Bellevue Medical Center

Bellevue, NE

MEDICAL STAFF BYLAWS

Part I: Governance

October 6, 2009 Revised
March 1, 2011
Reviewed May 2013
Reviewed December 2015
Reviewed June 26, 2016

Table of Contents

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 Bellevue Medical Center (BMC) in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital Board. Specifically, the medical staff is to be responsible to the Board for the quality of medical care and treatment provided in the Hospital.

1.2 Authority

Subject to the authority and approval of the Board the medical staff shall exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the BMC. Henceforth, whenever the term "the hospital" is used, it shall mean Bellevue Medical Center (BMC); and whenever the term "the Board" is used, it shall mean Board.

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, oromaxillofacial surgeons and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies 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).

2.3 Nondiscrimination

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

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). Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Hospital privileges

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

2.6 Practitioner Responsibilities

2.6.1 Each staff member or other practitioner with privileges (collectively "practitioners") shall provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

2.6.2 Each practitioner shall participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as assigned.

2.6.3 Each practitioner, consistent with his/her granted category of membership and hospital privileges, shall participate in the on call coverage of the emergency department in addition to other clinical needs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each practitioner shall submit to any type of health evaluation as requested by the MEC and/or credentials committee when it appears necessary to protect the well-being of patients and/or staff. This shall be considered part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing practitioner health or impairment.

2.6.5 Each practitioner shall abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.

2.6.6 Each practitioner shall provide evidence of professional liability coverage of a type and in an amount established by the Board.

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

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

2.6.9 Each practitioner shall use confidential information only as necessary for treatment, payment or healthcare operations in accordance with Hospital policy, HIPAA laws and any other applicable regulations. 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 practitioner shall participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's hospital privileges.

2.6.11 Each practitioner shall maintain professional standards of conduct and behavior and abide by the medical staff code of professional conduct and hospital and medical staff policy.

2.6.12 Each practitioner shall provide, with or without request, new or updated information to Medical Staff Services Department as it occurs as specified in Medical Staff Policy MED 01.006 Medical Staff Mandatory Reporting Requirements.

2.6.13 Each practitioner shall support the mission of the Hospital to provide care to the region it serves and to 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.

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. In the event such practitioner is unable to resolve a matter of concern after working with 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 request to discuss the issue.

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

2.7.3 Each staff member in the active category may call a special staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty-five percent (25%) of the members of the active category, the MEC shall schedule a special 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 or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by twenty-five percent (25%) of the members of the active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.2.1 shall be followed. This section shall not be invoked to challenge a rule or policy during corrective action which is addressed in Part I Governance, Section 2.7.6 below.

2.7.5 Each staff member in the active category may call for a Hospital Service Line meeting by presenting a petition signed by twenty-five percent (25%) of the members of the Hospital Service Line. Upon presentation of such a petition the Hospital Service Line Chief shall schedule a Hospital Service Line 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 hospital privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan) provides recourse in these matters.

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

2.8 Staff Dues

Annual medical staff dues, if any, shall be determined by the MEC. Failure of a medical staff member to pay dues shall be considered a voluntary resignation from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Immunity

2.9.1 Members of the medical staff are entitled to the applicable immunity provisions of state and federal law and these Bylaws 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, the hospital shall indemnify against actual 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 s/he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Members of this category shall have successfully completed their period of focused professional practice evaluation and be involved in twenty-five (25) or greater patient contacts per year except as expressly waived for practitioners with at least twenty (20) years of service in the active category or for those physicians who document their efforts to support the hospital's patient care mission to the satisfaction of the MEC and the Board. A patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient procedure at the hospital.

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

3.1.2 Prerogatives

Members of this category:

a. Attend medical staff and Hospital Service Line/section meetings of which s/he is a member and any medical staff or hospital education programs;

b. Vote on all matters presented by the medical staff, Hospital Service Line, and committee(s) to which the member is assigned;

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;

c. Fulfill or comply with any applicable medical staff or hospital policies or procedures.

3.2 The Associate Category

3.2.1 Qualifications

The associate category is reserved for medical staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status.

3.2.2 Prerogatives

Members of this category may:

a. Attend medical staff and Hospital Service Line//section meetings of which s/he is a member and any medical staff or hospital education programs;

b. Not vote on matters before the entire medical staff or be an officer of the medical staff.

c. Serve on medical staff committees, other than the MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities

Members of this category shall have the same responsibilities as active category members.

3.3 The Community Category

3.3.1 Qualifications

The community category is reserved for members who maintain a clinical practice in the hospital service area and wish to be able to follow the course of their patients when admitted to the hospital.

3.3.2 Prerogatives

Members of this category:

a. May order non-invasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records and attend medical staff and Hospital Service Line/section meetings, CME functions and social events;

b. Are not eligible for hospital privileges, may not manage patient care in the hospital and may not vote on medical staff affairs or hold office.

3.3.3 Responsibilities

Members of this category shall:

a. Fulfill or comply with any applicable medical staff or hospital policies and procedures.

3.4 Honorary Category

The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff and Hospital Service Line/service/section meetings, continuing medical education activities, and may be appointed to committees. They shall not hold hospital privileges, hold office or be eligible to vote.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff and MEC Members

4.1.1 President of the Medical Staff

4.1.2 President Elect of Medical Staff

4.1.3 Communications Officer

4.1.4 MEC Members

a. Elected MEC at-large members
b. Selected Hospital Service Line Chiefs (as outlined in these Bylaws Part I: Governance, Section 6.2.1)

4.2 Qualifications of Officers and MEC Members

4.2.1 Officers and MEC members shall be members in good standing of the active category and be actively involved in patient care in the hospital, have previously served in a significant leadership position on a medical staff, (e.g. Hospital Service Line, department or section leadership, committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or hospital privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. The medical staff leadership & succession committee shall have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

4.2.2 Officers may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement shall result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Election of Officers and MEC At-Large Members

4.3.1 The leadership & succession committee shall offer at least one nominee for each available position. Nominations shall be announced, and the names of the nominees distributed to all members of the active medical staff at least thirty (30) days prior to the election.

4.3.2 A petition signed by at least ten percent (10%) of the members of the active staff may add nominations to the ballot. The medical staff shall submit such a petition to the President of the medical staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The leadership & succession committee shall determine if the candidate meets the qualifications in Section 4.2 above before he/she can be placed on the ballot.

4.3.3 Officers and MEC at-large members shall be elected at least one (1) month prior to the expiration of the term of the current officers. Only members of the active category shall be eligible to vote. The medical staff support professional shall determine the mechanisms by which votes may be cast, subject to the approval of the MEC. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting shall be permissible. The nominee(s) who receives the greatest number of votes shall be elected. In the event of a tie vote, the medical staff support professional shall make arrangements for a repeat vote(s) until one candidate receives a greater number of votes.

4.4 Term of Office

All officers shall serve a term of two (2) years. They shall take office in the month of January. All elected MEC at-large members shall serve a term of three (3) years and may succeed themselves one (1) consecutive term. MEC members that are Hospital Service Line Chiefs shall serve a term of two (2) years.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the medical staff year, except the office of the President of the medical staff. If there is a vacancy in the office of the President of the medical staff, the President Elect shall serve the remainder of the term.

4.6 Duties of Officers and MEC Members

4.6.1 **President**: The President shall represent the interests of the medical staff to the MEC and the Board. The President shall fulfill the duties specified in Part IV of these bylaws (Organization and Functions Manual).

4.6.2 **President Elect**: In the absence of the President, the President Elect shall assume all the duties and have the authority of the President. S/he shall perform such further duties to assist the President as the President may request from time to time. The President Elect shall succeed the President when the President's term has ended.

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

4.6.4 **MEC Members**: MEC members shall 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 or Hospital Service Line.

4.7 Removal and Resignation from Office

4.7.1 The medical staff may remove any officer if at least 25% sign a petition advocating for such action. The petition shall be followed by an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes.

a. Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary suspension of hospital privileges that lasts more than thirty days. The Board shall determine if the member has failed in his/her duties after consulting with the joint conference committee as outlined in Part I Governance, Section 8 of these bylaws.

4.7.2 **Resignation**: Any elected officer or MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The medical staff shall be organized into Hospital Service Lines. The medical staff may create clinical sections within a Hospital Service Line in order to facilitate medical staff activities. A list of Hospital Service Lines organized by the medical staff and formally recognized by the MEC is listed in Part IV of these bylaws (Organization and Functions Manual).

The MEC, with approval of the Board, may designate new medical staff Hospital Service Lines or clinical sections or dissolve current Hospital Service Lines or clinical sections as it determines shall best promote the medical staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.1.2 The MEC may recognize any group of practitioners who wish to organize themselves into a clinical section to facilitate medical staff activities. Any clinical section, if organized, shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the clinical section is making a formal recommendation to the MEC. A clinical section may identify a section leader. Clinical sections are optional and shall exist to perform any of the following activities:

a. Continuing education/discussion of patient care;

b. Grand rounds;

c. Discussion of policies and procedures;

d. Discussion of equipment needs;

e. Development of recommendations for Clinical Service Chiefs or MEC;

f. Participation in the development of criteria for hospital privileges when requested by the credentials committee or MEC;

g. Participation in evaluating clinical privilege requests and making recommendation to the Hospital Service Line Chief;

h. Discussion of a specific issue at the request of a medical staff committee or the MEC.

5.1.3 Hospital Service Lines and any authorized clinical sections that are organized by the medical staff and formally recognized by the MEC shall be listed Part IV of the bylaws (Organization and Functions Manual).

5.2 Qualifications, Selection, Term, and Removal of Hospital Service Line Chief

5.2.1 Each Hospital Service Line Chief shall be appointed to serve a term of two (2) years commencing on January 1 and may be reappointed to serve two (2) additional consecutive terms. All chiefs shall be members of the active medical staff, have relevant hospital privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

5.2.2 Hospital Service Line Chiefs shall be appointed by the MEC after receiving input from the active staff members of the Hospital Service Line. Each Hospital Service Line shall establish procedures for identifying and electing candidates and these procedures shall be ratified by the MEC.

5.2.3 Hospital Service Line Chiefs may be removed from office by the MEC if two-thirds (2/3) of the members of the Hospital Service Line recommend such action, or, in the absence of such recommendation, the MEC may remove a chief on its own by a two thirds vote if any of the following occurs:

a. The chief ceases to be a member in good standing of the medical staff;

b. The chief suffers an involuntary loss or significant limitation of practice privileges;

c. The MEC determines that the chief has failed to demonstrate to the satisfaction of the MEC and the Board that he or she is effectively carrying out the responsibilities of the position;

d. If a Hospital Service Line Chief is removed through this process, a new appointment shall be made according to established Hospital Service Line procedures.

e. Hospital Service Line Chiefs shall carry out the responsibilities assigned in Part IV of these bylaws the (Organization and Functions Manual).

5.3 Assignment to Hospital Service Line

The MEC shall, after consideration of the recommendations of the chief of the appropriate Hospital Service Line, recommend Hospital Service Line assignments for all members in accordance with their qualifications. Each member shall be assigned to one primary Hospital Service Line. Hospital privileges are independent of Hospital Service Line assignment.

Section 6. Committees

6.1 Designation and Substitution

The Medical Executive Committee (MEC) shall be the single medical staff committee designated to carry out the purpose in Nebraska Rev. Statute 71-2046. Other standing and special committees shall be established by the MEC and enumerated in Part IV of these bylaws (Organization and Functions Manual) and shall report to the MEC. 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 MEC may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEC

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of nine (9) voting members including: the three (3) officers of the medical staff, three (3) Hospital Service Line Chiefs and three (3) MEC at-large members. Officers and MEC at-large members shall be elected as outlined in these bylaws Part I: Governance, Section 4. Hospital Service Line Chiefs serving on the MEC shall be selected by consensus of all the Hospital Service Line Chiefs.

b. Chair and Other Members: The chair shall be the President of the medical staff. The chairs of the credentials committee and the medical staff quality committee shall be MEC members without vote. The CEO, or designee, shall be an ex-officio member without vote.

c. Initial Composition of MEC: The initial MEC shall consist of three (3) officers; three (3) Hospital Service Line Chiefs as selected by consensus of all the Hospital Service Line Chiefs; and three (3) initial at-large members who will have staggered terms to initiate the process, that is 1/3 for 1 year , 1/3 for 2 years and 1/3 for 3 years.

d. Subsequent Composition of MEC: The subsequent compostion of the MEC shall consist of two year rotations of officers and Hospital Service Line Chiefs elected or self-determined as in Part I: Governance, Section 6.2.1.a ; and three (3) year rotations of elected at-large members.

e. Removal from MEC: An officer or Hospital Service Line Chief who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2.3 above shall automatically lose his/her membership on the MEC. When the chair of either the credentials or medical staff quality committees (MSQC) or Hospital Service Line Chief resigns or is removed from these positions, his/her replacement shall serve on the MEC. MEC at-large members may be removed by an affirmative vote of six (6) members of the MEC. MEC at-large members shall not vote on the subject of their own removal. When a member of the MEC who was elected at-large resigns or is removed, the MEC shall arrange for an at-large election for a replacement to serve out the remainder of the vacated term. Such an election shall follow procedures established by the MEC and shall take place within sixty (60) days of the removal of an MEC member.

6.2.2 Duties: The duties of the MEC, as delegated by the medical staff, shall be to:

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

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Hospital Service Line assignments, hospital 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 hospital privileges and coordinate the participation of the medical staff in organizational performance improvement activities;

e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and 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, Hospital Service Lines, 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 member'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 appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the medical staff;

o. Hold medical staff leaders, committees, and Hospital Service Lines accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws.

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.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

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

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

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. 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. If the special meeting is the result of a petition, the process outlined in Part I Governance, Section 2.7.3 shall be followed.

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 Hospital Service Lines

Committees and Hospital Service Lines may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Hospital Service Lines

A special meeting of any committee or Hospital Service Line may be called by the Hospital Service Line Chief thereof or by the President of the Medical Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: A quorum consists of those members present and eligible to vote on an issue.

7.4.2 MEC, Credentials Committee, and Medical Staff Quality Committee: A quorum shall exist when fifty percent (50%) of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and hospital privileges the MEC quorum shall consist of at least three members.

7.4.3 Hospital Service Line meetings or medical staff committees other than those listed in 7.4.2 above: Those present or those eligible medical staff members voting on an issue.

7.5 Attendance Requirements

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

a. MEC, Credentials Committee, and Medical Staff Quality Committee meetings: Members of these committees are expected to attend at least seventy-five percent (75%) of the meetings held.

b. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the President of the medical staff or the applicable Hospital Service Line/committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner shall 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 after two notices, unless excused by the MEC for an adequate reason, shall result in an automatic relinquishment of the practioner's membership and privileges as also outlined in these bylaws Part II: Section 3.1.6. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of hospital privileges or other corrective action steps as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the CEO

The CEO or his/her designee may attend any general, committee or Hospital Service Line meetings of the medical staff.

7.7 Robert's Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest 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 Hospital Service Line or committee not less than three (3) days before the time of such meeting 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 Hospital Service Line

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Hospital Service Line. Such recommendation shall 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 including the right to vote and be counted in determining the existence of a quorum, unless such authority is withheld by the appointing authority or these bylaws.

7.11 Minutes

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

Section 8. HISTORY AND PHYSICAL EXAMINATION

8.1 History and Physical Examination (H&P)

The History and Physical Examination (H&P) shall be performed and recorded by a doctor of medicine or osteopathy, or, for patients admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon. All or part of the H&P may be delegated to other practitioners in accordance with State law and hospital policy. The History and Physical Examination report shall include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;

d. An age-appropriate social history;

e. A pertinent family history;

f. A review of systems;

g. Relevant physical findings; and

h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

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

An updated history and physical examination shall:

a. Address the patient's current status and/or any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted);

b. Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical, or to address any areas where more current data is needed;

c. Confirm that the necessity for the admission, procedure, or care is still present;

d. Be written or otherwise recorded on, or attached to, the previous History and Physical; and

e. Be placed in the patient's medical record within twenty-four (24) hours after admission or prior to surgery or performance of an invasive procedure for which an H&P is required.

Section 9. Conflict Resolution

9.1 Conflict Resolution – Board and Medical Staff

a. In the event the Board acts in a manner contrary to a recommendation by the MEC or the active staff (in the case of a direct recommendation by the active staff as described in Section 9 of this Part I), the matter may, at the request of the Board, MEC or the active staff, be submitted to a Joint Conference Committee (JCC). The JCC shall be composed of the officers of the medical staff and an equal number of members of the Board. If the matter involves direct recommendation by the active staff, the JCC shall include a like number of representatives of the active staff appointed by the Board from among members of the active staff who are proponents of the recommended action. The JCC shall review and make a recommendation to the full Board. The committee shall submit its report to the Board within thirty (30) days of its meeting. In addition, individual JCC participants may submit individual written reports to the Board. Following receipt of the report or reports, the Board may make a final decision on the matter.

b. In addition to conflicts involving actions before the Board, the chair of the Board or the President of the medical staff may call for a JCC meeting as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

c. The foregoing shall not be construed to prevent individual members of the organized medical staff from communicating positions or concerns directly to the Board under such terms as the Board may establish.

9.2 Conflict Resolution – MEC and Medical Staff

d. In the event of a conflict between the members of the active medical staff and the MEC regarding the adoption or enforcement of any bylaw, rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by twenty-five percent 25% of the members of the active staff, the matter shall be submitted to the conflict resolution process described in this Section 8.2. In such case, a conflict resolution committee (CRC) shall be formed consisting of an equal number of members of the active medical staff designated by the active staff and representatives of the MEC appointed by the President of the Medical Staff. The Hospital CEO or designee shall be an ex-officio non-voting member of any CRC formed under this Section 9.1.

e. Following conclusion of the CRC process the MEC or active staff shall implement any consensus reached, or, if consensus is not reached, the MEC or active staff may proceed with the action that prompted the disagreement, provided, that if it is an action requiring Board or active staff approval, such approval shall be required.

f. Any matter presented to the Board for approval by the MEC or active staff as to which the Board is advised there is a significant unresolved disagreement between the MEC and active staff may at the election of the Board be submitted to an expanded JCC process as described in Section 8.1 with four (4) additional JCC members representing the active staff also participating.

g. In the event of a dispute between or among the leaders or segments of the medical staff, the matter in dispute may at the election of the MEC be submitted to a CRC composed of an equal number of members representing opposing viewpoints who are appointed by the Medical Staff President or the MEC and who will meet under the supervision of the MEC. Alternatively

the MEC may facilitate and preside over a meeting to discuss differences. At the conclusion of the process the MEC may take action to resolve the differences, provided that any action that requires approval of the Board or active staff will require such approval.

9.3 General Standards.

h. The members of the JCC or CRC shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with a desire to maintain smooth operations and high quality care for patients.

i. If deemed appropriate by the President of the Medical Staff and the Hospital CEO, a disinterested outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

Section 10. Review, Revision, Adoption, and Amendment

10.1 Adoption and Amendment of Bylaws Generally

The active staff adopts and amends medical staff bylaws, following the processes described in this Section 9, and such bylaws and amendments become effective only when approved by the Board. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

a. The medical staff shall follow a process for biennial review of the bylaws and of medical staff rules and regulations with all recommendations being presented to the MEC for consideration.

b. In addition to the biennial review process, amendments to the medical staff bylaws, rules and regulations and policies may be proposed and acted upon as described below in Sections 9.2 and 9.3(bylaws) and 9.5 (rules, regulations and policies).

10.2 Bylaw Amendment With MEC Approval.

c. Bylaw amendments whether originated by the MEC, another standing committee, a member of the active staff, or the Board, shall be submitted to the MEC for consideration and shall be discussed by the MEC prior to vote. The MEC shall vote on proposed amendments at a regular meeting or a special meeting called for such purpose.

d. If the MEC approves an amendment, it shall be submitted to the organized medical staff for approval. Bylaw amendments are approved upon receiving the affirmative vote of a simple majority of the active staff. Each active staff member shall 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 fourteen (14) days advance notice of the proposed changes. A ballot shall be counted as an affirmative vote if returned within the time permitted marked "yes" or if not returned. Amendments when so approved by the organized medical staff shall be forwarded by the MEC to the Board and effective only when approved by the Board.

e. If the Board *rejects* an amendment that has been approved by the MEC and medical staff, it shall notify the MEC. If the MEC requests, the Board shall invoke the conflict resolution process through the Joint Conference Committee as described at Section 8 of this Part I.

f. If the Board *modifies* an amendment that has been approved by the MEC and medical staff, the amendment as modified shall be returned to the MEC, which may accept or reject the modifications. If the MEC rejects the modifications, it shall notify the Board and the Board shall invoke the conflict resolution process described at Section 8 of this Part I. If the MEC accepts the modifications, it shall submit the amendments as thus modified to the organized medical staff and the process for vote by the active staff in Section 9.2.2 shall be followed.

10.3 Bylaw Amendment Without MEC Approval.

g. Bylaw amendments may also be proposed to the Board directly by the organized medical staff without prior MEC approval upon receiving the affirmative vote of a majority of the members of the active staff. In order to initiate a direct vote by the active staff, the interested parties must first present a petition to the MEC signed by twenty-five percent (25%) of the members of the active staff setting forth the proposed amendments. The MEC shall have an opportunity to review and comment before the amendments are submitted to the organized medical staff. Upon receipt of a petition, the MEC shall promptly consider the proposed amendments and schedule a vote by the active staff. The MEC may schedule a meeting of the active staff prior to or concurrent with the scheduled vote to discuss the proposed amendment. The procedure in Section 9.2.2 shall be followed in conducting the vote.

h. Any amendments thus approved by the active staff shall be submitted to the Board for approval. The MEC shall have an opportunity to submit comments to the Board.

i. If the Board approves the proposed amendment it shall become effective.

j. If the Board *rejects* the proposed amendment, the Conflict Review Committee process described in Section 8.1 shall be followed. Decision of the Board following such process is final.

k. If the Board *modifies* the proposed amendment it shall be treated as a request to the MEC under Section 9.2.1. No modified amendment may be approved by the Board unless the modified terms are first acted upon by the active staff.

10.4 Resolution of Differences.

The responsibilities described in this Section 9 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.

10.5 Adoption and Amendment of Rules and Regulations, Policies.

l. In addition to medical staff bylaws, 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.

m. Rules and regulations may be adopted by the MEC or by direct action of the active staff and are effective when approved by the Board. Medical staff policies may be adopted by the MEC or by direct action of the active staff and are effective when approved by the CEO or, at the CEO's election, the Board. The CEO reviews proposed rules, regulations and policies and amendments thereto for consistency with Hospital bylaws and policies and regulatory requirements.

n. All proposed amendments to the rules and regulations and any associated medical staff policy manual, whether originated by the MEC, another standing committee, or by a member of the active category of the staff, shall be reviewed and discussed by the MEC prior to an MEC or active staff vote.

o. If the MEC proposes to adopt a rule or regulation or an amendment thereto, it first communicates its proposal to the organized medical staff and allows opportunity for comment by individual members. If the active staff proposes to adopt a rule, regulation or policy, or an amendment thereto, it first communicates its proposal to the MEC and allows opportunity for comment by the MEC. If the MEC adopts a policy, it communicates the policy to the organized medical staff.

p. Individual members of the organized medical staff may comment and make recommendations regarding rules and regulations and policies to the MEC. Upon receipt of a petition signed by twenty-five percent (25%) of the members of the active staff (in the case of a rule, regulation or policy proposed by the MEC), or at the election of the MEC, the conflict resolution process at Section 8 of this Part I shall be invoked.

q. In the event the MEC determines there is a documented need for an urgent amendment to rules and regulations, or the adoption of a new rule or regulation to comply with a law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the rules and regulations without prior notification to the organized medical staff. In such event, the organized medical staff shall be immediately notified of the amendment and members of the organized medical staff may, within fifteen (15) calendar days, submit comments regarding the provisional amendment to the MEC. If twenty-five percent (25%) of the voting members of the medical staff sign a petition opposing the provisional amendment, the provisional amendment shall be submitted to the conflict resolution process described in Section 8 of these bylaws. The results of the Conflict Management process shall be communicated to the MEC, the voting members of the MEC, the members of the active medical staff and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

10.6 Technical Corrections and Amendments

The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the MEC's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but shall be approved by the hospital CEO.

Bellevue Medical Center
Bellevue, NE

MEDICAL STAFF BYLAWS

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

October 6, 2009 Reviewed
May 2013
Reviewed December 2015
Reviewed June 28,, 2016

Table of Contents

Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Collegial Intervention

These bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and 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 collegial intervention efforts by medical staff leaders and hospital management shall be treated as part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial 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 steps to improve performance;

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

1.2 Criteria for Initiating Investigation or Corrective Action

Investigation or corrective action may be initiated when the person or body initiating it has reason to believe that:

a. A practitioner has failed to meet the practitioner responsibilities as outlined in Part I: Governance, Section 2.6; or elsewhere in these Bylaws, or

b. A practitioner is not meeting the qualifications and criteria for category of membership or privileges held by the practitioner.

Section 2. Investigations

2.1 Initiation

A request for an investigation or corrective action shall be submitted by a medical staff officer, committee chair, Hospital Service Line Chief, CEO, or hospital board chair to the MEC or by the MEC on its own initiative. The request shall be supported by references to the specific activities or conduct that is of concern. If the MEC initiates an investigation, it shall appropriately document its reasons. The Board shall be notifed of all decisions regarding whether or not the MEC has determined an investigation is necessary. In lieu of investigation, the MEC may direct a period of focused professional practice evaluation or other fact finding steps.

2.2 Investigation

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

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

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO. 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 that the investigation is being conducted and offer an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process or other action.

2.2.1 An external peer review consultant should be considered when:

a. Litigation seems likely;

b. The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;

c. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2.3 MEC Action

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

a. Determining not to take corrective action; and if the MEC determines there is not credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

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

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee/Hospital Service Line/section chiefs from issuing informal written or oral warnings prior to or in the absence of 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. Placing the practitioner under focused professional practice evaluation or concurrent monitoring for a period of time;

e. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of hospital privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

f. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of hospital privileges;

g. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

h. Recommending suspension, revocation, or probation of medical staff membership;

i. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, that recommendation shall be transmitted in writing to the board. The recommendation of the MEC shall become final unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment or Limitation/Voluntary Resignation

In the following instances, the practitioner's privileges and/or membership shall be considered 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 shall stand until the MEC determines it is not applicable. The MEC shall make such a determination as soon as practicable. The President of the medical staff 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 days, the practitioner shall be required to apply for reinstatement before membership and/or privileges are fully restored. In addition, further corrective action may be recommended in accordance with these bylaws whenever the MEC deems it is warranted. Automatic relinquishment is appropriate 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 Nebraska is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and hospital privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective**.**

b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or certifying authority, any hospital 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 hospital privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d. **Medicare, Medicaid, Tricare, or other federal programs:** Whenever a practitioner is barred from participating in Medicare, Medicaid, Tricare, or other federally funded healthcare programs, medical staff membership and hospital privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the Office of the Inspector General's List of Excluded Individuals/Entities or the General Services Administration Excluded Parties List System shall be considered to have automatically relinquished his or her privileges.

3.1.2 Controlled substances

a. **DEA certificate**: Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate is revoked, limited, or suspended, the practitioner shall 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 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.

3.1.3 **Medical record completion requirements**: Failure of a practitioner to maintain medical records shall result in automatic suspension or termination of the practitioner's membership and privileges as outlined in the Medical Staff Rules and Regulations, Article 3.18

3.1.4 **Professional liability insurance**: Failure of a practitioner to maintain professional liability insurance of a type and in the amount required by the Board shall result in immediate automatic suspension of a practitioner's hospital privileges. If within sixty (60) calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner shall notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.5 **Medical Staff dues/special assessments**: Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 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 appointment to the medical staff and clinical privileges.

3.1.6 **Failure to satisfy the special appearance requirement**: A practitioner who fails without good cause to appear at a meeting after two notices where his/her special appearance is required in accordance with these bylaws Part I: Governance, Section 7.5.1.b shall be considered to have automatically relinquished all hospital privileges with the exception of emergencies and imminent deliveries. These privileges shall be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days shall be considered a voluntary resignation from the medical staff.

3.1.7 **Failure to participate in an evaluation**: A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges until the practitioner participates in the evaluation. Failure to comply within thirty (30) calendar days shall be considered a voluntary resignation from the medical staff.

3.1.8 **Failure to Execute Release and/or Provide Documents:** A practitioner who fails to execute a general or specific release and/or provide documents when requested by the President of the medical staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. If the release is not executed or the documents are not provided within thirty (30) calendar days, the member shall be deemed to have resigned voluntarily from the staff and shall reapply for staff membership and privileges.

3.1.9 **MEC Deliberation**: As soon as practicable after action is taken or warranted as described in Sections 3.1.1 through Section 3.1.8, 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 the Section 1.3 above.

3.2 Precautionary Restriction or Suspension

3.2.1 **Criteria for Initiation**: A precautionary restriction or suspension may be imposed when in the judgement of the party imposing it, immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person, or when medical staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety, the effective operation of the institution, the compliance or financial status of the hospital or when the reputation of the medical staff or hospital is at stake. Under such circumstances either the CEO or designee; or President of the medical staff or designee; or the MEC may restrict or suspend the medical staff membership or hospital privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's hospital privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's hospital privileges at this hospital.

a. 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 CEO, and the board. If imposed by an individual, this decision shall be ratified by the MEC as outlined in Part II(Investigations, Corrective Action, Hearing and Appeal Plan), Section 3.2.2 to remain effective.

b. 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, is not disciplinary in nature and it shall not imply any final finding regarding the circumstances that caused the suspension.

c. 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

3.2.2 **MEC action**: As soon as practicable 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 and at the discretion of the MEC, the practitioner shall be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 **Procedural rights**: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2.2, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than fourteen (14) calendar days.

3.3 Administrative Time Out

The MEC may, with approval of the CEO and the Board chair, institute one or more administrative time outs for a practitioner for a cumulative period not to exceed seven (7) consecutive calendar days. During an administrative time out the practitioner may not exercise any hospital privileges except in an emergency situation or to address an imminent delivery. An administrative time out may be instituted only for non-clinical matters and when all of the following conditions are met:

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

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

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

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

An administrative time out shall take effect after the practitioner has been given an opportunity to either arrange for his/her patients currently at the hospital to be cared for by another qualified practitioner or until s/he has had an opportunity to provide needed care prior to discharge. During this period, the practitioner shall not be permitted to schedule any elective admissions, surgeries, or procedures. The President of the medical staff or designee shall determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the administrative time out.

Section 4. Initiation and Notice of Hearing

4.1 Grounds for Hearing

Any practitioner eligible for medical staff appointment shall be entitled to request a hearing whenever the Board or the MEC takes or recommends one of the following adverse actions based on the practitioner's clinical competence or professional conduct, which conduct may adversely affect patient welfare:

a. Denial of medical staff appointment or reappointment;

b. Revocation of medical staff appointment;

c. Denial or restriction of requested hospital privileges;

d. Involuntary reduction or revocation of hospital 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;

f. Suspension of staff appointment or hospital privileges, other than automatic suspension, 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 by any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Shall Not Be Triggered by the Following Actions

The following actions shall not trigger a right to a hearing. The MEC may, nevertheless, grant a hearing if it determines any such action under the circumstances of the case will require a report to the National Practitioner Data Bank:

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) or concurrent monitoring 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. Conducting or extending focused professional practice evaluation of the practitioner;

f. Requirement to appear for a special meeting under the provisions of these bylaws;

g. Automatic relinquishment or voluntary resignation of appointment or privileges;

h. Imposition of a precautionary suspension or administrative time out that does not exceed 14 calendar days;

i. Denial of a request for leave of absence, or for an extension of a leave;

j. Determination that an application is incomplete or untimely;

k. Determination that an application shall not be processed due to misstatement or omission;

l. Decision not to expedite an application;

m. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

n. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

o. 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;

p. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

q. Termination of any contract with or employment by hospital;

r. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

s. Any recommendation voluntarily accepted by the practioner;

t. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

u. Change in assigned staff category;

v. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

w. Removal or limitations of emergency department call obligations;

x. Any requirement to complete an educational assessment;

y. Retrospective chart review;

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

aa. Grant of conditional appointment or appointment for a limited duration;

bb. Appointment or reappointment for duration of less than twenty-four (24) months;

cc. Denial, suspension, reduction or revocation of privileges of an Allied health Practitioner with whom the practitioner has a supervisory or collaborative relationship.

4.3 Notice of Recommendation

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 CEO delivered either in person or by certified mail, return receipt requested. This notice shall contain:

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

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

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

d. The individual shall receive a copy of Section 6 of Part II of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan) outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

Such individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the CEO 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

The CEO 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 shall give testimony or evidence in support of the MEC, (or the Board), at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known;

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or hospital privileges of the individual requesting the hearing, and that individual and the individual's counsel have sufficient time to study this additional information and rebut it.

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

4.6 Witness List

At least fifteen (15) calendar days before the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf and shall include a brief summary of the anticipated testimony. The list of witnesses who shall testify in support of the recommendation of the MEC or the Board shall likewise be supplemented as necessary to include a brief summary of the nature of the anticipated testimony of each witness. 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 and the matters to which they may testify.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested as a result of a Medical Executive Committee action involving direct clinical care, the President of the Medical Staff, after considering the recommendations of the Medical Executive Committee, shall appoint a hearing panel.

b. When a hearing is requested as a result of a Board action or as the result of a matter that does not involve direct clinical care, the CEO, acting for the Board, and after considering the recommendations of the President of the Medical Staff or those of the chair of the Board, shall appoint a hearing panel or a hearing officer.

c. The hearing panel shall be composed of not fewer than three individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

d. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

e. The CEO or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner shall object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO, who shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members shall rest with the CEO.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the CEO, acting for the Board and after considering the recommendations of the President of the medical staff or those of the chair of the Board, if the hearing is occasioned by a Board determination may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. Such presiding officer shall not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO from among the hearing panel members to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing shall last no more than eight (8) hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with this policy, 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 hospital privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel;

h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair;

i. Conduct pre-hearing proceedings to organize and rule on witnesses, evidence and testimony.

5.3 Hearing Officer

If the hearing is occasioned by a Board determination or as the result of a matter not involving direct clinical care, then a hearing Officer may be appointed as an alternative to the hearing panel described in Section 4.1 of this manual. Under these circumstances, the CEO, acting for the Board and after considering the recommendations of the President of the medical staff or those of the chair of the Board, may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.

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

Section 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 panel 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 that will be introduced or testified to in the MEC's or the Board's case, at his or her expense;

b. Reports of experts relied upon by the MEC that will be introduced or testified to in the MEC's or the Board's case;

c. Copies of redacted relevant committee minutes that will be introduced or testified to in the MEC's or the Board's case;

d. Copies of any other documents relied upon by the MEC or the Board that will be introduced or testified to in the MEC's or the Board's case;

e. No information regarding other practitioners shall be requested, provided or considered;

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant hospital privileges shall be excluded.

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

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

6.1.4 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel or directed by the presiding officer.

6.2 Pre-Hearing Conference

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

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 shall be determined by the presiding officer, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing 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 Nebraska.

6.5 Rights of the Practitioner and the Hospital

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

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may call, examine, cross-examine witnesses and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

e. To submit a written statement at the close of the hearing.

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 panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

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

6.7 Burden of Proof

The hearing panel shall recommend in favor of the MEC or the Board unless it finds that the individual who requested the hearing has proved with a preponderance of the evidence that the recommendation which prompted the hearing was arbitrary, capricious, or appears to be unfounded or not supported by credible evidence. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and hospital privileges and fully complies with all medical staff and hospital bylaws, rules and policies

6.8 Post-Hearing Memoranda

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

6.9 Official Notice

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

6.10 Postponements and Extensions

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

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 or CEO. One or more representatives of the MEC or the Board whose action or recommendation triggered the hearing, may be present.

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 Basis of Recommendation

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

6.14 Adjournment and Conclusion

The presiding officer may adjourn 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 panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

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

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO 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 panel's report and recommendation shall be forwarded to the board.

7.2 Grounds for Appeal

A party requesting an appeal shall be required to state the grounds for an appeal and to describe the basis for believing the grounds to be supported. The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

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.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence may be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

d. The Board may affirm, modify or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and hospital privileges.

7.5 Final Decision of the Hospital Board

Within forty (40) 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 Hearing and 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. If a practitioner requests a hearing in connection with a precautionary suspension or limitation which is followed by an adverse action or recommendation listed in Part II: Investigations, Corrective Actions, Hearing and Appeal Plan, Section 4.1, the hearings shall be combined.

7.7 Time Period for Reapplication

In the event that the Board ultimately determines to deny medical staff appointment, reappointment or clinical privileges to an applicant, or to revoke or terminate the medical staff appointment and/or hospital privileges of a current member, that individual may not apply within three (3) years for medical staff appointment or for those hospital privileges at this hospital, unless the Board advises otherwise

Bellevue Medical Center
Bellevue, NE

MEDICAL STAFF BYLAWS

Part III: Credentials/Privileges Procedures

October 6, 2009
Revised March 1, 2011
Revised May 21, 2013
Reviewed December 2015
Reviewed June 26, 2016

Table of Contents

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the medical staff credentials committee shall consist of at least five (5) members of the active medical staff. The members will be chosen to provide appropriate balance and expertise to the committee. Practitioners from other specialties may be invited to the meeting as needed on an "ad hoc" basis. The committee members and Chair shall be nominated by the Leadership and Succession Committee and appointed by the President of the medical staff and approved by the MEC. Members and the Chair shall be appointed for three (3) year terms. The chair and members may be reappointed for additional terms subject to a performance evaluation process recommended by the MEC. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the whole MEC. The committee may also invite ex officio members such as representatives from hospital administration and the Board who may attend and participate without vote.

1.2 Meetings

The medical staff credentials committee shall meet on call of the chair or President of the medical staff.

1.3 Responsibilities

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

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

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

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

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

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

1.4 Confidentiality

This committee reports to the MEC and 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.

1.4.1 The credentials file is the property of the hospital and shall be maintained with strictest confidence and security. The files shall 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 CEO or designee.

1.4.2 Individual practitioners may review their credentials file only upon written request approved by the President of the medical staff, CEO, or credentials chair. Review of such files shall be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and shall be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file. The practitioner may make notes for inclusion in the file. A written or electronic record shall 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, or privileges at any other healthcare organization.

2.2 The following qualifications shall be met by all applicants for medical staff appointment, reappointment or hospital privileges:

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

2.2.2 Be currently licensed or otherwise authorized to practice his/her profession in Nebraska in accordance with state licensing requirements;

2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities or the GSA Excluded Parties List System;

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

2.2.5 Dentists shall have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation; and have completed a hospital-based residency in general dentistry, a dental specialty residency, or have equivalent experience as a dentist member of a hospital medical staff;

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

2.2.7 A podiatric physician, DPM, shall have successfully completed an approved residency in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training from an accredited national Podiatric certification program; additionally, per Nebraska statute, no Podiatrist initially licensed in this state shall be granted privileges to perfrom surgery on the ankle unless such person has successfully completed an advanced postdoctoral surgical residency program of at least two (2) years duration.

2.2.8 A psychologist shall have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have met the training requirements for licensure established by the appropriate Nebraska licensing authority;

2.2.9 Other practitioners eligible for privileges shall have successfully completed educational and training requirements for current certification to practice in Nebraska and as required by Hospital Service Line policies and delineation of privileges applicable to the profession;

2.2.10 Possess a current, valid, unrestricted drug enforcement administration (DEA) number if applicable;

2.2.11 Have appropriate written and verbal communication skills;

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

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

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

2.2.13 Board certification, or lack therof, shall not be the sole criteria for decision for any practitioner;

2.3 The following qualifications shall also be met by all applicants requesting hospital privileges:

2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

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

2.3.3 Any practitioner requesting privileges to admit an inpatient shall demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.4 Demonstrate recent clinical performance within the last twelve (12) months with an active clinical practice in the area in which hospital privileges are sought adequate to meet current clinical competence criteria;

2.3.5 Request privileges for a service the Board has determined appropriate for performance at the hospital. There shall also be a need for this service under any Board approved medical staff development plan;

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

2.4 Exceptions

2.4.1 Only the Board may create additional exceptions to the above Section 2.2 after recommendation from the MEC.

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

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

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

d. All applicable fees;

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport);

f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;

g. Relevant practitioner-specific data as compared to aggregate data, when available; and

h. Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application shall not be processed and the applicant shall 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 shall be terminated and no further action taken.

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

3.1.3 Upon receipt of a completed application, the medical staff office shall determine if the qualifications of Section 2.2 are met. In the event the qualifications of Section 2.2 are not met, the potential applicant shall be notified that s/he is ineligible to apply for membership or privileges on the medical staff, the application shall not be processed and the applicant shall not be eligible for a fair hearing. If the qualifications of Section 2.2 are met, the application shall be accepted for further processing.

3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of their qualifications, and of resolving any doubts.

3.1.5 Upon receipt of a completed application, the medical staff office, shall verify current licensure, education, relevant training, and current competence from the primary source whenever feasible. 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 shall 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 five (5) years;

b. Documentation of the applicant's past clinical work experience;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office shall primary source verify Nebraska or federal licensure at the time of renewal or revision of hospital privileges, whenever a new privilege is requested, and at the time of license expiration.

d. Information from sources that may include the AMA or AOA Physician Profile, Federation of State Medical Boards, OIG List of Excluded Individuals/Entities, GSA Excluded Parties List System and FACIS (Fraud and Abuse Control Information System),

e. Information from professional training programs including residency and fellowship programs;

f. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB shall be queried at the time of renewal of privileges and whenever a new privilege(s) is requested.

g. Other information about adverse credentialing and privileging decisions;

h. One or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental and emotional ability to perform requested privileges.

i. Information from a criminal background check;

j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;

k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

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

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

3.2 Applicant's Attestation, Authorization and Release

The applicant shall complete and sign the application form. By signing this application or accepting membership or privileges, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees 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 hospital privileges, the individual's appointment and privileges shall lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

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

3.2.3 Authorizes the hospital and its representatives to solicit, obtain, review, and act upon information bearing upon, or reasonably believed to bear upon, the practitioner's competence or professional conduct, and releases the hospital and its authorized representatives for so doing to the fullest extent permitted by law;

3.2.4 Authorizes any other individual and organization to provide information to this hospital and its authorized representatives bearing upon, or reasonably believed to bear upon, the practitioner's competence or professional conduct, and agrees to execute authorizations and releases to facilitate obtaining such information and releases such other parties for so doing to the fullest extent permitted by law;

3.2.5 Consents to inspection of records and documents that may be material to an evaluation of his or her competence or professional conduct; authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying; agrees to execute authorizations and releases to facilitate obtaining or reviewing such records and documents from such parties; and releases such parties for so doing to the fullest extent permitted by law;

3.2.6 Agrees to provide accurate, current, and complete information in connection with the appointment, reappointment, privileging, quality improvement, and corrective action processes at the hospital, or in response to specific inquiries from the hospital and its authorized representatives, or as a continuing obligation under these Bylaws;

3.2.7 Agrees to immediately inform the Medical Staff Services Department of any material changes or developments affecting or changing the information provided in or with his or her application;

3.2.8 Agrees to cooperate with the hospital and its authorized representatives in the conduct of peer review activities involving him or her, which includes appearing at interviews, answering questions and working within the peer review structure described in these Bylaws;

3.2.9 Authorizes the hospital and its authorized representatives to disclose or report to other hospitals, medical associations, licensing boards, practice groups, government bodies and similar organizations information regarding his or her competence or professional conduct, in connection with such other party's peer review and related activities, and releases this hospital and its authorized representatives for so doing to the fullest extent permitted by law;

3.2.10 Releases from liability to the fullest extent permitted by law and agrees not to sue this hospital and its authorized representatives for their acts performed in connection with conducting peer review activity;

3.2.11 Acknowledges that the foregoing provisions are express conditions to an application for medical staff membership and privileges, the continuation of such membership and privileges and the exercise of clinical privileges at the hospital.

As used in this Section, the term "hospital and its authorized representatives" means this hospital and members of its workforce, the members of its Board of Directors and their appointed representatives, the CEO and his or her designee(s), all officers and members of the medical staff, any hearing officer, presiding officer and all members of any hearing committee and consultants to the hospital.

3.3 Application Evaluation

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

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 may be granted medical staff membership and/or privileges after review and action by the following: Hospital Service Line Chief, credentials chair acting on behalf of the credentials committee, the MEC and a Board committee consisting of at least two individuals.

3.3.2 Non-expedited credentialing: Any application for initial appointment that meets the following criteria shall be designated as Category 2 as follows:

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application shall be treated as Category 2. Applications in Category 2 shall be reviewed and acted on by the Hospital Service Line Chief, credentials committee, MEC, and the Board. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC is adverse or with limitation;

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

d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of $250,000;

f. Applicant changed medical schools or residency programs or has gaps in training or practice;

g. Applicant has changed practice locations more than three times in the past ten (10) years;

h. Applicant has practiced or been licensed in three (3) or more states;

i. Applicant has one or more reference responses that raise concerns or questions;

j. Discrepancy is found between information received from the applicant and references or verified information;

k. Applicant has an adverse National Practitioner Data Bank report other than related to medical malpractice as specified in 3.3.2.e;

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

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

n. Applicant has potentially relevant physical, mental and/or emotional health problems;

o. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

3.3.3 Applicant Interview

a. All applicants for appointment to the medical staff and/or the granting of hospital privileges may be required to participate in an interview at the discretion of the credentials committee, Hospital Service Line Chief, MEC or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided concerning qualifications. The interview may also be used to communicate medical staff performance expectations.

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

3.3.4 Hospital Service Line Chief Action

a. All completed applications are presented to the Hospital Service Line Chief for review, and recommendation. The Hospital Service Line Chief reviews the application to ensure that it fulfills the established standards for membership and/or hospital privileges. The Hospital Service Line Chief, in consultation with the medical staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Hospital Service Line Chief may obtain input if necessary from an appropriate subject matter expert. If a Hospital Service Line Chief believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he shall notify the credentials chair and forward the application without comment.

b. The Hospital Service Line Chief forwards to the medical staff credentials committee the following:

- A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- A recommendation to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;
- A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of hospital privileges;
- Comments supporting the recommendations in 3.3.3 a, b and c above.

3.3.5 Medical Staff Credentials Committee Action

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

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

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

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

d. Comments supporting the recommendations in 3.3.5 a, b and c above.

3.3.6 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with a quorum requirement established for expedited credentialing which shall be 1/3 of the members of the MEC. 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 hospital privileges. The MEC forwards the following to the Board:

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

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

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

d. Comments supporting the recommendations in 3.3.6 a, b and c above.

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

3.3.7 Board Action:

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 hospital 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 shall 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:

- 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 shall be made. If the Board concurs with the applicant's request for membership and/or privileges it shall grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months.

- In the event the decision of the Board differs substantially from the recommendations of the MEC, further action by the Board shall be held in abeyance for a period not to exceed thirty (30) calendar days while the matter is referred back to the MEC for further consideration and recommendation. The MEC shall review the proposed action of the Board, conduct any further investigation, and make such additional comments or recommendations as the MEC deems appropriate; or the Board or the MEC may refer the matter to a Joint Conference Committee pursuant to Part I, Section 8. In such case, following its deliberations, the Joint Conference Committee shall prepare a report to the Board setting forth its recommendations and the reasons supporting the recommendations.
- After receiving further recommendations from the MEC or the Joint Conference Committee, the Board shall take final action. In the event no comments or recommendations are received from the MEC or Joint Conference Committee within thirty (30) calendar days of the date that the Board referred the matter back to the MEC or the Board or the MEC referred the matter to the Joint Conference Committee, the proposed decision of the Board shall become final, unless the Board, in its sole discretion, extends the time for the MEC or the Joint Conference Committee to act.
- If the Board's action is adverse to the applicant, a special notice, stating the reason, shall be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan).
- The Board shall take final action in the matter as provided in Part II of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan).

3.3.8 Notice of final decision: Notice of the Board's final decision shall be given, through the CEO to the MEC and to the chair of each Hospital Service Line 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 Hospital Service Line to which s/he is assigned, the hospital privileges s/he may exercise, and any special conditions attached to the appointment.

3.3.9 Time periods for processing: All individual and groups acting on an application for staff appointment and/or hospital privileges shall do so in a timely and good faith manner, and, except for good cause, each application shall be processed within 180 (one-hundred eighty) calendar days. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Professional Practice Evaluation

All practitioners at the time of initial application shall be subject to a period of focused professional practice evaluation (FPPE). The credentials committee, after receiving a recommendation from the Hospital Service Line Chief and with the approval of the MEC shall define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of hospital 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 shall also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

The medical staff shall also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process shall 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 shall be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 5. Reappointment

5.1 Criteria for Reappointment

5.1.1 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 Part III Credentials Procedures, Section 2 of these bylaws and who have satisfactorily complied with the medical staff responsibilities as outlined in Part I Governance, Section 2.6 of these bylaws during the intervening period since prior appointment. The MEC shall 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 shall provide the information enumerated in Section 5.2 below. All reappointments and renewals of hospital privileges are for a period not to exceed twenty-four (24) months. The granting of new hospital privileges to existing medical staff members shall follow the steps described in Section 3 above concerning the initial granting of new hospital privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the Hospital Service Line Chief in the evaluation of current competency of the Hospital Service Line Chief, and recommend appropriate action to the credentials committee.

5.1.2 In the event a practitioner finds no need to utilize the facilities or resources of the institution for purposes of patient care through either admission, performance of a procedure, consultation, or referral, during a two (2) year period other than in the case of military leave, s/he may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of current appointment or privileges. This provision applies to individuals who have been granted a leave of absence, moved their practice location, established a relationship with another institution or otherwise find no need to utilize the clinical resources of the institution. Exceptions to this provision may be made by the Board upon recommendation of the MEC.

5.2 Information Collection and Verification

5.2.1 From appointee: On or before five (5) 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 a Provider Reappointment Application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner shall return the following to the medical staff office:

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

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

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

5.2.2 From internal and/or external sources: The medical staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in the Provider Reappointment Application.

5.2.3 The following information is also collected and verified

a. A summary of clinical activity at this hospital for each appointee due for reappointment;

b. Performance and conduct in the practitioner's primary and secondary hospital as identified on the Practitioner Reappointment Application 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. Certification of any required hours of continuing medical education activity;

d. Service on medical staff, Hospital Service Line, and hospital committees;

e. Timely and accurate completion of medical records;

f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;

g. Any significant gaps in employment or practice since the previous appointment or reappointment;

h. Verification of current Nebraska licensure;

i. National Practitioner Data Bank (NPDB) query;

j. Medicare and General Service Adminstration (GSA) excluded provider queries;

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 patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental and emotional ability to perform requested privileges;

l. Malpractice history for the past two (2) years which is primary source verified by the medical staff office with the practitioner's malpractice carrier(s).

5.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment shall result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

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

5.3.1 Expedited review reappointment applications shall be categorized as described in Section 3.3.1 above.

5.3.2 The reappointment application shall 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 hospital privileges or in the case of practitioners eligible for fair hearing as listed in these Bylaws Part II: Investigations, Corrective Actions, Hearing and Appeal Plan, Section 4.1. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment".

Section 6. Hospital Privileges

6.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency and disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advance Practice Registered Nurses (APRN's) including nurse practitioners, Clinical Nurse Specialists and those certified and practicing as Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse Midwives (CNMs); Physician Assistants (PA); physicians serving short locum tenens positions; telemedicine physicians; or others deemed appropriate by the MEC and Board.

6.2 Requests

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

6.3 Basis for Privileges Determination

6.3.1 Requests for hospital privileges shall 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 hospital privileges.

6.3.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request shall be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC shall:

a. Review the community, patient and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;

b. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting –specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information and staffing plans;

d. Work with management to ensure that, if granted, such privileges would not conflict with any exclusive or other contracts. Upon recommendation from the credentials committee and appropriate clinical service/specialty or subject matter experts (as determined by the credentials committee), the MEC shall formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request shall be processed as described herein.

- For the development of criteria, the medical staff service professional (or designee) shall compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate;
- Criteria to be established for the privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, shall be addressed including who may serve as proctor and how many proctored cases shall be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management shall be referred to the appropriate hospital administrator and/or Hospital Service Line director;
- If the privileges requested overlap two or more specialty disciplines, an ad hoc committee shall be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee shall consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee shall be a member of the credentials committee who has no vested interest in the issue.

6.3.3 Requests for hospital privileges shall be consistently evaluated on the basis of prior and continuing education, training, experience, compliance with all responsibilities of membership and privileges, 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 shall include documented clinical performance and results of the staff's performance improvement program activities. Privileges determinations shall 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 hospital privileges.

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

6.4 Special Conditions for Dental Privileges

Requests for hospital privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oromaxillofacial surgeons shall 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 shall be recorded in the medical record. Oromaxillofacial 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 oromaxillofacial surgery and demonstrated current competence.

6.5 Privileges without membership

Requests for privileges from individuals eligible for privileges but not membership are processed in the same manner as requests for hospital privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges.

Physicians in this category may exercise delineated privileges granted by the Board but shall not be eligible for membership on the medical staff. Examples include, but may not be limited to locum tenens physicians; telemedicine physicians; military physicians.

Allied health practitioners (AHP) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients either under the supervision of a physician or in collaboration with a physician. Examples include PAs and APRNs including clinical nurse specialists, nurse practitioners, CRNAs and CNMs. Special collaboration circumstances may apply to certain classes of AHPs (examples include, but are not limited to, Certified Nurse Midwives and Certified Registered Nurse Anesthestists). Such privileges with supervision or collaboration shall be as specifically outlined in the delineation of privileges form for each practitioner.

The privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the medical staff is terminated for any reason, or if the privileges of the supervising or collaborating physician terminate.

6.6 Special Conditions for Podiatric Privileges

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

6.7 Special Conditions for Residents or Fellows in Training

6.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific hospital privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the residency training program in collaboration with the Chief Medical Officer. The protocols shall delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician shall countersign. The protocol shall 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 shall be communicated to appropriate medical staff and hospital leaders.

6.7.2 The Residency program director shall communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and shall work with the MEC to assure that all supervising physicians possess hospital privileges commensurate with their supervising activities.

6.7.3 Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings. All aspects of patient care rendered by residents must receive close faculty supervision. All aspects of patient care are ultimately the responsibility of the attending physician. Attending physicians have the right to prohibit resident participation in the care of their patients. Attending physicians also have the right to determine the roles and responsibilities that are granted to a given resident under their supervision subject to any guidelines established by the medical staff. Residency is a process of increasing responsibility; residents will be granted those responsibilities based on demonstrated competence and within the parameters of the written protocols as outlined in Part III: Credentials/Privileges Procedures, Section 6.8.1 above. Those roles and responsibilities cannot exceed those privileges that have been granted to the attending physician by the Hospital. When a resident is involved in the care of a patient, it is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, examination and interpretation of diagnostic testing and intended implementation of a treatment plan. It is the attending physician's responsibility to personally examine all patients on a daily basis, review all entries in the medical record by the house staff, make necessary corrections in the treatment plan and document their involvement in the care of the patient.

6.8 Special Conditions for the Aging Practitioner

On an annual basis, the Credentials Committee shall specifically evaluate the mental and physical capabilities of each appointee who has attained the age of seventy (70) years and who is either admitting or caring for patients at the Hospital. Recommendations to the Credentials Committee for continued hospital privileges between ages seventy (70) and seventy-five (75) shall be based upon such evaluations. Such evaluations shall normally occur upon reappointment; however, as in the case of all practitioners appointed to the medical staff or holding privileges at the Hospital, may occur at any time during the appointment year if warranted as consistent with Part I Governance, Section 2.6.4 of these bylaws. The Credentials Committee shall submit a report of its evaluation to the MEC. The MEC shall submit a recommendation to the Board.

Upon attaining the age of seventy-five (75), practitioners shall ordinarily no longer have privileges to admit or care for patients at the Hospital unless an exception for continuing privileges is recommended by the Credentials Committee and the MEC; and approved by the Board.

6.9 Telemedicine Privileges

Telemedicine privileges are available only to physicians who will provide patient care services solely from a remote site. Physicians qualifying for telemedicine privileges are not eligible for membership on the medical staff. Telemedicine physicians shall complete the same application and follow the same application procedures as other physicians, subject to exceptions related to their remote site of service. Hospital affiliations for at least the past five (5) hospitals where services were provided will be verified.

6.10 Temporary Privileges

The CEO, 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 provided the medical staff office is able to verify the practitioner's current licensure and competence. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board. Temporary privileges may be granted as follows:

6.10.1 Non-Applicants to Fill a Need. The CEO, following consultation with the appropriate Hospital Service Line Chief, may grant temporary privileges for a period not to exceed one hundred twenty (120) days to a practitioner who is not applying for staff appointment, when determined necessary to fill a patient care, treatment or service need. Examples include practitioners who will provide *locum tenens* coverage for a member of the medical staff and practitioners who will provide needed coverage or services to the hospital under contract or other arrangement on a temporary basis.

a. Minimum Qualifications and Verifications. Before granting temporary privileges to non-applicants, the hospital shall:

(1) Verify current Nebraska licensure and current DEA certification, if applicable;

(2) Verify current professional liability insurance in amounts required for membership and privileges;

(3) Verify current membership and privileges at another hospital or Joint Commission accredited organization at least co-extensive with the temporary privileges being requested (may be waived in the case of dentists and podiatrists);

(4) Verify that the individual is not excluded from any federally-funded health care program;

(5) Review the individual's arrangements for continuous care of patients to be treated by such practitioner;

(6) Verify that the individual meets the education and training requirements for membership and privileges;

(7) Query the National Practitioner Data Bank and make follow-up inquiry as indicated; and

(8) Obtain one or more peer references for the individual to verify current core competency and ability to perform the privileges requested.

b. Duration. The duration of temporary privileges for non-applicants shall be stated at the time they are granted and communicated to the practitioner. The maximum duration of initial temporary privileges for non-applications and any extensions is one hundred twenty (120) days. All temporary privileges granted to cover a specific patient, practitioner or absence, or hospital coverage or service need shall end when the particular patient is discharged or the practitioner or absence or hospital coverage or service ends.

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

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

6.10.4 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the President of the medical staff or applicable Hospital Service line Chief, 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. Additionally a person entitled to impose precautionary suspension believes that grounds for precautionary suspension exist, he/she may terminate temporary privileges. In the event of any such termination, the practitioner's patients then shall be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

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

6.10.6 **Emergency Privileges:** In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Hospital Service Line 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. Such emergency privileges/authority shall end as soon as a regularly privileged practitioner is ready/able to assume the patient care or when the emergency ends.

6.10.7 **Disaster Privileges:**

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO 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 LIPs. These practitioners shall 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 current picture hospital ID card that clearly identifies professional designation;
- A current Nebraska license to practice unless otherwise directed by state or federal authorities;
- Primary source verification of the license;
- 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;
- 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);
- Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

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

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

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

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

Section 7. Preceptorship

7.1 A practitioner who has not provided acute inpatient care within the past three (3) years who requests hospital privileges at the hospital shall arrange for a preceptorship either with a current member in good standing of the medical staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. The practitioner shall assume responsibility for any financial costs required to fulfill the requirements of focused professional practice evaluation as outlined in Part III Credentials procedures, sections 7.1 and 7.2**.**

7.2 A description of the preceptorship program, including details of monitoring and consultation shall be written and submitted for approval to the credentials committee and MEC. At a minimum, the preceptorship program description shall include the following:

7.2.1 The scope and intensity of required preceptorship activities including but not limited to a description of whether the precepting will be prospective, concurrent or retrospective;

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

Section 8. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

8.1 Reapplication after adverse credentials decision

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

8.2 Request for modification of appointment status or privileges

Subject to Part III: Credentials Procedures, Section 8.1 above, a staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, Hospital Service Line assignment, or hospital privileges by submitting a written request to the medical staff office. A modification request shall be on the prescribed form and shall contain all pertinent information supportive of the request. All requests for additional hospital privileges shall be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the medical staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

8.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his/her staff appointment and/or hospital privileges shall provide written notice to the appropriate President of the medical staff and the CEO. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or hospital privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. A resignation is effective when accepted by the Board or its designee. The Board is not obligated to accept the resignation of a practitioner who is not current on medical records or other obligations.

8.4 Exhaustion of administrative remedies

Every practitioner agrees that s/he shall 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.

8.5 Reporting requirements

The CEO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any applicable Nebrasks state law and regulations. Actions that shall be reported include any adverse professional review action against a physician related to clinical competence or professional conduct that affects or may affect adversely patient welfare, and any voluntary surrender of membership or privileges or acceptance of limitations theron while under or to avoid an investigation. Reportable events including actions that lead to a denial of appointment and/or reappointment; reduction in hospital privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 9. Leave of Absence

9.1 Leave Request

A leave of absence shall be requested for any absence from the medical staff and/or patient care responsibilities longer than ninety (90) days if such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence shall provide written notice to the President of the medical staff 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 shall be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise hospital privileges or prerogatives and has no obligation to fulfill medical staff responsibilities. 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.

9.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the medical staff. The practitioner shall submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons shall provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner shall apply for reappointment, or his/her appointment and/or hospital privileges shall lapse at the end of the appointment period.

9.3 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.

9.4 Effect of Leave

A leave of absence shall not have the effect of extending a practitioner's period of appointment or privileges. Even while on leave, a practitioner must apply for reappointment or renewal of privileges according to his/her reappointment cycle.

Section 10. Practitioners Providing Contracted Services

10.1 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 and groups, then other practitioners shall, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. The terms of such exclusive contracts shall control application for initial appointment or for hospital privileges related to the hospital facilities or services covered by exclusive agreements shall not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which now become covered by an exclusive contract, shall not be able to exercise those privileges unless they become a party to the contract.

10.2 Qualifications

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

10.3 The terms of the medical staff bylaws shall govern disciplinary action taken by or recommended by the MEC.

10.4 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 hospital privileges shall 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 shall not affect the practitioner's staff appointment status or hospital privileges.

Section 11. Medical Administrative Officers

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

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

11.3 Effect of removal from office or adverse change in appointment status or hospital privileges:

11.3.1 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 hospital privileges has on his remaining in office.

11.3.2 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 hospital privileges. The effect of an adverse change in appointment status or hospital privileges on continuance in office shall be as determined by the Board.

11.3.3 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 hospital privileges unless the change is, by contract a consequence of removal from office

Bellevue Medical Center
Bellevue, NE

MEDICAL STAFF BYLAWS

Part IV: Organization and Functions Manual

October 6, 2009
Reviewed May 2013
Reviewed December 2015
Reviewed June 28, 2016

Table of Contents

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The medical staff shall be organized as a Hospital Service Line staff. The following shall be the designated Hospital Service Lines with a listing of the specialty areas encompassed by that Hospital Service Line:

- **Cardiovascular/Critical Care**
  - Cardiology
  - Pulmonology
  - Critical Care Medicine)
- **Women's and Children's Care**
  - Obstetrics
  - Gynecology
  - Maternal Fetal Medicine
  - Pediatrics
  - Neonatology
- **Medicine/Emergency Medicine**
  - Internal Medicine
  - Family Medicine
  - Medical Specialties
  - Neurology
  - Emergency Medicine
  - Psychiatry
- **Diagnostic Services**
  - Pathology
  - Radiology
- **Procedural/Surgical**
  - General Surgery
  - Anesthesia
  - Surgical Specialties including but not limited to Dental/Oral Surgery, Neurosurgery, Podiatry, Ophthalmology, Urology, Orthopedics, Otolaryngology, Plastic Surgery, Thoracic Surgery, Vascular Surgery.

A Hospital Service Line Chief shall head each clinical Hospital Service Line with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

Clinical sections may be authorized by the MEC as outlined in Part I: Governance of these Bylaws to facilitate the administrative work of the Hospital Service Lines or to offer additional forums for clinical and educational activities

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Hospital Service Line Chiefs, clinical section leaders, hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports to the appropriate Hospital Service Line/service/committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

1.3.1 Governance, direction, coordination, and action: The medical staff, acting through the MEC and the committee/service line structure which reports to the MEC, is responsible to:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from Hospital Service Lines, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to obtain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements recognizing that CEO shall hold final responsibility for HCQIA/NPDB and state reporting;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body;

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

- Medical assessment and treatment of patients
- Use of medications
- Use of blood and blood components
- Operative and other procedures
- Education of patients and families
- Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
- Appropriateness of clinical practice patterns
- Significant departures from established pattern of clinical performance
- Use of developed criteria for autopsies
- Sentinel event data
- Patient safety data
- Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
- Findings of the assessment process relevant to individual performance

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of physicians to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 The medical staff shall also participate in hospital performance improvement and patient safety programs to:

a. Understand the medical staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis;

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials review (see Credentials Procedures)

1.3.5 Information Management

a. Review and evaluate medical records to determine that they:

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

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

b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein.

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness: Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.7 Strategic Planning

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

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

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

1.3.8 Bylaws review

a. Conduct annual review of the medical staff bylaw, rules, regulations and policies;

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

1.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure;

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight

a. Oversee the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection.

b. Develop and approve policies describing the type and scope of surveillance activities including:

Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;

Review of prevalence and incidence studies, as appropriate;

Collection of additional data as needed;

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader;

h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by the Joint Commission;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to the Joint Commission "Care of Patient" Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

Prescribing/ordering of medications;

Preparing and dispensing of medications;

Administrating medications;

Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications;

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Health

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

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

c. Maintain a separate Practitioner Health Committee as outlined in Part IV Organization Functions Manual, Section 2.5, to address such issues.

d. Notify the impaired practitioner's Hospital Service Line/clinical service chief and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the practitioners' health committee does not alter the primary responsibility of the Hospital Service Line Chief for clinical performance within that chair's Hospital Service Line;

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

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

1.4 Responsibilities of Hospital Service Line Chiefs

1.4.1 The responsibilities of Hospital Service Line Chiefs or designee shall include:

a. To oversee all clinical and administratively-related activities of the Hospital Service Line otherwise provided by the hospital;

b. To provide ongoing surveillance of the performance of all individuals in the medical staff Hospital Service Line who have been granted hospital privileges;

c. To recommend to the credentials committee the criteria for requesting hospital privileges that are relevant to the care provided in the medical staff Hospital Service Line;

d. To recommend hospital privileges for each member of the Hospital Service Line and other practitioners practicing with privileges within the scope of the Hospital Service Line;

e. To collaborate with the hospital on business, operational and strategic initiatives involving the Hospital Service Line to support the provision of patient care services.

f. Other duties as delegated by the MEC to assist in carrying out the administrative functions of the medical staff under these bylaws and related medical staff documents.

1.5 Responsibilities of the President of the Medical Staff

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

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 committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

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

d. 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;

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

f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of hospital privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

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

i. 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;

j. Attend Board meetings and Board committee meetings as invited by the Board;

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

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

1.6 Responsibilities of Clinical Section Leaders

1.6.1 Where such clinical sections have been formed to supplement the activities of the Hospital Service Lines, they shall be responsible to:

a. Formulate continuing education and encourage discussion of patient care issues pertinent to that clinical specialty;

b. Conduct grand rounds as desired by physicians in the clinical section;

c. Discuss policies and procedures and recommend same to the appropriate Hospital Service Line Chief;

d. Discuss equipment needs pertinent to that clinical section;

e. Develop recommendations of a specific issue at the request of a Hospital Service Line Chief or the MEC;

f. Encourage participation in the development of criteria for hospital privileges and give input on an application or reapplication, when requested by the Hospital Service Line Chief, credentials committee or MEC.

Section 2. Medical Staff Committees

Standing committees shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the medical staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees shall cease to meet when they have accomplished their appointed purpose or on a date set by the President of the medical staff when establishing the committee. The President of the medical staff and the CEO, or their designees, are ex officio members without vote of all standing and ad hoc committees with the exception of any committee to which they are appointed as a regular voting member under these Bylaws or the Rules and Regulations.

Committee members may be removed from the committee by the President of the medical staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made. A vacancy on any committee shall not impair such committee's authority to act.

The following shall be the standing committees of the medical staff

2.1 Medical Executive Committee (MEC)

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

2.2 Credentials Committee

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

2.3 Medical Staff Quality Committee (MSQC)

2.3.1 **Composition**: The MSQC shall be constituted as outlined in the Medical Staff Quality and Peer Review policy which contains a charter for MSQC. Representatives from nursing service and hospital administration shall serve as ex officio members at the invitation of the chair.

2.3.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.2 a-d above. This committee shall be formed and operated for the purpose of peer review and utilization management consistent with Nebraska Statutes 71-2046 to 71-2048 and shall report to the MEC.

2.4 Practitioner Health Committee

2.4.1 **Composition**: The practitioner health committee shall consist of at least five (5) members of the active medical staff and shall include the chair of the MEC, the chair of the MSQC and, a physician with a previous history of impairment whose impairment who has been successfully treated (if feasible), and other members of the medical staff selected by the President of the medical staff to bring the total complement to five (5) physician members. The CEO, or designee, shall serve as an ex officio member.

2.4.2 **Responsibilities**: This committee shall be responsible for those functions described in section 1.3.12 above.

2.5 Leadership & Succession Committee

2.5.1 **Composition**: The leadership and succession committee shall consist of five (5) members of the medical staff including the President and immediate past President of the medical staff and three others appointed by the MEC. The chair shall be the immediate past President of the medical staff. Except for the President and immediate past President, terms shall be determined by the MEC. All members should be active members of the medical staff and have current or past leadership experience as a medical staff officer, Hospital Service Line Chief, committee chair or department chair in another hospital.

2.5.2 **Responsibilities**: The committee shall:

a. Develop criteria for leadership positions to include tenure, leadership training, previous experience in leadership positions and character;

b. Provide a slate of nominees for the elected medical staff positions;

c. Provide an annual list of potential leaders;

d. Define a process for evaluating current leaders including Hospital Service Line Chiefs, committee chairs, medical staff officers, and MEC members and potential leadership candidates;

e. Outline a plan and processes for developing potential leaders;

f. Submit recommendations for medical staff committee chairs based on the potential leaders' needs for development and readiness to serve. The President of the medical staff and the MEC shall consider these recommendations for committee chairs but shall not be bound by them;

g. Develop job descriptions for officer positions;

h. Report at least once a year to the MEC

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

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

3.2 Immunity from Liability

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

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article and in Part III: Credentials Procedures, Section 3.2 apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's professional review activities concerning, but not limited to:

a. Applications for appointment/affiliation, hospital privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, hospital privileges, or specified services;

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities;

i. Other hospital, committee, Hospital Service Line, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct..

3.4 Releases

When requested by the President of the medical staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or hospital privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating. When a potential relative conflict is identified, the committee chair shall be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.