



**Trinity Health Mid-Atlantic St. Mary Medical Center**

**MEDICAL STAFF BYLAWS**

**Part I: Governance**

## Table of Contents

---

Section 1.	Medical Staff Purpose and Authority	1
Section 2.	Medical Staff Membership	5
Section 3.	Categories of the Medical Staff	10
Section 4.	Officers and At-Large Members of the Medical Staff	12
Section 5.	Medical Staff Organization	16
Section 6.	Committees	19
Section 7.	Medical Staff Meetings	26
Section 8.	Conflict Resolution	29
Section 9.	Review, Revision, Adoption, and Amendment	30

## **Section 1. Medical Staff Purpose and Authority**

---

### **1.1 Purpose**

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at Trinity Health Mid-Atlantic St. Mary Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the hospital Board of Directors. The purpose is also to initiate and maintain rules and regulations for self government of the medical staff and provide a means through which the Medical Staff actively and constructively may participate in the Medical Center's policy-making and planning processes.

### **1.2 Authority**

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules, regulations, and policies and under the corporate bylaws of St. Mary Medical Center. Henceforth, whenever the term "the hospital" is used, it shall mean St. Mary Medical Center; and whenever the term "the Board" is used, it shall mean the St. Mary Medical Center Board of Directors. Whenever the term "Hospital President" is used, it shall mean the person appointed by the Board to act on its behalf in the overall management of the hospital. The term Hospital President includes a duly appointed acting administrator serving when the Hospital President is away from the hospital.

### **1.3 Definitions**

"Advanced Practice Professional" or "APP" means those individuals eligible for privileges but not medical staff membership who provide a level of service including the evaluation and treatment of patients including documentation in the medical record and the prescribing of medications. Individuals in this category are, but not limited to, clinical psychologists, physician assistants (PAs), doctors of physician assistant studies (DPAS), advance practice registered nurses (APRNs), doctors of nursing practice (DNP), dieticians, RN First Assists and anesthesia assistants.

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

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

"Application" means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the *Medical Staff Bylaws*.

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

"Chief Medical Officer" or "CMO" is the individual appointed by the Hospital President to serve as a liaison between administration and the Medical Staff. This term is meant to include Chief Clinical Officers and is inclusive for the purposes of this document of both hospital level and regional positions. If there is no CMO, the Hospital President will serve in their stead or appoint a physician as the interim CMO in their stead.

“Clinical Assistant” means those individuals eligible for privileges but not medical staff membership who provide a limited scope of activity that require them to be privileged. Individuals in this category are, but not limited to, registered nurse first assistants (RNFAs) and scrub techs.

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

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

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

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

“Department Chair” means an Active Medical Staff Member who has been selected in accordance with these Bylaws and has the qualifications and responsibilities for Department Chair as outlined in Part I, Section 5.2 of these Bylaws.

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

“Executive Session” is a meeting of a Medical Executive Committee and departments, excluding administrators and invited guests, unless they or others are expressly requested by the members presiding at the meeting to attend. Executive Session may be called by the presiding member (chair or chair’s designee) at the request of any Medical Staff committee member, and shall be called by the presiding member pursuant to a duly adopted motion. Executive Session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

“Good Standing” means having no adverse actions, limitations, or restriction on privileges or medical staff membership at the time of inquiry based on a reason of competence or conduct.

“Governing Body”, “Board of Directors” or “Board” means the Board of Directors of St. Mary Medical Center.

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

“Hospital” means St. Mary Medical Center.

“Hospital Bylaws” mean those Bylaws established by the Board of Directors.

“Hospital President ” is the individual appointed by the Board of Directors to serve as the Board’s representative in the overall administration of the Hospital. The Hospital President may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

“Medical Staff” or “Staff” means an individual who is either a medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist who has obtained membership status and have been granted privileges that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

“Medical Staff leaders” shall mean the officers of the Medical Staff.

“Medical Staff Bylaws” means these Bylaws covering the operations of the Medical Staff of St. Mary Medical Center.

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

“Medical Staff Year” is defined as the 12-month time period beginning on January 1<sup>st</sup> of each year and ending December 31<sup>st</sup>.

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

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

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

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

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Pennsylvania or Delaware, as applicable.

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

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

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

“Quorum” means, unless specifically stated otherwise, the number of voting Medical Staff Members, but not fewer than 2 members, who must necessarily be present in order for the body to

transact business. Exceptions to this general definition of Quorum is referenced in Part 1, Section 7.4.

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

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

## **Section 2. Medical Staff Membership**

---

### **2.1 Nature of Medical Staff Membership**

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

### **2.2 Qualifications for Membership**

The qualifications for Medical Staff membership are delineated in Part III of these bylaws (Credentials Procedures Manual).

### **2.3 Nondiscrimination**

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

### **2.4 Conditions and Duration of Appointment**

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

### **2.5 Medical Staff Membership and Clinical Privileges**

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

### **2.6 Medical Staff Members Responsibilities**

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a practitioner with similar privileges at this Hospital that can care for the practitioner's patients when the practitioner is not available.

2.6.2 Each staff member and practitioner with privileges will participate in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be necessary.

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

- 2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by any of the Officers of the Medical Staff, CMO (local or regional), or CEO if no CMO, and/or their Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician/practitioner health or impairment.

Collaboration between officers of the medical staff and CMO is to take place in non-urgent conditions. If an urgent matter needs to be addressed, the officer of the medical staff, Department Chairman, or CMO may act timely, with notification to the others within 24 hours.

- 2.6.5 Each staff member and practitioner with privileges must abide by the Medical Staff bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital, including the Ethical and Religious Directives for Catholic Health Care Services.
- 2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the CMO (local or regional), or CEO if no CMO, or designee, within seven (7) days, of any and all filed malpractice claims or notices of intent to sue against the Medical Staff member or practitioner with privileges.
- 2.6.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/ her credentials.
- 2.6.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, Sections, or departments.
- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, APRN, Physician Assistant, or other qualified licensed individual in accordance with State law and hospital policy.
  - b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, APRN, PA, or other qualified licensed individual in accordance with State law and hospital policy.



- c. The content of a complete and focused history and physical examinations is delineated in the rules and regulations.
- 2.6.9 Each staff member and practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.
- 2.6.10 Each staff member and practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges.
- 2.6.11 Each Medical Staff leader shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical Staff leadership will deal with conflict of interest issues per the Trinity Health System Conflict of Interest policy.
- 2.6.12 Acceptance of a unified medical staff. If the Trinity Health Mid-Atlantic Board of Directors elects to have a unified medical staff, then the medical staff of each affected separately certified Hospital must vote, by majority, in accordance with medical staff Bylaws, whether to accept unification or remain a separate Medical Staff. Each Active member of the medical staff will be eligible to vote on the proposed unification via printed or secure electronic ballot in a manner determined by the MEC. All Active members of each medical staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by each medical staff if the vote is taken in which the proposed unification amendment receives a two-thirds (2/3rds) supermajority of Active staff casting ballots. As it relates to St. Mary Medical Center, the proposed unification shall be considered approved only if there is a two-thirds (2/3rds) supermajority of active staff members at St. Mary Medical Center casting ballots approving such proposal.
- 2.6.13 Opting out of a unified medical staff. Once there is a unified medical staff, the Active members at each Hospital in which the Members have clinical privileges, has the ability to vote to "opt out" of the unified medical staff. This would require a petition signed by ten percent (10%), but not less than two (2), of the members who would qualify for voting privileges at that Hospital. Upon presentation of such a petition, a medical staff meeting will be scheduled. Each Active member who would qualify for voting privileges at that Hospital will be eligible to vote on the proposed "opt out" proposal. Each Active member of the medical staff at each Hospital will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of each Hospital's medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by each Hospital's medical staff if the vote is taken in which the proposed opting out unification amendment receives a two-thirds (2/3rds) supermajority of Active staff casting ballots. As it relates to St. Mary Medical Center, the proposed unification shall be considered approved only if there is a two-thirds (2/3rds) supermajority of active staff members at St. Mary Medical Center casting ballots approving such proposal.

## **2.7 Medical Staff Member Rights**

2.7.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with their Department Chair or other appropriate Medical Staff leader(s), that practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

The President of the Medical Staff may request a meeting with the Board on matters that affect patient care or safety after efforts to resolve such matters with the Hospital President or CMO have failed.

2.7.2 Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Part I Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC exempting those policies mandated by Trinity Health of the Mid-Atlantic Region, law, professional or regulatory standards. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Part I Section 9.3 will be followed.

2.7.5 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by ten percent (10%) of the members of the Department, but in no case less than two (2). Upon presentation of such a petition the Department Chair will schedule a Department meeting.

2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these bylaws).

## **2.8 Staff Dues**

Annual dues, if any, shall be determined by the MEC. Failure of a member to pay dues by March 31 of each year shall be considered a voluntary resignation from the Medical Staff.

## **2.9 Indemnification**

2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and Medical Staff.

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

## **Section 3. Categories of the Medical Staff**

---

### **3.1 The Active Category**

#### **3.1.1 Qualifications**

Members of this category must have served on the Medical Staff and assigned to a specific department for two (2) years and be involved in either:

At least forty-eight (48) patient contacts per two (2) years (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic),

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, the member may be appointed to another Medical Staff category if they meet the eligibility requirements for such category.

#### **3.1.2 Prerogatives**

Members of this category may:

- a. Attend Medical Staff, Department, and Section meetings of which they are a member and any Medical Staff or hospital education programs;
- b. Vote on all matters presented by the Medical Staff, Department, Section, and committee(s) to which the member is assigned; and
- c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff bylaws or Medical Staff policies.

#### **3.1.3 Responsibilities**

Members of this category shall:

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

### **3.2 The Associate Category**

#### **3.2.1 Qualifications**

The Associate category is reserved for Medical Staff members in their first two (2) years on Staff or who do not meet the eligibility requirements for the Active category.

### 3.2.2 Prerogatives

Members of this category may:

- d. Attend Medical Staff, Department, and Section meetings of which they are a member and any Medical Staff or hospital education programs;
- e. Not vote on matters presented by the entire Medical Staff, Department, or Section or be an officer of the Medical Staff; and
- f. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

### 3.2.3 Responsibilities

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

## 3.3 Emeritus Recognition

Emeritus Recognition is restricted to those individuals recommended by the Credentials Committee and MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Emeritus Recognition shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned, or pay dues. Emeritus recognition does not require recredentialing.

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

---

### **4.1 Officers of the Medical Staff**

- 4.1.1 President of the Medical Staff
- 4.1.2 Vice President of the Medical Staff
- 4.1.3 Secretary of the Medical Staff
- 4.1.4 Treasurer of the Medical Staff

### **4.2 Qualifications of Officers**

- 4.2.1 Officers and MEC At-Large Members must be Members in good standing of the Active category, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, and be in compliance with the professional conduct policies of the hospital. Previous leadership experience either as a Department Chair, Section Chief, or membership on a medical staff committee is preferred, but not required. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.
- 4.2.2 Officers and MEC at-large members may not simultaneously hold a leadership position (position on the MEC or Board) on another hospital's medical staff or in a facility that is unaffiliated with Trinity Health Mid-Atlantic. Noncompliance with this requirement will result in the officer being automatically removed from office.

### **4.3 Election of Officers**

- 4.3.1 The Nominating Committee shall nominate at least one (1) candidate for each of the positions of Vice President of the Medical Staff, Secretary and Treasurer. Nominations must be announced, and the names of the nominees announced sixty (60) days prior to the election.
- 4.3.2 A petition signed by at least 20 Members of the Active staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office at least forty-five (45) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before they can be placed on the ballot.
- 4.3.3 Ballots will be mailed or delivered electronically to all Active Members at least thirty (30) days prior to the election. Elections shall take place by ballots, the manner of which will be determined by the MEC, and cast by Active Medical Staff Members and returned to the Medical Staff Office on or before the date specified by the MEC or cast in person at the annual meeting. The nominee(s) who receives a majority of votes cast will be elected. If there are three (3) or more candidates and no candidate receives a majority, there will be successive balloting, such that the candidate with the fewest votes is omitted from each successive slate until a majority is obtained by one candidate.
- 4.3.4 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position.

#### **4.4 Term of Office and Member At-Large Positions**

All officers serve a term of two (2) years. They shall take office on January 1<sup>st</sup> following their election. The Vice President of the Medical Staff automatically assumes the position of the President after completion of their term as Vice President. If there is no opponent, an officer may run again for the same position. Each officer shall serve in office until the end of their term of office or until a successor is appointed/elected or unless they resign sooner or are removed from office.

#### **4.5 Vacancies of Office or Member At-Large Positions**

Vacancies in office during the Medical Staff year, except for the President and Vice President of the Medical Staff, shall be filled by the MEC via appointment. If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term. With respect to the Vice President vacancy, the Nominating Committee shall meet and submit candidates for election at the next scheduled meeting of the medical staff and additional candidates may be nominated from the floor at that time and then an election will take place for the office.

#### **4.6 Duties of Officers**

**4.6.1 President of the Medical Staff:** The President of the Medical Staff shall represent the interests of the Medical Staff to the MEC and the Board. The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority of the President of the Medical Staff, or designee, are to:

- a. Call and preside at all general and special meetings of the Medical Staff;
- b. Serve as chair of the MEC and as ex officio member of all other Medical Staff standing committees without vote, and to participate as invited by the CMO (local or regional), or Hospital President if no CMO, or the Board on hospital or Board committees;
- c. Serve as the individual assigned the responsibility for the organization and conduct of the hospital's medical staff;
- d. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/hospital policies;
- e. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with hospital administration, appoint Medical Staff members to appropriate hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
- f. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
- g. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

- h. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;
- i. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;
- j. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;
- k. Attend Board meetings and Board committee meetings as invited by the Board;
- l. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and
- m. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff bylaws.

4.6.2 **Vice President of the Medical Staff:** The Vice President of the Medical Staff automatically assumes the position of the President after completion of the term of the President. In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. They shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time. The Vice President of the Medical Staff serves as chair of the Credentials Committee.

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

4.6.4 **Treasurer:** This officer will act as medical staff treasurer. They shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.6.5 **MEC At-Large Members:** These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.



#### **4.7 Removal and Resignation from Office or At-Large Member Position**

4.7.1 **Removal by Vote of the Medical Staff:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, and/or for conduct thought to be detrimental to the performance of his/her duties. The Medical Staff may initiate the removal of any officer if at least ten percent (10%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those Active staff members casting ballot/electronic votes. Removal from this office does not afford the practitioner Fair Hearing Rights pursuant to Part 2, Section 4.

4.7.2 **Removal by Vote of the Medical Executive Committee:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, and/ or conduct thought to be detrimental to the performance of his/her duties.. The Medical Executive Committee may initiate the removal of any officer if at least twenty percent (20%) of the MEC members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those MEC members casting ballot votes. Removal from this office does not afford the practitioner Fair Hearing Rights pursuant to Part 2, Section 4.

4.7.3 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications, as noted in Section 4.2.1, for being an Officer or MEC Member At-Large. This removal is not discretionary and is effectuated by the President of the Medical Staff.

4.7.4 **Resignation:** Any elected officer may resign at any time by giving thirty (30) days' written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

4.7.5 The immediate past president of the Medical Staff will be a member of the Medical Executive Committee for the two years immediately following expiration of his/her term as president. The immediate past president's duties are advisory in nature. The immediate past president has voting rights during the first year after his presidency and no voting rights in the second year after his presidency.

## **Section 5. Medical Staff Organization**

---

### **5.1 Organization of the Medical Staff**

- 5.1.1 The Medical Staff shall be organized into Departments. The Medical Staff may create Sections within a Department in order to facilitate Medical Staff activities. A list of Departments organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is part of the Rules and Regulations.
- 5.1.2 The MEC, with approval of the Board, may designate new Medical Staff Departments or Sections or dissolve current Departments or Sections as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging. Dissolution of a department is not grounds for a Fair Hearing pursuant to Part 2, Section 4.

### **5.2 Qualifications, Selection, Term, and Removal of Department Chairs and Section Chiefs**

- 5.2.1 Appointment or Election of Department Chairs and Section Chiefs
  - a. Qualifications for Department Chairs and Section Chiefs: All Chairs and Chiefs must be members of the Active Medical Staff, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. In addition, Department Chairs and Section Chiefs shall indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, and be in compliance with the professional conduct policies of the hospital. Department Chairs may not simultaneously hold a leadership position (any position in which the Member serves on the MEC or the Board) on another hospital's medical staff or in a facility that is unaffiliated with Trinity Health Mid-Atlantic. Noncompliance with these requirements will result in the Department Chair or Section Chief being automatically removed from office.
  - b. Appointment of Department Chairs of Contracted Services: Department Chairs are recommended by the Board and approved by the MEC
  - c. Election of Department Chairs Non-Contracted Services: Department Chairs shall be elected every two (2) years by those members of their department who are eligible to vote for general officers of the Medical Staff. Each department shall have a Nominating Committee, and shall offer one (1) or more candidates for each available position. Department Chairs will be elected by majority vote of the Active members of the Department, subject to ratification by the MEC and appointment by the Board. The election process will be the same as that for Officers of the Medical Staff other than voting shall be limited to the Active Members of the affected Department and there shall be no additional nominations made by petition. If the election results in a tie, the MEC will break the tie. Each Department Chair shall be elected to serve a term of two (2) years commencing on January 1<sup>st</sup> and may be elected to serve one (1) successive term if elected by a two-thirds (2/3rds) supermajority vote.

### 5.2.2 Removal of Department Chairs

- a. Appointed Department Chairs shall be removed by the authority that approved the selection.
- b. Removal of Elected Chairs by Vote of the Department: Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct thought to be detrimental to the performance of his/her duties. A request for removal by a petition signed by ten percent (10%) of the Active Members of the Department shall initiate the removal of any Chair. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active Department members casting ballot/electronic votes and approved by the MEC and the Board. Removal from this position does not afford the practitioner Fair Hearing Rights pursuant to Part 2, Section 4.
- c. Removal by Vote of the Medical Executive Committee: Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct thought to be detrimental to the performance of his/her duties. The Medical Executive Committee may initiate the removal of any Department Chair if at least twenty percent (20%) of the MEC members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those MEC members casting ballot votes and approved by MEC and the Board. Removal from this position does not afford the practitioner Fair Hearing Rights pursuant to Part 2, Section 4.
- d. Automatic Removal of elected Chairs: The Department Chair may be automatically removed from their position if they no longer meet the qualifications of the position as defined in these bylaws.
- e. If a Department Chair is removed through these processes, or a vacancy occurs for any other reason, an election shall be held within fourteen (14) days or at its next scheduled meeting, whichever is the shortest amount of time, to elect a new Chair who will preside through the remainder of the term for those positions that are elected. In the interim, the President of the Medical Staff shall appoint an interim Department Chair to serve until either the appointment, or election, of the new Department Chair occurs.

### 5.3 Responsibilities of Department Chair

- 5.3.1 To oversee all clinically-related activities of the Department;
- 5.3.2 To oversee all administratively-related activities of the Department, unless otherwise provided by the hospital;
- 5.3.3 To provide and/or coordinate ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted clinical privileges;
- 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;
- 5.3.5 To recommend clinical privileges, as appropriate, for each member of the Department and other licensed independent practitioners practicing with privileges within the scope of the Department;
- 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;

- 5.3.7 To integrate the Department into the primary functions of the hospital;
- 5.3.8 To coordinate and integrate interdepartmental and intradepartmental services and communication;
- 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;
- 5.3.10 To recommend to the CMO (local or regional), or interim CMO, sufficient numbers of qualified and competent persons to provide patient care and service;
- 5.3.11 To provide input to the CMO (local or regional), or interim CMO, regarding the qualifications and competence of Department or service personnel who are not licensed independent practitioners (LIPs) but provide patient care, treatment, and services;
- 5.3.12 To continually assess and improve of the quality of care, treatment, and services;
- 5.3.13 To maintain quality control programs as appropriate;
- 5.3.14 To participate in orientation and facilitate ongoing education of all persons in the Department; and
- 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.

#### **5.4 Department Vice Chairs**

Department Vice Chairs may be appointed by the Department Chair. There is no automatic succession from Department Vice Chair to Department Chairs. If the position of Department Chair becomes vacant, a new election will be held as soon as possible using the process noted in Part I Section 5.2.1.b.ii. Department Vice Chairs shall act in the temporary absence of the Department Chair and shall perform such other duties as assigned by the Department Chair.

#### **5.5 Section Chiefs**

Section Chiefs, if present, are appointed by the Department Chair. Sections Chiefs can be removed by action of the Department Chair. If the position of Section Chief becomes vacant, the Department Chair shall appoint a new Section Chief. Section Chiefs shall perform such duties as assigned by the Department Chair.

#### **5.6 Assignment to Department**

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

## **Section 6. Committees**

---

### **6.1 Designation and Substitution**

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations, and includes but is not limited to the Credentials, Pharmacy and Therapeutics, Infection Control, Medical Staff Bylaws and Nominating Committees. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

### **6.2 Medical Executive Committee (MEC)**

#### **6.2.1 Committee Membership:**

- a. **Composition - voting:** The Officers of the Medical Staff, the Department Chairs, the Chair of the Credentials Committee, and two (2) elected At-Large Members, one of which must represent general or specialty medicine and one of which must represent general or specialty surgery (whichever is not represented by the Department Chair). The chair will be the President of the Medical Staff.
  - i. A designee, such as a vice chair, can be used in the absence of the Department Chair in instances 1) when there is a short-term absence of the Department Chair and departmental representation is needed or 2) when there is a prolonged absence of the Department Chair.
- b. **Composition – nonvoting:** The non-voting attendees to the MEC shall consist of the Hospital President, Chief Medical Officer (CMO), the Chief Clinical Officer (CCO), the Chief Quality Officer (CQO), the Chief Nursing Officer (CNO), the Designated Institutional Official (DIO), and the Chief Medical Information Officer (CMIO), if applicable.
- c. **Removal from MEC:** A Medical Staff Officer or Department Chair who is removed from their position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose their membership on the MEC.

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

- a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws and provide oversight for all Medical Staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action;
- d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

- e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including educational efforts and investigations, when warranted;
  - f. Make recommendations to the Board on medical administrative and, as requested, on hospital management matters;
  - g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;
  - h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
  - i. Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups;
  - j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures;
  - k. Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner's ability to perform privileges requested or currently granted;
  - l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
  - m. Consult with administration on the quality, timeliness, and quality metrics of contracts for patient care services provided to the hospital by entities outside the hospital;
  - n. Assist with that portion of the corporate compliance plan that pertains to the Medical Staff;
  - o. Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;
  - p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws; and
  - q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.
- 6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

### **6.3 Credentials Committee**

Refer to Part III: Section 1.

### **6.4 Pharmacy and Therapeutics Committee**

6.4.1 Composition: Membership shall consist of at least five representatives of the Medical Staff and one each from the pharmacy service, the nursing service and from hospital management. The hospital pharmacist shall be a member of and act as secretary for the committee.

6.4.2 Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and other matters relating to drugs in the hospital. It shall also perform the following specific functions:

a. Drug utilization functions:

Develop and implement a systematic and ongoing criteria based mechanism to evaluate and continuously improve the appropriate and effective use of drugs. This is carried out in cooperation with nursing management, pharmacy and other services as appropriate. This process shall measure prescription or ordering of medications, preparation and dispensing, administration, and monitoring the medications' effects on patients

- b. Select drugs for evaluation based on the frequency of use, risk involved, known or suspected problems, drugs used for specific diagnosis, condition or procedure.
- c. Recommend to the Medical Executive Committee and appropriate clinical departments mechanisms to evaluate drugs and the criteria for evaluation and monitoring of drugs.
- d. Recommend actions and report individual and/or aggregate results of monitoring and evaluation activity to the Medical Executive Committee, clinical departments and Administrative departments as appropriate to be considered during privileging and performance appraisals.

6.4.3 Make recommendations concerning drugs to be stocked on the nursing floors and by other services.

6.4.4 Develop and review periodically a formulary or drug list for use in the hospital.

6.4.5 Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

6.4.6 Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

6.4.7 Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

6.4.8 Meetings: this committee should meet at least six times a year, shall maintain a record of its proceedings and activities, and shall report in writing to the Medical Executive Committee.

## **6.5 Infection Control Committee**

6.5.1 Composition: This committee shall consist of at least one representative from each clinical department and at least one each from Nursing Services, pathology services, hospital administration and the person(s) directly responsible for management of the surveillance, prevention and control program. Representation from remaining hospital department/services is available on a consultative basis.

6.5.2 Authority: The Infection Control Committee or its designee has the authority to institute any surveillance, prevention and control measure or study when there is reason to believe that any patient or personnel may be in danger of acquiring an infection.



6.5.3 Duties: The Infection Control Committee shall be responsible for the type and scope of surveillance activities, review and analysis of actual infections, promotion of preventative and corrective programs designed to minimize infection hazard and supervision of infection control in all phases of the hospital's activities including inpatient care areas, outpatient services, diagnostic or specialized care areas including surgical anesthesia services and support services.

I

6.5.4 Meetings: The committee shall meet no less than six times yearly, shall maintain a record of its proceedings and activities, forward written reports of its meetings to the Medical Executive Committee, Chief Executive Officer, Nurse Executive, and persons responsible for hospital-wide quality assessment and improvement activities.

## **6.6 Invasive Procedure Review Committee**

The Invasive Procedure Review Committee is delegated by the Medical Staff to conduct and oversee review of Surgical and other invasive procedures to improve the selection and performance of surgical and other invasive procedures and to improve the appropriateness and effectiveness with which blood and blood components are used.

6.6.1 Composition: Committee membership consists of at least one physician from each clinical department, a physician from the department of Pathology, Administrative Representative and representative from the Quality Management Services Department.

6.6.2 The Chairperson is appointed by the President of the Medical Staff who will be responsible for directing the committee activities and acting upon committee recommendations.

6.6.3 Duties: The committee function includes, but is not limited to:

- a. Developing and implementing an ongoing, systematic program for evaluating the appropriateness and effectiveness of performing surgical and other invasive procedures. This includes review of specimens removed during a surgical or other invasive procedure, the agreement or disagreement of preoperative and pathologic diagnosis and infractions of the directives for Catholic hospitals.
- b. Developing and implementing an ongoing systematic review process for blood, blood components and autologous transfusion in order to improve the appropriateness and effectiveness of its use. The processes measured include ordering practices, distributing, handling and dispensing blood and blood products; administration of blood and blood products; monitoring the blood and blood components' effects on patients;
- c. Develop and recommending screening criteria or indications to identify single cases or patterns of cases requiring more intensive evaluation.

6.6.4 Meetings: The Committee shall meet monthly and report results of these activities to appropriate clinical departments and the Medical Executive Committee.

## **6.7 Cancer Committee**

The Cancer Committee is responsible for planning, initiating, stimulating and assessing cancer related activities in the hospital.



6.7.1 **Composition:** The Cancer Committee is an interdisciplinary standing committee consisting of board certified physicians from all medical specialties involved in the care of patients with cancer. Members shall include, but not be limited to, representatives from surgery, internal medicine, dermatology, gynecology, medical oncology, pediatrics, diagnostic and therapeutic radiology, pathology and family practice. The committee must also include members from administration, nursing, quality management, social service, rehabilitation, pharmacy, dietary and medical records, including cancer registry.

6.7.2 **Duties:** Required duties include but are not limited to:

- a. Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.
- b. Ensure that educational and consultative cancer conferences cover all major sites and related issues.
- c. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
- d. Promote clinical research.
- e. Supervise cancer registry and ensure accurate and timely abstracting staging, and follow-up reporting
- f. Perform quality control of registry data.
- g. Encourage data usage and regular reporting.
- h. Ensure that the content of the annual report meets mandated requirements.
- i. Publish the annual report.
- j. Uphold medical and ethical standards.
- k. Report its proceedings and actions to the Medical Executive Committee.

## **6.8 Medical Staff Bylaws Committee Composition:**

6.8.1 **Composition:** The Bylaws Committee of the Medical Staff shall consist of members appointed by the President of the Medical Staff.

6.8.2 **Meetings:** They shall meet as often as needed to process recommended changes to the Bylaws and Rules and Regulations of the Medical Staff. The Bylaws Committee shall also review the Medical Staff Bylaws, Rules and Regulations and policies, the Bylaws of the Board of Directors and hospital policies periodically to ensure compatibility with each other and compliance with law and regulation. Amendments shall be processed as described in Part I, Section 9 of these Bylaws. A report of the Bylaws Committee's activities shall go to the Medical Executive Committee.

## **6.9 Nominating Committee**

6.9.1 **Composition:** The Nominating Committee shall consist of at least seven members of the active staff; the President of the staff as Chairman, the most recent Past President of the staff if available, the President-Elect, and at least four active members of the staff appointed by the President of the staff. Members of the Nominating Committee may not be nominated for Medical Staff office while serving on the Committee.

6.9.2 Duties: The Nominating Committee shall:

- a. Announce to the staff at least 75 days prior to elections that the Committee is considering nominations. The Staff is invited to submit names at this time.
- b. Submit to the Medical Staff Office the names of one or more qualified nominees for each office to be filled by election, as well as for vacancies to the Executive Committee.
- c. Obtain an appropriate commitment from the candidate in writing.
- d. Report such nominees to the staff in writing at least forty-five (45) days prior to the annual meeting.
- e. Also be prepared to submit substitute nominees should all the candidates be unable to accept the nomination pursuant to Part I, Sections 4 and 5.

## **6.10 PEER REVIEW ACTIVITIES AND PROTECTIONS**

All credentialing, peer review, and quality and patient safety activities pursuant to these Bylaws and related Medical Staff policies shall be performed by "Peer Review Committees" in accordance with Pennsylvania law.

-1- Peer review committees include, but are not limited to:

-Standing and ad hoc Medical Staff and Hospital committees engaged in peer review/quality oversight activity;

-the Board and committees of the Board when engaged in peer review/quality oversight;

-Medical Staff and hospital departments when engaged in peer review activities

- In addition, individuals acting for or on behalf of any such entity, including but not limited to department chairs, committee chairs and members, officers of the Medical Staff involved in peer review and experts or consultants retained to assist in peer review activities are considered to be part of a Peer review committee

and

-any ad hoc committees reviewing the quality or safety of patient care and/or a practitioner's medical practice or professional conduct

-All reports, recommendations actions, and minutes made or taken by peer review committees are confidential, privileged pursuant to the Pennsylvania peer review privilege, and may constitute Patient Safety Work Product, subject to the privilege under the Patient Safety and Quality Improvement Act of 2005.

2.-All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act.

## **6.11 MULTISPECIALTY PEER REVIEW COMMITTEE (MSPRC)**

The Multispecialty Peer Review Committee (MSPRC) shall consist of voting members appointed by the President of the Medical Staff for terms consistent with the policy. Only Medical Staff members will be allowed to vote. The Chair of the Peer Review Committee will be appointed by the President of the Medical Staff and the chair should not be the President of the Medical Staff.

The duties of the Peer Review Committee shall be:

A. To review aspects of the quality of care rendered in the Hospital, and any other duties assigned by the President of the Medical Staff, the MEC, or pursuant to the Performance Improvement or Utilization Review Plans approved by the Medical Staff and the Governing Body; and

B. To oversee efforts to meet the Joint Commission Standards in order to maintain and improve the accreditation status of the Hospital.

The Multispecialty Peer Review Committee shall meet at least ten (10) times per year and report its activities to the MEC and any Clinical Departments or Committees as appropriate.

## **Section 7. Medical Staff Meetings**

---

### **7.1 Medical Staff Meetings**

- 7.1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members.
- 7.1.2 The action of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these bylaws. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.
- 7.1.3 Special Meetings of the Medical Staff
  - a. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC, or by a petition signed by ten percent (10%) of the Active Medical Staff. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.
  - b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

### **7.2 Regular Meetings of Medical Staff Committees and Departments**

Committees, Departments, and Sections may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments, Sections, and committees shall meet at least annually, unless otherwise stipulated in these bylaws or no less frequently as may be required by state law. Attendance at meeting may be by physical presence or by secure videoconferencing. Telephonic participation is permitted when confidential items are discussed only when confidentiality is assured.

### **7.3 Special Meetings of Committees and Departments**

A special meeting of any committee, Department, or Section may be called by the committee chair or Chair or of the Department/Section thereof or by the President of the Medical Staff. The committees also retain the right to call an Executive Session.

### **7.4 Quorum**

- 7.4.1 Medical Staff Meetings: Those present (in person, or via video/telephonically) and eligible Active Medical Staff members voting on an issue.
- 7.4.2 MEC, Bylaws Committee, Credentials Committee, and Multidisciplinary Peer Review Committee : A quorum will exist when fifty percent (50%) of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least two (2) members.
- 7.4.3 Department or Section meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible Active Medical Staff members voting on an issue.

## **7.5 Attendance Requirements**

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

a. Committee attendance:

- i. MEC: Members of this committee are expected to attend at least two-thirds (2/3rds) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee.
- ii. Credentials Committee, Bylaws Committee and Multi-Specialty Peer Review Committee meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee.
- iii. All other committees: Attendance is encouraged.

## **7.6 Participation by the Hospital President and the CMO**

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

## **7.7 Robert's Rules of Order**

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, and it does not conflict with these Bylaws, the latest abridged edition of Robert's Rules of Order shall determine procedure.

## **7.8 Notice of Meetings**

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

## **7.9 Action of Committee or Department**

Unless otherwise specified in these Bylaws, the recommendation of a majority of its Active members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.

## **7.10 Rights of Ex Officio Members**

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

### **7.11 Minutes**

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

## **Section 8. Conflict Resolution**

---

### **8.1 Conflict Resolution**

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

If deemed appropriate by the President of the Medical Staff, and Chair of the Board, and the Hospital President, an agreed upon outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

## **Section 9. Review, Revision, Adoption, and Amendment**

---

### **9.1 Medical Staff Responsibility**

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

### **9.2 Methods of Adoption and Amendment to these Bylaws**

- 9.2.1 Proposed amendments to these bylaws may be originated by the MEC, through the Bylaws Committee, or by a petition signed by ten percent (10%) of the members of the Active category.

These Bylaws shall be reviewed at least biennially and may be amended or changed with a proposed amendment or change from the MEC or any other standing committee of the Medical Staff, administration, or from any Active Staff Meeting and then be referred to the Bylaws Committee for discussion.

After review and formulation by the Bylaws Committee, these amendments shall be reviewed by the MEC and then presented at the next regular or special meeting of the Medical Staff.

Each Active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff when the amendment receives a two-thirds (2/3rds) supermajority of the ballots cast.

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

Proposed amendments to these bylaws by any Medical Staff within the Trinity Health Mid-Atlantic region should be shared with all Medical Staffs within the region at least 20 days prior to the submission of the proposed changes to the SMMC Medical Staff in an effort to see if a common amendment could be proposed at all hospitals within the region. After 20 days, the approval process for SMMC will be timely followed pursuant to this section.

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

- 9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
- 9.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.



- 9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.
- 9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by ten percent (10%) of the members of the Active category using the Conflict Resolution Mechanism noted in Part I Section 8.1.3. Upon presentation of such petition, the adoption process outlined in Part I Section 9.2.1 above will be followed.
- 9.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with state and/or federal 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.
- 9.3.6 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or non substantive legal modifications, or clarifications. Such modifications will be limited to reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations.

**Trinity Health Mid-Atlantic St. Mary Medical Center**

**MEDICAL STAFF BYLAWS**

---

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

## **Table of Contents**

---

Section 1.	Educational and/or Informal Proceedings	1
Section 2.	Investigations	2
Section 3.	Corrective Action	4
Section 4.	Initiation and Notice of Hearing	9
Section 5.	Hearing Committee and Presiding Officer or Hearing Officer	12
Section 6.	Pre-Hearing and Hearing Procedure	14
Section 7.	Appeal to the Hospital Board	19

## **Section 1. Educational and/or Informal Proceedings**

---

### **1.1 Criteria for Initiation**

Medical Staff leaders and hospital management must work together to share information and to use progressive steps, beginning with education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All educational intervention efforts by Medical Staff leaders and hospital management, including the CMO, shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Educational intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. As appropriate and in accordance with the Peer Review Policies, Medical Staff leaders are to be made aware of the concerns and actions taken. When observations arise suggesting opportunities for a practitioner to improve their clinical skills or professional behavior, which could include, but is not limited to, review of records, independent review, and/or referring the matter for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Educational intervention efforts may include but are not limited to the following:

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

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

## **Section 2. Investigations**

---

### **2.1 Initiation**

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

### **2.2 Investigation**

If the MEC decides that an investigation is warranted based on the specific activities giving rise to the inquiry, it shall direct an investigation to be undertaken through the adoption of a formal resolution by the MEC. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation. The affected practitioner will also be advised promptly that an investigation has been started.

In situations where a Department Chair or the MEC has reasonable cause to believe that a member's issues pertain to a physical health, mental health or an addiction issue, the SMMC Impaired Practitioner Policy and Procedure will be followed.

The MEC shall assign the task to an appropriate standing or ad hoc committee of the Medical Staff. Members of this ad hoc committee should not include direct competitors of the affected practitioner or partners or associates of the affected practitioner.

The committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CMO (local or regional). 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 investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The practitioner may also request to review relevant patient records and or reports prepared by an independent reviewer related to the practitioner's patient care.

The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant may be considered when:

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

### **2.3 MEC Action**

If the recommendation of the ad hoc committee includes a recommendation of reduction, suspension or termination of privileges, the MEC shall give the affected practitioner an opportunity to appear before the MEC, prior to the MEC taking its action.

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

- a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;
- b. Deferring action for a reasonable time when circumstances warrant;
- c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;
- d. Recommending the imposition of terms of probation or a special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;
- f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff membership; or
- h. Taking other actions deemed appropriate under the circumstances.

Subparagraphs 2.3 d, e, f, g and h may require a report of an adverse action to the National Practitioner Data Bank.

If there is a recommendation that does not impair the practitioner's privileges (2.3 a-c), the practitioner will be advised of the MEC's recommendation, with a notation that such recommendation is not final and needs to be acted upon by the Board.

### **2.4 Subsequent Action**

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

## Section 3. Corrective Action

---

### 3.1 Automatic Suspension and/or Relinquishment

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered suspended or relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff with the approval of the CMO, may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within **sixty (60) days**, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

#### 3.1.1 Licensure

- a. **Revocation and suspension:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
- b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

- 3.1.2 **Medicare, Medicaid, Tricare or other federal programs:** Whenever a practitioner is excluded, precluded, or barred from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

### 3.1.3 **Controlled Substances**

- a. **DEA Certificate or CSR in Delaware, as applicable:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or Controlled Substance Registration (CSR) in Delaware, as applicable, 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 Controlled Substance Registration (CSR) in Delaware, as applicable, is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

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

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

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues by March 31 of each year shall be considered a voluntary resignation from the Medical Staff. Failure to pay any special assessment shall be considered an automatic suspension of a practitioner's appointment and privileges. If within sixty (60) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership and privileges on the Medical Staff.

### 3.1.7 **Felony Convictions:**

A practitioner who has been convicted of, or entered a plea of "guilty" or "no contest" involving any of the following: professional practice, controlled substance, illegal drugs, or violence, abuse (physical, sexual, child, or elder ) of another person, insurance or Medicare, Medicaid or healthcare fraud or abuse, in any jurisdiction may be suspended by the President of the Medical staff or his designee. Such suspension shall remain in effect until the matter is reviewed by subsequent action of the MEC, who shall make its recommendation to the Board, which could include relinquishment of the affected practitioner's Medical Staff membership and privileges.



- 3.1.8 **Failure to Satisfy the Special Appearance Requirement:** Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable Department Chair or Medical Staff committee chair or CMO may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting twice, unless excused by the MEC for an adequate reason, will result in a suspension of the practitioner's membership and privileges or other corrective action pursuant to these Bylaws as deemed appropriate by the MEC. In any case, the appearance must occur within 60 days of the MEC's first request. Such suspension would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.
- 3.1.9 **Failure to Participate in an Evaluation:** A practitioner who fails to participate in an evaluation of their qualifications for Medical Staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills) and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.
- 3.1.10 **Failure to Fulfill Mandatory Health Requirements:** A practitioner who fails to be compliant with the Trinity Hospital policy on required testing (i.e., Tb testing) or required vaccinations/immunizations shall be automatically suspended until compliance is noted. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation from the Medical Staff, unless an exemption is approved.
- 3.1.11 **Failure to Become Board Certified:** A practitioner who fails to become board certified, which can include certification through the American Board of Medical Specialists (ABMS) or the National Board of Physicians and Surgeons (NBPAS), a recertification board, in compliance with these bylaws or Medical Staff credentialing policies, will be deemed to be ineligible for reappointment, unless a prior exception was given.
- 3.1.12 **Failure to Board Recertify:** A practitioner who fails to maintain their primary area of practice board certification or recertification with NBPAS, will be deemed to be ineligible for reappointment unless an exception, for a period of up to two (2) years for extenuating circumstances, is granted by the Board upon recommendation from the MEC.
- 3.1.13 **Failure to Execute Release and/or Provide Documents:** A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have all privileges automatically suspended. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic suspension, the practitioner may be reinstated. After sixty (60) calendar days, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

- 3.1.14 **Suspension at a Trinity Hospital Within the Region:** A practitioner who is suspended at another Trinity Hospital within the Region, with the exception of suspensions due to medical records violations or the payment of dues, shall be considered to have all privileges at this Hospital automatically suspended. If the suspension is terminated at the other Trinity Hospital in the Region, the suspension will be automatically rescinded at this Hospital.
- 3.1.15 Involuntary limitation, reduction, or loss of clinical privileges at another hospital, with the exception of suspensions due to medical records violations or the payment of dues, shall be reported in writing by the practitioner to the Credentials Committee within 45 days. Upon notification, a credentials review, as deemed appropriate by the Credentials Committee, will begin.
- 3.1.16 **Involuntary Termination at a Trinity Hospital:** A practitioner who is involuntarily terminated at another Trinity Hospital shall result in automatic termination at this Hospital.
- 3.1.17 **Loss of supervising/collaborating physician for Advanced Practice Professionals:** If an APP loses their relationship with a supervising/collaborating physician on staff at this Hospital, then the APP is automatically suspended until the APP develops a new supervision/collaboration relationship with another Member of the Medical Staff. If another supervising/collaborating relationship is not developed within sixty (60) days, then the APP automatically relinquished their privileges.
- 3.1.18 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

### **3.2 Precautionary Restriction or Suspension**

- 3.2.1 **Criteria for Initiation:** Some or all of a medical staff member's clinical privileges may be precautionarily restricted or suspended when a good faith belief exists that the failure to take such action may result in a danger to the health and safety of any individual or may seriously interfere with the orderly operations of the hospital. Such action shall be deemed an interim precautionary step in the professional review activity that will be taken with respect to the suspended physician but is not a complete professional review action in and of itself, shall not indicate the truth of the charges. The following persons are authorized by the Medical Staff to make a request for Precautionary Restriction or Suspension: the Chairperson of the Practitioner's Department, the Chair of the MEC, the CMO, the Hospital President or a member of the Board. In order for initiation of this action there must be an agreement of the President of the Medical Staff and the CMO. If there is a dispute over whether the practitioner should be summarily suspended, the Chairperson of the Practitioner's department or the Vice President of the Medical Staff shall make the decision.
- 3.2.2 A suspension 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.

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

Unless otherwise indicated by the terms of the precautionary restriction 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.

If the suspension and or a restriction of certain privileges lasts longer than 30 days, a report must be made to the National Practitioner Data Bank. (42 U.S.C. § 11133(a)(1)(a).) It shall not imply any final finding of responsibility for the situation that caused the suspension, and shall be grounds for initiation of a hearing. In the alternative, prior to suspension being entered, the Medical Executive committee may afford the affected member an opportunity to voluntarily refrain from exercising privileges pending the investigation.

- 3.2.3 **MEC Action:** As soon as feasible and within fourteen (14) calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary, begin the investigation process as noted in Section 2.2 above. Upon request by the practitioner 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 a hearing and appeal apply. The practitioner is not entitled to legal representation at this meeting. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.
- 3.2.4 **Procedural Rights:** Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member or other physician or dentist with privileges without membership (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

## **Section 4. Initiation and Notice of Hearing**

---

### **4.1 Initiation of Hearing**

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following “adverse 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, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;
- d. Involuntary reduction or revocation of clinical privileges;
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than fourteen (14) calendar days; or
- f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member’s failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

### **4.2 Hearings Will Not Be Triggered by the Following Actions**

- a. Issuance of a letter of guidance, warning, or reprimand;
- b. 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;
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or privileges;
- g. Imposition of a precautionary suspension that does not exceed fourteen (14) calendar days;
- h. Denial of a request for leave of absence, or for an extension of a leave;
- i. Determination that an application is incomplete or untimely;
- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;
- l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

- m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;
- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of any contract with or employment by hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed, prior to escalation to the MEC, in order to fulfill any accreditation standards on focused professional practice evaluation;
- r. Any recommendation voluntarily accepted by the practitioner
- s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- t. Change in assigned staff category;
- u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges after a final adverse decision at any hospital within the Trinity Health System regarding such request;
- v. Removal or limitations of emergency department call obligations;
- w. Any requirement to complete an educational assessment;
- x. Retrospective chart review;
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;
- z. Grant of conditional appointment or appointment for a limited duration; or
- aa. Appointment or reappointment for duration of less than 24 months.

#### **4.3 Notice of Recommendation of Adverse Action**

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the President of the Medical Staff with assistance from the CMO/Medical Staff Office delivered either 1) in person, 2) by certified mail, return receipt requested, or 3) by overnight delivery with delivery confirmation and also by email with a confirmed delivery receipt. 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; and

- d. The individual shall receive a copy of Part II of these bylaws outlining procedural rights with regard to the hearing.

#### **4.4 Request for Hearing**

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the President of the Medical Staff CMO/Medical Staff Office, or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action.

#### **4.5 Notice of Hearing and Statement of Reasons**

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

- a. The time, place, and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;
- c. The names of the Hearing Committee members and Presiding Officer or Hearing Officer, if known; and
- d. A statement of the specific reasons for the recommendation 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 the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

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

#### **4.6 Witness List**

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



## **Section 5. Hearing Committee and Presiding Officer or Hearing Officer**

---

### **5.1 Hearing Committee**

- a. When a hearing is requested, a Hearing Committee of not fewer than three (3) individuals will be appointed. This panel will be appointed by the President of the Medical Staff in conjunction with the CMO. No individual appointed to the Hearing Committee shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Committee. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the Hearing Committee. Panel members need not be clinicians in the same specialty as the member requesting the hearing, although, if feasible, one member of the Committee can have the same healing arts qualifications as the Affected Practitioner, (i.e. Surgery). If necessary in limited situations, appointees to the Committee may be a practitioner who is not a member of the Medical Staff.
- b. The Hearing Committee shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the Presiding Officer.
- c. The President of the Medical Staff, with cooperation from the CMO/Medical Staff Office, 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 Committee or to the Hearing Officer or Presiding Officer shall be made in writing to the MEC and CMO/Medical Staff Office. The President of the Medical Staff, in conjunction with the CMO, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, they are not entitled to veto that member's participation. Final authority to appoint panel members will rest with the President of the Medical Staff in conjunction with the CMO
- d. Once nominated to serve on the Committee and continuing thereafter through the course of the hearing and deliberation, the hearing officer and members of the Committee shall not engage in any ex parte discussions with any of the parties to the hearing. Violation of this provision shall be grounds for disqualification of the hearing officer or committee member and sanctions.

### **5.2 Hearing Committee Chairperson or Presiding Officer**

- 5.2.1 In lieu of a Hearing Committee chair, the President of the Medical Staff in conjunction with the CMO, after considering the recommendations of the chair of the Board, if the hearing is occasioned by a Board determination, may appoint an attorney at law or other individual experienced in legal proceedings as a Presiding Officer. The Presiding Officer should have no previous relationship with either the hospital (other than in the capacity of a Presiding Officer), organized Medical Staff, or the practitioner. Such Presiding Officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Committee and may serve in an advisory capacity only, and shall not be entitled to vote on the Hearing Committee's recommendation. The services of the Presiding Officer will be paid for by the Hospital.

- 5.2.2 If no Presiding Officer has been appointed, the President of the Medical Staff in conjunction with the CMO will appoint someone from the Committee to serve as the chair of the Hearing Committee and shall be entitled to one vote.
- 5.2.3 The Presiding Officer or Hearing Committee chair shall do the following:
- a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
  - b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;
  - c. Maintain decorum throughout the hearing;
  - d. Determine the order of procedure throughout the hearing;
  - e. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
  - f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Committee in formulating its recommendations;
  - g. Conduct argument by counsel on procedural points and may do so outside the presence of the Hearing Committee; and
  - h. Seek legal counsel when they feel it is appropriate. Legal counsel to the hospital may advise the Presiding Officer or Hearing Committee chair on procedural issues only and will not address the substantive issues related to the hearing.

### **5.3 Hearing Officer**

5.3.1 As an alternative to the Hearing Committee described above, the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) and the CMO, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer may be an attorney in non-clinical matters. Any objection to the Hearing Officer related to a conflict of interest must be made in writing to the MEC and CMO/Medical Staff Office. The President of the Medical Staff shall determine whether a replacement Hearing Officer should be identified. The services of the Hearing Officer will be paid by the hospital.

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



## **Section 6. Pre-Hearing and Hearing Procedure**

---

### **6.1 Provision of Relevant Information**

- 6.1.1 There is no right to formal “discovery” in connection with the hearing. The Presiding Officer, Hearing Committee chair, or Hearing Officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual’s counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:
- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons;
  - b. Reports of experts relied upon by the MEC;
  - c. Copies of redacted relevant committee minutes;
  - d. Copies of any other documents relied upon by the MEC or the Board;
  - e. No information regarding other practitioners shall be requested, provided, or considered; and
  - f. Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges shall be excluded.
- 6.1.2 Prior to the hearing, on dates set by the Presiding Officer, Hearing Committee 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 prior to the hearing. The Presiding Officer, Hearing Committee chair, or Hearing Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

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

## **6.2 Pre-Hearing Conference**

The Presiding Officer, Hearing Committee Chair/Presiding Officer 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 Committee Chair/Presiding Officer 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. The appropriate role of attorneys will be decided at the pre-hearing conference.

## **6.3 Failure to Appear**

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

## **6.4 Record of Hearing**

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

## **6.5 Rights of the Practitioner and the Hospital**

- 6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer, Hearing Committee Chair or Hearing 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. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
  - e. To submit a written statement at the close of the hearing.

- 6.5.2 Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.
- 6.5.3 The Hearing Committee may question the witnesses, call additional witnesses or request additional documentary evidence.

## **6.6 Admissibility of Evidence**

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

## **6.7 Burden of Proof**

It is the burden of the MEC (or Board of Directors) to demonstrate by a preponderance of the evidence that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate by a preponderance of the evidence that they satisfy, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully comply with all Medical Staff and hospital policies and that the adverse recommendation lacks any factual basis or that the conclusions drawn therefrom are arbitrary, unreasonable, or capricious.

## **6.8 Post-Hearing Memoranda**

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

## **6.9 Official Notice**

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

## **6.10 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 Committee Chair, Hearing Officer or the Hospital President on a showing of good cause. The hearing shall not proceed unless all hearing panel members are present .

## **6.11 Persons to be Present**

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Medical Staff. All members of the Hearing Committee shall be present in person, absent good cause, for all stages of the hearing and deliberations. Remote attendance at the hearing will only be considered if there are demonstrated extenuating circumstances. The Hearing Committee Chair and/or Presiding Officer will make the determination whether extenuating circumstances exist.

## **6.12 Order of Presentation**

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

## **6.13 Adjournment and Conclusion**

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

## **6.14 Deliberations and Recommendation of the Hearing Committee**

Within twenty (20) calendar days after final adjournment of the hearing, the Hearing Committee shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation. The recommendation of the Hearing Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

## **6.15 Basis of Recommendation**

The decision of the Hearing Committee shall be based on the evidence produced at the hearing.

This evidence may contain the following:

- a. Oral testimony of witnesses;
- b. Written statements presented in connection with the hearing;
- c. Any material contained in the documentary evidence, including, without limitation, medical records, regarding the Practitioner so long as this material has been admitted into evidence at the hearing and the Practitioner had the opportunity to comment on and, by other evidence, refute it;
- d. Any and all applications, references, and accompanying documents;
- e. All officially noticed matters; and
- f. Any other admissible evidence.

## **6.16 Disposition of Hearing Committee Report**

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

## **Section 7. Appeal to the Hospital Board**

---

### **7.1 Time for Appeal**

Within twenty (20) calendar days after the Hearing Committee makes a recommendation, or after the MEC or Board makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and shall be delivered to the CMO/Medical Staff Office 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, both parties shall be deemed to have accepted the recommendation involved, and the Hearing Committee's report and recommendation shall be forwarded to the Board.

### **7.2 Grounds for Appeal**

The grounds for appeal shall be limited to the following:

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

### **7.3 Time, Place, and Notice**

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

### **7.4 Nature of Appellate Review**

- a. The Chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the Hearing Committee or Hearing Officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Pennsylvania or Delaware, as applicable.

- 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 minute) oral argument. The review panel shall recommend final action to the Board.
- d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

#### **7.5 Final Decision of the Hospital Board**

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

#### **7.6 Right to One Appeal Only**

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that an applicant/appointee resigns while under investigation or in lieu of performing an investigation or the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may never apply for Medical Staff appointment or for those clinical privileges at this or another Trinity Health System hospital unless the Board advises otherwise.

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

APPs and Clinical Assistants are not entitled to the hearing and appeals procedures set forth in the medical staff Bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect their exercise of clinical privileges, the practitioner and their supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The practitioner and the supervising physician, if applicable, must request such a meeting in writing to the Hospital President within ten (10) business days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician, if applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the medical staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board.

The practitioner and the supervising physician, if applicable, may request an appeal in writing to the Hospital President within ten (10) days of receipt of the findings of the review body. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the medical staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the practitioner, they will not be allowed to reapply for privileges.

#### **7.8 Reporting Requirements**

The CMO or their designee, shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist 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. The hospital is responsible to report to the NPDB any and all revisions to the initial NPDB report and/or satisfaction of conditions imposed.





**Trinity Health Mid-Atlantic St. Mary Medical Center**

**MEDICAL STAFF BYLAWS**

---

**Part III: Credentials Procedures Manual**

May 17, 2023

## **Table of Contents**

---

Section 1.	Medical Staff Credentials Committee	1
Section 2.	Qualifications for Membership and/or Privileges	3
Section 3.	Initial Appointment Procedure	6
Section 4.	Reappointment	14
Section 5.	Clinical Privileges	16
Section 6.	Clinical Competency Evaluation	21
Section 7.	Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies	22
Section 8.	Leave of Absence	23
Section 9.	Practitioners Providing Contracted Services	25
Section 10.	Medical Administrative Officers	26

## **Section 1. Medical Staff Credentials Committee**

---

### **1.1 Composition**

The composition of the Credentials Committee is noted in the Rules and Regulations.

### **1.2 Meetings**

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or President of the Medical Staff. In any instance where a member of the Credentials Committee has a conflict of interest in any matter involving an applicant or member of the Staff which comes before the Credentials Committee, that member shall not participate in the voting on the matter and shall excuse himself or herself from the meeting during that time at the request of a majority of the Credentials Committee, although he may be asked and answer any questions concerning the matter before leaving.

#### **Responsibilities**

- 1.2.1 To review and recommend action following a thorough assessment and interview of applicants as may be necessary, in order to evaluate the professional practice information on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;
- 1.2.2 To review and recommend action on all requests regarding privileges from eligible practitioners. The Credentials Committee may in its discretion consider a request for a waiver regarding board certification or exception in unusual circumstances. The individual requesting the waiver or exception bears the burden of demonstrating the circumstances and why the request should be granted.;
- 1.2.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges;
- 1.2.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;
- 1.2.5 To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendation from the departments in which such applicant requests privileges
- 1.2.6 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or hospital leaders;
- 1.2.7 To perform such other functions as requested by the MEC.

### **1.3 Confidentiality**

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

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

Only upon written request approved by the President of the Medical Staff, Hospital President, credentials chair or Chief Medical Officer (CMO). Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference and other verifications responses 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 by the practitioner. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner; no photographs may be taken. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

## **Section 2. Qualifications for Membership and/or Privileges**

---

- 2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, contract with the hospital or an existing medical practice group at St. Mary's or privileges at any other healthcare organization.**
- 2.2 The following qualifications are to be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges unless a waiver or exception is previously granted:**
- 2.2.1 Demonstrate that they have successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, advanced practice nursing, physician assistant program, dietetics, or applicable recognized course of training in a clinical profession eligible to hold privileges;
  - 2.2.2 Have a current state or federal license, that is not actively suspended, as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Pennsylvania or Delaware, as applicable. The license must be unrestricted for initial appointment unless an exception is granted.;
  - 2.2.3 Have a record that is free from current Medicare/Medicaid exclusions/preclusions and not be on the OIG List of Excluded Individuals/Entities;
  - 2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony, relating to the death or injury of another person, insurance or health care fraud or abuse, violence, or abuse (physical, sexual, child or elder) in any jurisdiction in the past ten (10) years); and
  - 2.2.5 Have a record that shows the applicant has not been convicted of or entered a plea of guilty or not contest to any felony, relating to alcohol, controlled substances, illegal drugs in the past ten (10) years. Practitioners should also provide information as to whether staff membership status and/or privileges have ever been revoked, suspended, diminished or not renewed at any other hospital or institution and/or if there is an ongoing relationship with a Physician Health Program;
  - 2.2.6 Have a record that is free from involuntary termination at any hospital or voluntary resignation in lieu of termination;
  - 2.2.6 Have appropriate communication skills;
  - 2.2.7 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 illegal or unethical payment activities, receipt, or remuneration with respect to referral or patient service opportunities; and
    - b. A history of acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.
  - 2.2.9 Physicians, Physician Assistants, Dentists, Podiatrists, and Oral Surgeons of the Medical Staff must be certified by the appropriate American specialty board or admissible for examination (board eligible) for certification by the appropriate American specialty board in the area in which clinical privileges are requested or any foreign board accepted by the American board or is deemed to meet the training/qualifications of the American board. If board eligible at the time of credentialing, the physician

must become certified within the time period mandated by their applicable Board. Acceptable specialty boards include but are not limited to the American Board of Physician Specialties, the American Osteopathic Association, the American Board of Medical Specialties, the National Board of Physicians and Surgeons, the American Board of Oral and Maxillofacial Surgery, the National Commission on Certification of Physician Assistants, and /or the American Board of Podiatric Surgery. Those with time-limited board certificates are required to maintain these certificates. Maintenance of time-limited board certificates will be required at the time of privilege renewal.

**2.3 In Addition to Privilege-Specific Criteria, the Following Qualifications Must Also be Met and Maintained by All Applicants Requesting Clinical Privileges:**

- 2.3.1 Demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;
- 2.3.2 Possess a current and valid drug enforcement administration (DEA) number if applicable. The DEA or Controlled Substance Registration (CSR) in Delaware, as applicable, must be unrestricted for initial appointment;
- 2.3.3 Possess a valid NPI number;
- 2.3.4 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of their responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant. This certification of physical and mental health must be from a practitioner acceptable to the Credentials Committee;
- 2.3.5 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;
- 2.3.6 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which independent clinical privileges are sought adequate to meet current clinical competence criteria;
- 2.3.7 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;
- 2.3.8 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board.

**2.4 Exceptions**

2.4.1 All practitioners who are current Medical Staff members and/or hold privileges as of January 1, 2008 and who have met prior qualifications for membership and/or privileges shall be exempt from these board certification requirements. All practitioners who are current Medical Staff members and/or hold privileges as of [REDACTED], 2023 and who have met prior qualifications for membership and/or privileges although have not recertified with an applicable Board shall be exempt from these board recertification requirements.

Only the Board may create additional exceptions in extenuating circumstances, but only after consultation with the MEC, and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

2.4.2 No individual is entitled to an exception or a hearing if the Board determines not to grant an exception. A determination that a practitioner is not entitled to an exception is not a “denial” of an appointment or clinical privileges. The practitioner requesting the exception bears the burden that the requirement is not necessary, and that he can help satisfy an unmet clinical need at the Hospital.

2.4.3 If Board Certification lapses, a written plan of action for recertification must be submitted to and approved by the MEC. The MEC will determine if loss of privileges in the specific specialty will occur.

## **Section 3. Initial Appointment Procedure**

---

### **3.1 Completion of Application**

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

A completed application includes, at a minimum:

- a. A completed, signed, dated application form;
- b. A completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees;
- e. Receipt of all references; references shall be selected by the applicant and come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one reference must be from someone in the same professional discipline and additional references may be required;
- f. Relevant practitioner-specific data as compared to aggregate data, when available; and
- g. Morbidity and mortality data, when available.

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

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office timely 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 within 60 days. If information is missing from the application, or new, additional, or clarifying information is required, notification requesting such information will be sent to the applicant. Said application shall not be deemed completed for purposes of processing until such satisfactory information is provided by the applicant and verified by the Medical staff office. The applicant shall have the responsibility of keeping their file current, and will notify the Medical Staff office about the initiation and status of disciplinary actions and/or investigations, including suspensions or restriction of privileges, at other Hospitals or clinics and/or federal or state governmental programs or private payors.



- 3.1.3 If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.
- 3.1.4 Upon receipt of a completed application the CMO or credentials chair, in collaboration with the Medical Staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that they are ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed, and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.
- 3.1.5 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
- 3.1.6 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, excluding scrub techs and registered nurse first assistants;
  - b. Verification of the applicant's past clinical work experience for at least the past ten (10) years with the exception that ten (10) affiliations over the past five (5) years will be checked for telemedicine and locum tenens practitioners;
  - 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 AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities or SAM (System for Award Management), and FSMB (Federation of State Medical Boards) for applicants with out-of-state experience;
  - 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 through use of the continuous query process;
  - g. Other information about adverse credentialing and privileging decisions;
  - h. Three (3) peer recommendations, as selected by the applicant, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

- i. Information from a ten (10) year criminal background check for initial application only. A two (2) year criminal background check will be done at each reappointment;
- j. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and
- k. Morbidity and mortality data and relevant practitioner-specific data (OPPE data) as compared to aggregate data, when available.

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.

- 3.1.7 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.
- 3.1.8 An applicant will also be advised that the Hospital shall report an adverse action to the National Practitioner Data Bank if the denial is based on the practitioner’s professional competence or professional conduct that could adversely affect the health or welfare of a patients.

### **3.2 Applicant’s Attestation, Authorization, and Acknowledgement**

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

- 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 may terminate effective immediately upon notification of the individual without the right to a fair hearing or appeal.
- 3.2.2 Consents to appear for any requested interviews in regard to their application.
- 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 their 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.
- 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 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; and

- e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.
- 3.2.5 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 their 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.
- 3.2.6 Authorizes the hospital Medical Staff and administrative representatives to release any and all credentialing information to other hospitals, licensing boards and appropriate government bodies and other health care entities or to engage in any valid discussion with these governmental agencies relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications. The Practitioner acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.
- 3.2.7 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.
- 3.2.8 Agrees to provide accurate answers to the questions on the application, and agrees to immediately, within twenty-four (24) hours, notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

### 3.3 Application Evaluation

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

**Category 1:** A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Department Chair or designee, Credentials Chair or designee acting on behalf of the Credentials Committee, the MEC, 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. Applications in Category 2 must be reviewed and acted on by the Department Chair, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that they meet 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, state controlled substance registration authority, DEA or has prior disciplinary actions or legal sanctions;
- e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment or settlement in a professional liability action in excess of \$250,000 within the past five (5) years;
- f. Applicant changed medical schools or residency programs or has unexplained gaps in training or practice twenty-eight (28) days or greater;
- g. Applicant has changed practice affiliations three or more times in the past ten (10) years, excluding telemedicine and locum tenens practitioners and those serving in the military;
- h. Applicant has one or more reference responses that raise concerns or questions;
- i. Substantive discrepancy is found between information received from the applicant and references or verified information;
- j. Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions;
- k. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- l. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- m. Applicant has potentially relevant physical, mental health problems;
- n. Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

### 3.3.2 Applicant Interview

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

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

### 3.3.3 Department Chair Action

- a. All completed applications are presented to the Department Chair for review, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair, in consultation with the Medical Staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Department Chair may obtain input if necessary, from an appropriate subject matter expert. If a Department Chair believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation, they will notify the credentials chair and forward the application without comment.
- b. The Department Chair forwards to the Medical Staff Credentials Committee the following:
  - i. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
  - ii. A recommendation as to 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
  - iii. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
  - iv. Comments to support these recommendations.

### 3.3.4 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the credentials chair, or designee, for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair 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 to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- c. Comments to support these recommendations.

### 3.3.5 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing as noted in Part I, Section 7.4.2. The President of the Medical Staff 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; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- d. Comments to support these recommendations.

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

#### 3.3.6 Board Action:

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

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

- iii. If the Board's action is to reject the recommendation of the MEC, then the Joint Conference Committee shall be convened within two (2) weeks to determine if there is a resolution acceptable to both the MEC and the Board. If not, the decision of the Board shall prevail.
- iv. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.7 **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 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 they are assigned, the clinical privileges they may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

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. A recommendation shall be made to the MEC within sixty (60) days of a complete application.

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



## Section 4. Reappointment

---

### 4.1 Criteria for Reappointment

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

### 4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least forty-five (45) calendar days after release of the reapplication, the practitioner must return the following to the Medical Staff office:

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

4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each practitioner's professional and collegial activities to include those items listed in Section 3.2.8, items a. to y.

4.2.3 The following information is also collected and verified:

- a. A summary of clinical activity at this hospital for each practitioner due for reappointment;
- b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided relevant clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
- c. Attestation of any required hours of continuing medical education activity;
- d. Service on Medical Staff, Department, and hospital committees;
- e. Timely and accurate completion of medical records;



- f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff;
  - g. Any significant gaps in employment or practice since the previous appointment or reappointment twenty-eight (28) days or greater;
  - h. Verification of current licensure;
  - i. Verification of identity by comparing a current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current photo hospital ID card to compare it to the applicant.
  - j. National Practitioner Data Bank query, information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management) and FSMB (Federation of State Medical Boards);
  - k. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and
  - l. Malpractice history for the past three (3) years, which is primary source verified by the Medical Staff office with the practitioner's malpractice carrier(s).
- 4.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment may result in automatic expiration of appointment when the appointment period is concluded if the application cannot be processed within the shortened timeframe. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

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

- 4.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1 above.
- 4.3.2 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 5. Clinical Privileges**

---

### **5.1 Exercise of Privileges**

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

### **5.2 Requests**

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

### **5.3 Basis for Privileges Determination**

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

5.3.2 Requests for clinical privileges will be consistently evaluated 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 practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

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

### **5.4 Special Conditions for Dental Privileges**

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

## 5.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff that will be recorded in the medical record.

## 5.6 Special Conditions for Residents or Fellows in Training

- 5.6.1 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 Designated Institutional Official in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must 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.
- 5.6.2 The CMO must communicate periodically with the MEC and the Board about the performance of 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.

## 5.7 Telemedicine Privileges

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

Requests for telemedicine privileges at the Hospital that includes patient care, treatment, and services will be reviewed by the MEC and will be processed through one of the following mechanisms:

- a. The Hospital fully privileges and credentials the practitioner if the telemedicine Hospital/entity is not Joint Commission accredited; **OR**
- b. The Hospital privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited Hospital or telemedicine entity and the information is then processed through the routine medical staff credentialing and privileging process. The distant-site practitioner must have a license that is issued or recognized by the State of Pennsylvania or Delaware, as applicable; **OR**
- c. The hospital uses the credentialing and privileging decision from the distant site if all of the following requirements are met:
  - i. The distant site is a Joint Commission-accredited hospital or ambulatory care organization;
  - ii. The practitioner is privileged at the distant site for those services to be provided at this hospital and the practitioner has a license that is issued or recognized by the State of Pennsylvania or Delaware, as applicable; and

- iii. The hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

## **5.8 Temporary Privileges**

The Hospital President, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, 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.

- 5.8.1 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. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.
- 5.8.2 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 1) complete application 2) fully verified application, 3) positive recommendation from the Department Chair, and 4) positive recommendation from the Credentials Committee. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in section 3 of this manual.
- 5.8.3 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 their 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.
- 5.8.4 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. When a patient's life or wellbeing is endangered, any person entitled to impose a precautionary suspension under the Medical Staff bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the President of the Medical Staff or their designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

5.8.5 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 their request for temporary privileges is refused or because all or any part of their temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

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

**5.10 Disaster Privileges:**

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

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

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

5.10.3 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

- 5.10.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.
- 5.10.5 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.
- 5.10.6 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 6. Clinical Competency Evaluation**

---

### **6.1 Focused Professional Practice Evaluation (FPPE)**

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

### **6.2 Ongoing Professional Practice Evaluation (OPPE)**

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

### **6.3 Physician Re-Entry**

A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, that is acceptable to the Credentials Committee and MEC, either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. If a practitioner has not provided any clinical care within the past five (5) years, they may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other approved formal process to assess and confirm clinical competence. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Department Chair and/or Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

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



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

---

### **7.1 Reapplication After Adverse Credentials Decision**

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

### **7.2 Request for Modification of Appointment Status or Privileges**

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the Medical Staff office. A modification request must be on the prescribed form and must contain all pertinent information 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 they no longer exercise, or wish to restrict or limit the exercise of, particular privileges that they have been granted shall send written notice, through the Medical Staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

### **7.3 Resignation of Staff Appointment or Privileges**

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

### **7.4 Exhaustion of Administrative Remedies**

Every practitioner agrees that they 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.



## **Section 8. Leave of Absence**

---

### **8.1 Leave Request**

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities for more than sixty (60) days and not longer than one (1) year and whether such absence is related to the military, education, family or the individual's physical or mental health or the ability to care for patients safely and competently.

- 8.1.1 In circumstances where a practitioner requires an urgent leave of absence due to physical or mental health reasons, the President of the Medical Staff or the CMO (local or regional), may trigger an immediate medical leave of absence.
- 8.1.2 A practitioner who wishes to obtain a voluntary leave of absence must provide written notice thirty (30) calendar days in advance of the requested absence to the Department Chair stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave are approved by the Department Chair. Any individual requesting or being placed on a leave of absence shall complete all medical records, if possible, prior to the initiation of the leave and make arrangements for care for their patients during their absence.

While on leave of absence, the practitioner may not exercise clinical privileges at SMMC or prerogatives and has no obligation to fulfill Medical Staff responsibilities. While on a leave of absence, there will be no reappointment process. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

### **8.2 Termination of Leave**

- 8.2.1 Prior to the termination of the leave for non-medical reasons, the practitioner must request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave if the Department Chair so requests. The Department Chair can reinstate the practitioner's membership and/or privileges.
- 8.2.2 At least thirty (30) calendar days prior to the termination of a leave for medical reasons, the practitioner must provide a report from their physician who has no conflict of interest, indicating that the practitioner is fit to resume the exercise of all granted privileges prior to the termination of the leave. The physician may also be asked to provide answers to any questions that the MEC may have as part of considering the request for reinstatement. The MEC can reinstate the practitioner's membership and/or privileges.

8.2.3 If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the reappointment process will occur at the end of the leave of absence.

### **8.3 Failure to Request Reinstatement**

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Extension of a leave of absence greater than one (1) year will be considered at the discretion of the credentials committee, but it is not to exceed a total of 2 years from the initial request for the leave.

## **Section 9. Practitioners Providing Contracted Services**

---

### **9.1 Exclusivity policy**

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

### **9.2 Qualifications**

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

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

### **9.4 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 10. Medical Administrative Officers**

---

- 10.1** 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.
- 10.2** Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge staff obligations appropriate to their staff category in the same manner applicable to all other staff members.
- 10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:**
- 10.3.1 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.
- 10.3.2 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.
- 10.3.3 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.