Medical Center is analyzed effectively and efficiently for trends. The goals of this effort are:

- To assure that indicator data trends are consistently identified using objective standards.
- To maximize the efficiency of hospital and medical staff in performing trend analysis.
- To minimize the time spent by hospital and medical staff committees involved in performance improvement activities in trend analysis and maximize the time spent on improving performance.

Scope

Initial analysis for all aggregate or rate indicator data collected as ongoing indicators for either hospital performance improvement or physician improvement activities that are the responsibility of the System Performance Improvement Committee or the MSQOC/MSQC. This function is delegated to the Data Trends Council by these committees and fulfills the need for that analysis of data typically performed by those oversight committees. These oversight committees have the responsibility to discuss adverse performance trends identified by the Data Trends Council and create the initiatives necessary to address them.

For physician performance data, the Data Trends Council will routinely look at overall physician performance measures, and when appropriate, perform more detailed analysis to advise the MSQOC/MSQC as to whether a trend is due to one or multiple physicians. The Data Trends Council will not analyze the results of individual case reviews performed as peer review through the MSQOC/MSQC.

Responsibilities

- Submit data using either control charts or predetermined targets. Potential performance issues from failure to achieve targets or change in performance exceeding allowable limits either as an individual time period or as a trend over time will be identified and reported.
- Obtain from the appropriate oversight committee the necessary indicator targets to perform the analysis.
- Report findings of potential performance issues to the appropriate oversight committee.
- Conduct additional analyses when necessary to determine potential sources of variation.
- Make recommendations to the appropriate oversight committee regarding the feasibility and validity of requests for new indicators or studies from hospital or medical staff committees or individuals.
- Create and maintain the indicator scorecard.

Membership

The Data Trends Council will be chaired by the Director of Quality and will be composed of the following:

- Quality Specialists
- Infection Control Practitioner
- Pharmacy Director or designee
- Data Analyst
- Director of HIM or designee
- Representative of Hospital Information Systems
- A minimum of three physicians as approved by the MEC

Meeting and Reporting

The Council will meet at least quarterly and will report potential performance trends at the regularly scheduled meetings of the responsible oversight committees. Data on all indicators not showing trends will be reported to the responsible oversight committee chair prior to each regular meeting but not discussed at the oversight committee meetings unless the chair has a concern. Data showing outstanding performance may be presented at the discretion of the chair.

SECTION 10 Attachment I: Peer Review Rebuttal Process

Final determinations of the Multi-Specialty Quality Committee (MSQC) and/or the Multi-Specialty Quality Oversight Committee (MSQOC) are communicated in writing to the provider following completion of case review and discussion. In cases where a final determination of Care Controversial or Care Inappropriate is rendered, and the provider does not agree with that determination, the provider may contest the finding through a rebuttal process. The provider must request reconsideration of the final determination in writing to the MSQC Chair and/or the MSQOC Chair and provide supporting information as to why the case and/or final determination should be formally re-reviewed and/or re-considered.

The Chief Quality Officer, MSQOC Chair, MSQC Chair, and Peer Review Coordinator will meet to discuss the rebuttal request and basis for the reconsideration request. If the group determines that re-review of the case in light of new information would not change the final determination, the case is not formally re-reviewed and the provider is sent a letter noting the request for rebuttal and that the final determination will remain the same.

If the group determines that re-review of the case is necessary in light of new information, the case is reviewed, presented, and discussed at the next scheduled meeting of the MSQOC. The lead reviewer may be the initial MSQC reviewer and/or the MSQC Chair from the Committee in which the case was reviewed. In cases where conflict of interest or bias existed as a concern during the case review process, or are suggested as a concern by the provider, the MSQOC Chair may appoint a reviewer from the MSQOC membership. If a suitable reviewer cannot be appointed from the MSQOC membership, the MSQOC Chair reserves the right to appoint an ad hoc reviewer from the Institution who is a subject matter expert in the circumstances regarding the contested issues or concerns. This individual will attend the MSQOC as a non-voting member and must maintain confidentiality and peer review protection of the case and discussions per Connecticut Statute. If, following this review, the MSQOC determines that there is no change in final determination, the provider is sent a letter noting the request for rebuttal, the review discussed, and that the final determination will remain the unchanged.

In the event the MSQOC votes to overturn the existing final determination, a letter is sent to the provider noting the request for formal rebuttal and that the final determination has been formally changed. This letter and final determination supersedes the initial final determination and the new final determination will be updated in the peer review database and a copy of the letter will be kept on file in the provider's Quality file which is maintained through the Medical Staff Office.

Each provider subject to the Peer Review Process will be permitted only one rebuttal per case, therefore subsequent rebuttal requests on the same case will not be entertained. If the provider continues to contest the final determination and have concerns about the case's outcome, the Chief Quality Officer, MSQOC Chair, MSQC Chair, Peer Review Coordinator, and the President of the Medical Staff will meet to determine any other further measures, which may include external review on a case-by-case basis.