Lovelace

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Medical Staff Bylaws

Lovelace Medical Center
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Part I: Medical Staff Bylaws

ARTICLE I. MEDICAL STAFF PURPOSE & AUTHORITY

Section 1. Purpose

The purpose of this Medical Staff is to organize the activities of qualified physicians and other clinical practitioners who practice at Lovelace Medical Center in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Hospital's Governing Board. The Medical Staff provides oversight of care, treatment and services provided by clinicians with privileges at Lovelace Medical Center. The members of the Medical Staff work together as an organized body to promote a uniform standard of quality patient care, treatment and services and to offer advice, recommendations, and input to the Chief Executive Officer (CEO) and the Governing Board. The Medical Staff is an organ of the hospital which promulgates bylaws, policies and procedures to determine its governance and administrative structures and the processes for carrying out its work, subject to the ultimate authority of Governing Board.

Section 2. Authority

Subject to the authority and approval of the Governing Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of the Hospital.

ARTICLE II. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of Lovelace Medical Center is a privilege that shall be extended only to professionally competent physicians (M.D. and D.O.), dentists, oral surgeons, podiatrists, optometrists and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and Lovelace Medical Center.

Section 2. Qualifications for Membership

2.1 Specific qualifications for membership are delineated in Part III of these Bylaws (the Credentials

Procedure Manual).
2.1.1 A list of available medical staff privileges along with the criteria for initial application, maintenance, and reappointment that have been approved by the Lovelace Medical Center Governing Board are available in the Lovelace Medical Center Privileging Manual.

2.2 General qualifications include evidence of the following:

a. (1) current licensure,
(2) the applicant is not currently excluded by the government from participation in federal health insurance programs such as Medicare or Medicaid. This does not mean that the applicant must participate in these insurance programs.
(3) adequate education, training, experience and evidence of current competence and sound clinical judgment to warrant all privileges requested,
(4) the ability to safely and competently meet the obligations of the Medical Staff category requested, and the physical and mental ability to safely and competently perform the clinical privileges requested, and
(5) demonstration to the satisfaction of the Medical Staff and Governing Board that patients applicant may treat can reasonably expect quality medical care; and

b. willingness to properly discharge the responsibilities established by the Hospital;

c. any applicable office or residence location requirements established by the Governing Board are satisfied;

d. the applicant is requesting privileges in a specialty which is neither subject to an exclusive contract granted by the Governing Board nor closed in accordance with any Medical Staff development plan adopted by the Governing Board;

e. compliance with professional liability insurance requirements as set out in these bylaws or in Medical Staff policies;

f. an ability and willingness to work cooperatively with other clinicians and Hospital staff in a professional manner and in compliance with established Medical Staff and Hospital policies;

g. compliance with any other criteria for eligibility that may be established by the Governing Board.

Exemptions from any of these criteria may be allowed by the Governing Board after consultation with the Medical Staff.

Section 3. Nondiscrimination

The Lovelace Medical Center will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care, or on any other basis prohibited by applicable law, to the extent the Applicant is otherwise qualified.

Section 4. Conditions and Duration of Appointment

The Governing Board shall make initial appointment and reappointment to the Medical Staff. The Governing 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.

Section 5. Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and clinical Privileges will be processed only when the potential Applicant meets the current minimum qualifying criteria approved by the Governing Board. Requested clinical privileges will be considered only when the request demonstrates compliance with any threshold criteria recommended by the MEC and approved by the Governing Board. In the event there is a request for a clinical privilege for which there are no approved criteria, the Governing Board, with input from the MEC and Hospital administration, will first determine if it will allow the privilege to be practiced at the Hospital and, if so, direct the MEC to promptly develop privileging criteria by considering required licensure, relevant training or experience, current competence, and ability to perform the privilege requested. Once specific criteria for the clinical privilege have been recommended by the MEC and approved by the Governing Board, the request for the clinical privilege will be evaluated as described in Part III of these Bylaws (the Credentials Procedure Manual).

Section 6. Responsibilities of Each Medical Staff Member

6.1 Each staff member must provide appropriate, timely, and continuous care of his/her patients.

6.2 Each staff member must participate, as assigned, in quality/performance improvement/peer review activities, cooperate with utilization review activities of the hospital and participate in the discharge of other Medical Staff functions as may be required.

6.3 Each staff member must reasonably[i] participate in the on call coverage of the emergency service and other coverage programs as determined by the MEC and Governing Board. All Call Coverage

requirements are governed by Rules & Regulations # 4.[4]

6.4 Each staff member must submit to any type of health evaluation as requested by the hospital CEO, or an officer of the Medical Staff, when deemed necessary to protect the well-being of patients or staff, when requested by the MEC or Credentials Committee as part of an investigation of the members ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any hospital or Medical Staff policies addressing physician health or impairment.

6.5 Each staff member must abide by the Bylaws, rules and regulations, and other policies, procedures, and plans of the Hospital and the Medical Staff, including but not limited to the Medical Staff and hospital policies on professional conduct and behavior.

6.6 Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Governing Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession.

6.7 Other responsibilities: Each Medical Staff member must:

Immediately notify the CEO and the Credentials Committee of any change in the information provided on his or her application for Medical Staff membership or clinical privileges, or if he or she ceases to meet the standards of the Hospital as set forth in these Bylaws, in the rules and regulations of the Medical Staff, and in any other applicable policies and procedures, in each case as required for continued enjoyment of Medical Staff membership and/or clinical privileges;

Notify the CEO immediately of any and all malpractice claims threatened in writing or filed against the medical staff member;

Reasonably assist the Hospital in fulfilling its uncompensated or partially compensated care obligations within the areas of his or her professional competence and clinical privileges;

Use the electronic medical records systems adopted by the hospital[6]; and

Release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the medical staff member and his or her credentials.

Will be in compliance with all Federal, State and Local Regulations as it pertains to the hospital environment and clinical services provided. The medical staff will be in compliance with EMTALA Basic Section 1866 and 1867 of the Social Security Act 42 U.S.C. Section 1395dd and

all Federal Regulations and interpretations of guidelines promulgated there under within the capabilities of the hospital.

If a patient needs to be transferred and the physician is not physically present at the time of transfer of a patient, then case management, charge nurse, or house supervisor in consultation with the physician can initiate the Certificate to Transfer. The[4] physician must co-sign the certificate within 24 hours.

The hospital provides an appropriate Medical Screening Examination, necessary stabilizing treatment for emergency medical conditions and labor. When patients are presented to the Emergency Department the Medical Screening Examination is completed by a qualified physician or Licensed Independent Practitioner (LIP) [3] and/or an appropriately supervised Physician Assistant on staff at Lovelace Medical Center.

6.8 History and Physical Examination[6]

Each patient admitted for inpatient care shall have a complete admission history and physical examination recorded by a qualified practitioner who has been credentialed and granted privileges to perform a history and physical examination within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring anesthesia. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. At a minimum, the history and physical examination and report thereof shall consist of an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission, including the chief complaint, history of present illness, relevant medical history, medication, allergies, comprehensive physical exam, statement of conclusions or impressions, and a plan of action. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance. If the history and physical is completed by a practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P

was reviewed, the patient was examined and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring anesthesia.

All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

Section 7. Medical Staff Member Rights

7.1 Each member of the Medical Staff in the active category has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event such member is unable to resolve a matter of concern after working with an appropriate Medical Staff leader(s), that member may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

7.2 Each member of the Medical Staff in the active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Article V, Section 7 of these Bylaws, regarding removal and resignation from office.

7.3 Each member of the Medical Staff in the active category may request a general staff meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by fifteen percent (15%) of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

7.4 Each member of the Medical Staff in the active category may raise a challenge to 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 fifteen percent (15%) of the active category. When the MEC has received such petition, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

7.5 Each member of the Medical Staff in the active category may call for a Clinical Service meeting by presenting a petition signed by 34% of the members of the Service if the Service has more than 10

members or 51% of the members if the Service has less than 10 members. Upon presentation of such a petition the Service Chief will schedule a Service meeting.

7.6 The above Sections 7.1 - 7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical Privileges, or any other matter relating to individual membership or privileges. Section 7.7 and Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provide recourse in these matters.

7.7 Any Medical Staff member has a right to a hearing/appeal pursuant to and under the circumstances described in Medical Staff's hearing and appeal plan (Part II of these Bylaws).

Section 8. Staff Dues

8.1 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 Medical Executive Committee may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

ARTICLE III. CATEGORIES OF THE MEDICAL STAFF

Section 1. The Active Category

1.1 Qualifications: Appointees to this category must be involved in thirty (30) patient contacts per two year appointment period (i.e., a patient contact is defined as an inpatient admission, consultation, referral for inpatient admission or an inpatient or outpatient surgical procedure) at Lovelace Medical Center, except as expressly waived for members who document their efforts to support the Hospital's patient care mission to the satisfaction of the MEC and Governing Board.

In the event that an appointee to the active category does not meet the qualifications for reappointment to the active category, and if the appointee is otherwise abiding by all Bylaws, Rules, Regulations, and policies of the staff, the appointee may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

1.2 **Prerogatives**: Appointees to this category may:

1.2.1 Exercise such clinical privileges as are granted by the Governing Board

1.2.2 Vote on all matters presented by the Medical Staff and by the appropriate Service and committee(s) to which the appointee is assigned.

1.2.3 Hold office and sit on or be the chairperson of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

1.3 Responsibilities: Appointees to this category shall:

1.3.1 Contribute to the organizational and administrative affairs of the Medical Staff.

1.3.2 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, monitoring activities and in the discharge of other staff functions as may be required**.**

1.3.3 Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC or Governing Board.

1.3.4 Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

Section 2. The Associate Category

2.1 Qualifications: The associate category is reserved for all Medical Staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status.

2.2 Prerogatives: Appointees to this category may:

2.2.1 Exercise such clinical privileges as are granted by the Governing Board.

2.2.2 Attend Medical Staff meetings and Clinical Service meetings of which he or she is an appointee and any staff or hospital education programs. Members of the associate category may not vote on matters before the entire medical staff and may not be an Officer of the Medical Staff. Members of the Associate Category may serve on Medical Staff Committees other than the Medical Executive Committee and may serve and vote on matters that come before such committees.

2.3 Responsibilities: Appointees to this category shall:

2.3.1 Contribute to the organizational and administrative affairs of the Medical Staff.

2.3.2 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, monitoring activities and in the discharge of other staff functions as may be required**.**

2.3.3 Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC or Governing Board.

2.3.4 Fulfill or comply with any applicable Hospital or Medical Staff policies and procedures.

Section *3.* The Refer & Follow Category[4]

3.1 Qualifications: The Refer & Follow category is reserved for all medical staff members who do not meet the eligibility requirements for the Active or Associate category or choose not to pursue Active or Associate status.

3.2 Prerogatives: Appointees to this category may:

3.2.a Refer patients to the hospital for outpatient testing and/or procedures.

3.2.b Refer patients to Active Staff members for inpatient treatment. Referring Staff may visit their patients in the Hospital, review patient medical records and receive information concerning patients' medical condition and treatment, but may not participate in any inpatient treatment or make entries in the medical record.

3.2.c Members of the Refer & Follow category may not vote on matters before the entire medical staff and may not be an Officer of the medical staff. Members of the Refer & Follow may not serve on medical staff Committees and may not vote on matters that come before those Committees.

Section 4. Administrative Privileges Category[5]

4.1 Qualifications: The Administrative category is reserved for Medical staff members who: 1) have no patient care or clinical responsibilities and 2) by nature of their relationship to the LMC Medical Staff, regularly attend LMC medical Staff meetings and have administrative responsibilities for interacting and supporting the medical staff.

The Administrative privilege category is reserved for Medical Staff members who at the minimum meet the criteria to in the Associate Category (Article III Section 2) this category is

most appropriate for LMC's Chief Medical Officer, but can be granted to other practitioners at the Medical Executive Committee's discretion.

4.2 Prerogatives: Appointees to this category:

4.2.1 Do not hold any clinical privileges

4.2.1 Are exempt from having to carry medical malpractice insurance

4.2.3 are exempt from any ED "call" requirements

4.2.4 Attend Medical Staff meetings and Clinical Service meetings of which he or she is an appointee and any staff or hospital education programs. Members of the Administrative category may not vote on matters before the entire medical staff and may not be an Officer of the Medical Staff. Members of the Administrative Category may serve on Medical Staff Committees other than the Medical Executive Committee and may serve and vote on matters that come before such committees.

4.3 Responsibilities: Appointees to this category shall:

4.3.1 .Contribute to the organizational and administrative affairs of the Medical Staff.

4.3.2 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, monitoring activities and in the discharge of other staff functions as may be required**.**

4.3.3 Fulfill any meeting attendance requirements as established by these Bylaws or by action of the MEC or Governing Board.

4.3.4 Fulfill or comply with any applicable Hospital or Medical Staff policies and procedures with exceptions as listed in 4.2[5]

ARTICLE IV. ALLIED HEALTH PROFESSIONALS (AHP)[6]

Section 1. Categories

Allied Health Professionals ("AHPs") shall be identified as any person(s) other than practitioners who are granted privileges to practice in the Hospital and are directly involved in patient care. Such persons may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of a staff physician . who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations).

Section 2. Qualifications

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

AHPs must:

2.1 Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

2.2 Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

2.3 Have professional liability insurance in the amount required by these bylaws;

2.4 Provide a needed service within the Hospital; and

2.5 Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

Section 3. Prerogatives

Upon establishing experience, training and current competence, AHPs, as identified in Section 1, shall have the following prerogatives:

3.1 To exercise judgment within the AHP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;

3.2 To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

3.3 To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

Section 4. Conditions of Appointment

4.1 AHPs shall be credentialed in the same manner as outlined in Part III of the Medical Staff Bylaws for credentialing of practitioners. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

4.2 Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Committee concerning the AHP's grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

4.3 The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement

of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

4.4 AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

4.5 If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

Section 5. Responsibilities

Each AHP shall:

5.1 Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.2 Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.3 Discharge any committee functions for which he/she is responsible;

5.4 Cooperate with members of the Medical Staff, administration, the Board of Trustees and employees of the Hospital;

5.5 Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.6 Participate in performance improvement activities and in continuing professional education;

5.7 Abide by the ethical principles of his/her profession and specialty; and

5.8 Notify the CEO and the Chief of Staff immediately if:

5.8.1 His/Her professional license in any state is suspended or revoked;

5.8.2 His/Her professional liability insurance is modified or terminated;

5.8.3 He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or

5.8.4 He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privileges.

5.9 Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

ARTICLE V. OFFICERS of the MEDICAL STAFF

Section 1. Officers of the Medical Staff

1 Chief of Staff
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1.2 Chief of Staff Elect (Chief Elect)

1.3 Secretary

1.4 Immediate Past Chief of Staff

Section 2. Qualifications of Officers

Officers must be members in good standing of the active category, have previously served in a leadership position on a Medical Staff, (e.g. Department or Service Chair or Chief, Committee Chair or Committee member), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges, have a history of attendance at continuing education relating to Medical Staff leadership or be willing to do so during their term of office, have demonstrated an ability to work well with others and compliance with the professional conduct policies of the Hospital, and should have excellent administrative and communication skills. The Medical Staff Nominations Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

Officers may not simultaneously hold leadership positions on another hospital Medical Staff ~~or~~[1] in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in automatic removal from office unless the Governing Board determines that continuation in office will serve the interests of the Hospital. The Governing Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

Section 3. Election of Officers

3.1 Every other year or as needed, the MEC shall appoint a Nominations Committee chaired by the Immediate Past Chief of Staff and comprised of at least three active staff members appointed by the MEC.[4] Wherever possible, at least one of these appointees should be a past Chief of Staff. If the Immediate Past Chief of Staff is not available then the MEC may appoint a chair at its

discretion. The Nominations Committee shall offer at least two nominees for each office in which a vacancy is expected. Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least forty-five (45) days prior to distribution of the mail ballot.[1] The Chief of Staff position is not elected in the manner described above. When the term for the Chief of Staff has expired; the Chief of Staff Elect will assume the duties of Chief of Staff for a two year term.

3.2 A petition signed by at least fifteen percent (15%) of the appointees of the active staff may also make nominations. Such petition must be submitted to the Chief of Staff at least fourteen (14) days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the Nominations Committee to meet the qualifications in Article V, Section 2 above before he/she can be placed on the ballot.

3.3 Officers shall be elected every other year at the annual meeting of the Medical Staff by a majority vote of those casting ballots either personally at the annual meeting or previously by mail or email ballot.[1] Only members of the Active category shall be eligible to vote. Election results will not be announced until the election deadline has been met and all votes are cast.[4]

Section 4. Term of Office

All officers serve a term of two (2) years, unless they resign or are removed hereunder. Officers shall take office in the month of January. The Past Chief of Staff shall serve a term of two (2) years, unless he/she resign or are removed hereunder.[4]

Section 5. Vacancies of Office

When the Office of Secretary becomes vacant during the Medical Staff year the MEC shall appoint an interim Secretary to fill the remainder of the vacated term. If the Office of Chief of Staff becomes vacant the Chief-Elect will fill the remainder of the vacated term and the Secretary will become Chief-Elect. Where the Chief-Elect position becomes vacant during the Medical Staff year, the Secretary will fill the remainder of the vacated term. Any vacancy in the position of Immediate Past Chief of Staff will not be filled.

Section 6. Duties of Officers

6.1 Chief of Staff – The Chief of Staff shall serve as the chair of the MEC and will fulfill duties specified in Part IV of these Bylaws (Organization and Functions Manual).

6.2 Chief of Staff-Elect – In the absence of the Chief of Staff, the Chief-Elect shall assume all the duties and have the authority of the Chief of Staff. He or she shall perform such further duties to

assist the Chief of Staff as the Chief of Staff may from time to time request.

6.3 Secretary – This Officer will collaborate with the hospital's Medical Staff office, assure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. He or she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

6.4 Immediate Past Chief of Staff – This Officer will serve as a consultant to the Chief of Staff and Vice-Chief of Staff and provide feedback to the Officers regarding their performance of assigned duties on an annual basis. He or she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may from time to time request.

Section 7. Removal and Resignation from Office

7.1 The Medical Staff may remove from office any Officer by petition of twenty-five percent (25%) of the active staff members and a subsequent affirmative vote for removal by two-thirds (2/3) of the votes cast by members of the active staff via ballot.

Automatic removal shall be for failure to conduct those responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements damaging to the Hospital, its goals, or programs, or an automatic or summary suspension of clinical privileges which lasts for more than thirty days. The existence of such failures will be determined by the Hospital's Governing Board after consulting with the Joint Conference Committee.

7.2 Resignation: Any elected officer of the Medical Staff 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 8. Conflict of Interest of Medical Staff Members[6]

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

8.1 Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

8.2 Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

8.3 Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

8.4 Business practices that may adversely affect the hospital or community.

In addition to the foregoing a new Medical Staff leader (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any service, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Governing Board) shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Secretary

will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section 8 or failure to abstain from voting on an issue in which the Medical Staff member has an interest other than as a fiduciary of the Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

ARTICLE VI. MEDICAL STAFF ORGANIZATION

Section 1. Organization of the Medical Staff

1.1 The Medical Staff of Lovelace Medical Center shall be organized as a non-departmentalized staff. The MEC may, upon approval of the Hospital's Governing Board, recognize any group of Practitioners who wish to organize themselves into a Clinical Service. Any Clinical Service, 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 Service is making a formal recommendation to the MEC. A Clinical Service recognized by the MEC shall identify a Service Chief. Clinical Services are completely optional, shall be advisory in nature only with no binding authority, and shall exist to perform any of the following activities:

1.1.1 Continuing education/discussion of patient care;

1.1.2 Grand rounds;

1.1.3 Discussion of policies and procedures;

1.1.4 Discussion of equipment needs;

1.1.5 Development of recommendations to the MEC or Management;

1.1.6 Participation in the development of criteria for Clinical Privileges when requested by the Credentials Committee or MEC; and

1.1.7 Discussion of a specific issue at the request of a Medical Staff committee or the MEC.

1.2 The current Clinical Services that are organized by the Medical Staff and formally recognized by the MEC shall be listed Part IV of the Bylaws (the Organization and Functions Manual).

Section 2. Functions of Clinical Service Chiefs

2.1 Clinical Service Chiefs shall carry out the responsibilities assigned in Part IV of these Bylaws the (Organization and Functions Manual).
2.2 Service chiefs will be elected by the clinical service members. The term of the chief of the service will be for a period of two years.

Section 3. Assignment to Clinical Service

The MEC may, after consideration of the recommendations of the Chief of the appropriate Clinical Service, recommend Clinical Service assignments for all members in accordance with their qualifications. Clinical privileges are independent of service assignment.

ARTICLE VII. COMMITTEES

Section 1. Designation and Substitution

There shall be an MEC and such other standing and special committees as established by the MEC and enumerated in Part IV of the Bylaws (the Organization and Functions Manual.) Those functions requiring participation of, rather than direct oversight by, the staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The MEC and appropriate Medical Staff leaders may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

Section 2. Medical Executive Committee

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Lovelace Medical Center Governing Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of department leadership are delegated to the MEC, it shall represent to the Lovelace Medical Center Governing Board the organized medical staff's views on issues of patient safety and quality of care. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 2 and additional functions may be delegated or removed through amendment of this Section. The functions and responsibilities of the MEC shall include, at least the duties as outlined in Section 2.2. [5]

2.1 Committee Membership:

2.1.1 Composition: The MEC shall be a standing committee consisting of:

- three (3) medical staff Officers (Chief of Staff, Chief of Staff Elect, Secretary/Treasurer)
- one (1) immediate Past Chief of Staff
- two (2) clinical service Chiefs (Medicine and Surgery)
- two (2) at-large (elected)
- three (3) in-house service Chairs[4]

The CEO and CMO of the Hospital may attend all meetings in an ex-officio, non-voting capacity.

2.1.2 Election/Appointment of non-officer MEC member process – At Large (2); In-House Service Chairs (3)

Nominations shall offer at least one candidate with provision for a "write-in" candidate for each office in which a vacancy is expected. Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least forty-five (45) days prior to distribution of the mail ballot.

The At-Large and In-House Service Chairs election shall alternate with the year of election of the Medical Staff Officers and Clinical Service Members. [5]

2.1.3 An Officer who resigns or is removed from his position in accordance with Article IV,

Section 7 above, or a Clinical Service Chief who resigns or is removed from his position, will automatically lose his membership on the MEC. At-large members of the MEC may be removed in accordance with the mechanism outlined in Article V, Section 7 for Officers.

2.2 DUTIES: The duties of the MEC shall be to:

2.2.1 Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws, except for those decisions requiring action by the full Medical Staff, and provide oversight for all Medical Staff functions.

2.2.2 Coordinate the implementation of policies adopted by the Governing Board;

2.2.3 Submit recommendations to the Governing Board concerning all matters relating to appointment, reappointment, staff category, Clinical Service assignments, Clinical Privileges, and corrective action;

2.2.4 Account to the Governing Board and to the staff for the overall quality and efficiency of professional patient care services provided in the Hospital by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

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

2.2.6 Make recommendations to the Governing Board on medico-administrative and Hospital management matters;

2.2.7 Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

2.2.8 Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

2.2.9 Represent and act on behalf of the full staff subject to such limitations as may be imposed by these Bylaws;

2.2.10 Formulate and recommend to the Governing Board Medical Staff rules, policies, and procedures;

2.2.11 Request evaluations of Practitioners privileged through the Medical Staff process in instances in which there is question about an Applicant or member's ability to perform privileges requested or currently granted;

2.2.12 Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

2.2.13 Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital; and

2.2.14 Oversee that portion of the corporate compliance plan that pertains to the Medical Staff.

2.2.15 Hold Medical Staff leaders and medical staff committees accountable for fulfillment of their duties and responsibilities.

2.2.16 Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws.

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.

ARTICLE VIII. MEDICAL STAFF MEETINGS

Section 1. Meetings of the entire Medical Staff

1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously at least 28[1] days in advance of the meeting.

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 at which a quorum is present is the action of the group. Action may be taken without a meeting by the staff by presentation of the question to each member eligible to vote, in person, via telephone, fax, 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.

1.3 General Medical Staff Meetings. Such meetings may be called by such persons, and for such purposes, as provided in Article I, Section 7.3 of these Bylaws.

1.4 Special Meetings of the Medical Staff

1.4.1 The Chief of Staff or the Governing Board may call a special meeting of the Medical Staff at any time. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

1.4.2 Written or printed notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent via e-mail[5] to each member of the Medical Staff at least seven (7) 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.

Section 2. Regular Meetings of Medical Staff Committees

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

Section 3. Special Meetings of Committees

A special meeting of any committee may be called by or at the request of the chairperson thereof or by the Chief of Staff.

Section 4. Quorum

4.1 Medical Staff meetings: those present or those eligible medical staff members voting on an issue.

4.2 Medical Executive Committee, Credentials Committee and Medical Staff Peer Review Committees: A quorum will exist when 50% of the members are present.

4.3 Clinical Service meetings or Medical Staff committees other than those listed in 4.2 above: Those present or those eligible medical staff members voting on an issue.

Section 5. Attendance Requirements

5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

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

5.1.2 Special meeting attendance requirements: Whenever suspected deviation from standard clinical or professional practice is identified, the Chief of Staff or other appropriate medical staff leader may require the Practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given special notice (with confirmation of receipt) of the conference at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will be considered a voluntary resignation of Medical Staff membership. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the Practitioner's participation in the previously referenced conference.

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

Section 6. Participation by Chief Executive Officer

The CEO or any representative assigned by the CEO may attend any committee or Clinical Service meetings of the Medical Staff.

Section 7. Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the individual who is 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.

Section 8. Notice of Meetings

Written 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 a committee not less than two (2) 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.

Section 9. Action of Committee or Clinical Service

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 a Clinical Service. Such action will constitute a recommendation only, which will not have any binding force or effect, and will then be forwarded to the MEC for information or for further action by the MEC.

Section 10. 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 officer shall sign the minutes, or the Medical Staff coordinator signing for the officer/chair[5], 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.

Article IX: Conflict Resolution

Conflict resolution: In the event the Governing Board acts in a manner contrary to a recommendation by the MEC the matter may (at the request of the MEC) be submitted for a Joint Conference composed of the officers of the Medical Staff and an equal number of members of the Governing Board for review and recommendation to the full Governing Board. The committee will submit its recommendation to the Governing Board within thirty (30) days of its meeting. The ultimate decision is for the Governing Board to make in its sole discretion.

The Chairperson of the Governing Board or the Chief of Staff may call for a Joint Conference 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.

Article X. General Provisions

Section 1. Rules of Construction

The time periods specified within these Bylaws are intended to be guidelines for action. Any action of the Medical Staff, Governing Board, or Hospital shall not be invalidated solely because such party did not strictly comply with specified time periods.

These Bylaws are intended to be read as a whole, and the fact that certain sections of these Bylaws may mention only particular rights or duties of Medical Staff members should not be construed to abrogate, limit, or exclude any rights or duties of such members mentioned in any other sections of these Bylaws

If any provision in these Bylaws requires judicial interpretation, the Medical Staff and Hospital, and each practitioner by accepting Medical Staff membership or clinical privileges, hereby agree and acknowledge that the judicial body interpreting or construing such provision shall not apply the assumption that the terms hereof shall be more strictly construed against the one who either itself or through its agents prepares the same. The Hospital, the Governing Board, the Medical Staff, the Medical Staff members, and all other practitioners exercising clinical privileges hereby agree that they and their agents have participated equally in the preparation of these Bylaws.

If any provision of these Bylaws, or the application of such provision to any person or circumstance, shall be held invalid by any court, government agency or regulatory body, the remainder of these Bylaws, or the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby and shall remain in full force and effect. To the extent permitted by applicable law, the parties hereto hereby waive any provision of law that renders any provision hereof prohibitive or unenforceable in any respect.

No waiver of any provision of these Bylaws shall be valid except in specific instances when agreed to by each party affected by the waiver. The failure of the Medical Staff, its individual members, the Governing Board or Hospital to insist upon strict adherence of any provision of these Bylaws shall not be considered a waiver and shall not justify any subsequent waiver.

These Bylaws have been drafted to comply with the provisions of both HCQIA and, to the extent not in conflict with HCQIA, applicable State peer review law. To the maximum extent practicable, the provisions of these Bylaws shall be interpreted as consistent with the requirements of the foregoing laws.

Section 2. Relationship between Hospital and Medical Staff Members.

Notwithstanding anything to the contrary herein, it is understood and agreed that nothing contained in these Bylaws shall create in fact, by implication or otherwise, a contract of any nature between the Medical Staff or any member of the Medical Staff and the Hospital or the Governing Board.

Section 3. Priority of Authorities

To the extent that there is any conflict between any of the various documents granting authority to the Corporation, the Governing Board and the Medical Staff, the priority of the documents shall be as follows: (1) the Corporation's Bylaws shall have priority over the Governing Board Bylaws, these Bylaws, and the rules and regulations of the Medical Staff, (2) the Governing Board Bylaws shall have priority over the Medical Staff Bylaws and the rules and regulations of the Medical Staff, and (3) the Medical Staff Bylaws shall have priority over the rules and regulations of the Medical Staff. Nonetheless, to the extent practicable, these documents shall be construed so as to avoid conflict.

Section 4. Reserved Authority

Notwithstanding anything to the contrary in these Bylaws, the Governing Board hereby specifically reserves authority to take any direct action that is appropriate with respect to any individual appointed to the Medical Staff or granted clinical privileges in the Hospital. Except for such actions that would if, taken in accordance with the procedures otherwise designated in these Bylaws, constitute an adverse action entitling the affected practitioner to a hearing under the Fair Hearing Plan incorporated within these Bylaws, actions taken by the Governing Board may, but need not, follow the procedures in such Fair Hearing Plan. Further, and without limiting the foregoing, the Governing Board hereby specifically reserves all authority with respect to making financial decisions for the Hospital, including, without limitation, initiating service lines, discontinuing service lines, and entering into exclusive service arrangements.

Article XI. Review, Revision, Adoption, and Amendment

Section 1. Medical Staff Responsibility

The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Governing Board Medical Staff Bylaws, procedures, plans, policies, rules & regulations, and amendments as needed, which shall be effective when approved by the Governing Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various Services of these Bylaws. Where the Medical Staff fails to maintain or create bylaws, procedures, plans, policies, or rules & regulations which comply with legal or accreditation requirements, the Governing Board may on its own initiative amend such documents to the degree necessary to achieve compliance. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these bylaws), and shall advise the staff of the basis for its action in this regard.[6]

Section 2. Methods of Adoption and Amendment Medical Staff Bylaws.

All proposed amendments to these Bylaws[5] whether originated by the MEC, another standing committee, a member of the active category of the staff, or the Governing Board must be reviewed and discussed by the MEC prior to a MEC vote.

The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following a vote by the MEC, each member of the active category of the Medical Staff will be eligible to vote on the proposed amendment to these Bylaws via printed ballot or in a manner determined by the MEC. All active members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. To be adopted, such changes must receive a majority of the votes cast by the eligible members of the Medical Staff. Amendments so adopted shall be effective when approved by the Governing Board.

The MEC may adopt such amendments to these Bylaws[5] as are, in the committee's good faith and reasonable judgment, technical or legal modifications or clarifications; reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Governing Board but must be approved by the CEO.

Section 3. Staff Rules & Regulations & Policies

Subject to approval by the Board, the Medical Staff hereby delegates authority to the MEC to adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular MEC meeting at which a quorum is present and without previous notice, or at any special MEC meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.[5]

3.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.[5]

3.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 3.1(c) of this Article shall be implemented.[5]

3.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the MEC or to limit the Board's final authority as to such issues.[5]

3.1(d)Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in Section 3.1(b) of this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.[5]

3.1(e) INTERPRETATION

Interpretation of these rules and regulations will be the responsibility of the Medical Executive Committee.

Section 4. Adoption and Approval

Adopted by:

Chief of Staff	Date
Chief Executive Officer, Hospital	Date
Chairperson, Governing Board	Date

Part II: Investigations, Corrective Action, Hearing & Appeal Plan

Section 1. Investigation and Corrective Action

1.1 **Criteria for Initiation:** Any person may provide information to any member of the Medical Executive Committee (MEC) about the conduct, performance, or competence of medical staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws, associated manuals, Medical Staff policies and/or any Rules and Regulations; (4) harassing or intimidating to colleagues, patients and their families, or staff; (5) disruptive of hospital or medical staff operations; or (6) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a Clinical Service Chief, the CEO of the Hospital, the Vice President of Medical Affairs of the Hospital, the Governing Board of the Hospital, or the Medical Executive Committee (MEC).

1.2 **Initiation**: A request for an investigation must be submitted by one of the above parties to the MEC through the Chief of Staff and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate record of the reasons

1.3 **Investigation**: If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. In the event the Governing Board believes the MEC has incorrectly determined an investigation 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 medical staff officer, medical staff clinical service, or standing or ad hoc committee of the medical staff, or refer out to an external peer review consultant, in each case so long as the composition and functioning of such investigative body qualifies for protection under applicable New Mexico peer review statutes. If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved, however, such investigation shall not constitute a "hearing" as that term is used in the hearing and appeal plan, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances including suspension, termination of the investigative process; or other action.

1.3.1 An External Peer Review Consultant should be considered only when any applicable attorney-client privilege and any applicable New Mexico peer review privileges can be preserved, and only when:

a. Litigation seems likely; an outside review is almost always the best course of action in these circumstances. Every step should be taken to avoid even the appearance that the outside reviewers are being asked to achieve a certain result.

b. The hospital is faced with ambiguous or conflicting recommendations from the medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances it may be wise for the MEC or even the Governing 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 that expertise are direct competitors, partners, or associates of the physician under review.

1.4 **Medical Executive Committee Action**: As soon as practicable after the conclusion of the investigation the MEC shall take action that may include, without limitation:

1.4.1 Determining no corrective action is taken, and if the MEC determines there was not credible evidence for the complaint in the first instance, making a note of that determination in the member's file.[6]

1.4.2 Deferring action for a reasonable time where circumstances warrant.

1.4.3 Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude service chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed -in the member's file, but in no event shall such letters be considered an adverse action entitling the member to a hearing under this Fair Hearing Plan.

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

1.4.5 Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

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

1.4.7 Recommending suspension, revocation, or probation of medical staff membership.

1.4.8 Taking other actions deemed appropriate under the circumstances.

1.5 **Subsequent Action**: If the MEC recommends corrective action, that recommendation shall be transmitted to the Governing 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.

1.6 **Automatic Suspension Or Limitation**: In the following instances, the member's privileges or membership will be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred.

1.6.1 Licensure:

a. **Revocation and Suspension**: Whenever a member's license or other legal credential authorizing practice in this or other state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

b. **Restriction:** Whenever a member's license or other legal credential authorizing practice in this or other state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at Lovelace Medical Center which 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 member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

d. **Medicare, Medicaid, CHAMPUS, and/or other Federal Programs**: Whenever a member is sanctioned or barred from the Medicare, Medicaid, CHAMPUS or other federal programs, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

1.6.2 Controlled Substance:

a. Whenever a member's DEA certificate is revoked, limited, or suspended, the member 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 terms.

b. **Probation**: Whenever a member's DEA certificate is subject to probation, the member'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.

1.6.3 **Medical Record Completion Requirements**: Penalties for failure to satisfy these requirements shall be delineated in Medical Staff Rules and Regulations or Policies and Procedures.

1.6.4 **Professional Liability Insurance**: Failure to maintain professional liability insurance in the amount required by state regulations and, sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a members' clinical privileges. If within 90 days of the delinquency the member does not provide evidence of required professional liability insurance (including tail coverage for any period prior during which insurance was not maintained), the member shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The medical staff office must be notified by the member immediately of any change in professional liability insurance carrier or coverage.

1.6.5 **Medical Staff Dues/special assessments**: Failure to promptly pay medical staff dues or any special assessment shall be grounds for automatic suspension of a member's appointment. If within (90) ninety days after written warning of the delinquency the member does not remit such payments the member shall be considered to have voluntarily resigned membership on the Medical Staff.

1.6.6 **Medical Executive Committee Deliberation**: As soon as practicable after action is taken or warranted as described in Section 1.6.1.through Section 1.6.5, 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.

1.6.7 **Felony Indictment or Conviction**. A Medical Staff member who has been indicted, convicted of, or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall be suspended automatically by the Chief of Staff or CEO. Such suspension shall become effective immediately upon such indictment, conviction or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Governing Board or through corrective action, if necessary

1.7 **Precautionary Restriction Or Suspension**:

1.7.1 Criteria For Initiation: Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any person, or when any Medical Staff Officer and the CEO determine that there is a need to carefully consider any event, concern or issue which, if confirmed, has the potential to affect patient or employee safety, the effective operation of the institution, or to impair the reputation of the medical staff or institution then the CEO, the Chief of Staff, the Chief Medical Officer[4], or[1] the MEC may restrict or suspend the medical staff membership or clinical privileges of such member as a precaution. 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 member, the MEC, the CEO and the Governing Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the member's patients shall be promptly assigned to another member by the Chief of Staff or designee, considering where feasible, the wishes of the affected practitioner and patient in the choice of a substitute member.

1.7.2 **Medical Executive Committee Action**: As soon as practicable after such precautionary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and if necessary begin the investigation process as noted in 1.3. Upon request, the member may attend this meeting at the discretion of the MEC and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning defined in the 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 member with notice of its decision.

1.7.3 **Procedural Rights**: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of the investigation described in 1.3, the member shall be entitled to the procedural rights afforded by the hearing and appeal plan once the restrictions or suspension last more than 14 days.

1.8 **Disciplinary Suspension:** The MEC may, with approval of the CEO and the Chair of the Governing Board, institute a disciplinary suspension of a member for a period not to exceed fourteen (14) days. A disciplinary suspension may be instituted only under the following circumstances:

1.8.1 When the action that has given rise to the suspension relates to the practitioner behavior (or disruptive practitioner) policy of the Medical Staff or to requirements for emergency coverage.

1.8.2 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 has been violated.

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

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

(Note that because a disciplinary suspension may not exceed fourteen days it will not entitle the affected practitioner to a fair hearing under these bylaws).

1.9 Disciplinary Suspension and provision for coverage of existing hospitalized patients:

1.9.1 A disciplinary suspension will 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 he/she has had an opportunity to provide needed care prior to discharge. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures.

1.9.2 The Chief of Staff or designee will determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the disciplinary suspension.

Section 2. Initiation And Notice Of Hearing

2.1 **Initiation of Hearing**: An applicant or an individual holding a medical staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation with regard to his or her competence or professional conduct has been made by the MEC or the Governing Board. Hearings will be triggered by the following actions, unless unrelated to the competence or professional conduct of the affected:

2.1.1 Denial of medical staff appointment or reappointment;

2.1.2 Revocation of medical staff appointment;

2.1.3 Denial or restriction of requested clinical privileges;

2.1.4 Reduction in or limitation of clinical privileges;

2.1.5 Involuntary revocation of clinical privileges;

2.1.6 Application of a mandatory concurring consultation or co-admitting requirement, or an increase in the stringency or a pre-existing mandatory concurring consultation or co-admitting requirement, when such requirement applies to an individual Medical Staff member, as opposed to the Medical Staff generally; and

2.1.7 Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) days and is not caused by the member's failure to complete medical records or any other reason unrelated to competence or professional conduct, including without limitation any voluntary relinquishment or automatic suspension of Medical Staff membership or clinical privileges under these Bylaws.

2.1.8 Actions in 1.4.4 through 1.4.7 to the extent not already covered by this section.

2.2 Hearings are not triggered by the following actions, or by any other actions unrelated to the competence or professional conduct of the affected practitioner:

2.2.1 Issuance of a letter of guidance, warning, or reprimand;

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

2.2.3 Deferral of a request for privileges not central or directly related to the applicant's prior training and practice;

2.2.4 Expiration of temporary privileges at the end of the specified period for which they are granted.

2.2.5 Automatic relinquishment or voluntary resignation of appointment or privileges;

2.2.6 Precautionary or disciplinary suspension which does not exceed fourteen days;

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

2.2.8 Determination that an application is incomplete;

2.2.9 Determination that an application will not be processed due to misstatement or omission, whether intentional or not;

2.2.10 Decision not to expedite an application;

2.2.11 A determination that an Applicant for membership or specific privileges does not meet the requisite qualifications/criteria for membership or those specific privileges; and/or

2.2.12 Ineligibility to request membership or privileges because a relevant specialty is closed under a Medical Staff Development plan or covered under an exclusive provider agreement

2.3 **Notice of Recommendation**: When a precautionary suspension lasts more than 14 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 Governing Board, the affected individual shall promptly (but no longer than 5 days) be given notice by the CEO, in writing, certified mail, return receipt requested. This notice shall contain:

2.3.1 A statement of the recommendation made and the general reasons for it;

2.3.2 Notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice or, with respect to with respect to a summary suspension or other suspension related to the competence or professional conduct of the affected practitioner, within thirty (30) days after the fourteenth day that the suspension has been in effect, if later.

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

2.3.4 A statement that the individual shall receive a copy of Section 4.5 of this manual outlining the rights of both sides in the hearing.

2.3.5 A statement that, after receipt of the hearing request, the affected practitioner will be notified of the date, time and place for the hearing

2.3.6 A statement that, if the affected practitioner fails to request a hearing within thirty (30) days after the affected practitioner's receipt of the notice (or, in the case of a summary suspension or other suspension related to the competence or professional conduct of the affected practitioner, within thirty (30) days after the fourteenth (14th) day that the suspension has been in effect, if later), the affected practitioner shall be deemed to have waived all hearing and appeal rights under these Bylaws and to have accepted the recommendation contained in the notice.

2.4 **Request for Hearing**: Such individual shall have (30) thirty days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the hospital 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, and such recommended action shall thereupon become effective immediately upon final Governing Board action.

2.5 **Notice of Hearing and Statement of Reasons**: The CEO shall schedule the hearing and shall give written notice, certified mail return receipt requested, to the person who requested the hearing. The notice shall include:

2.5.1 The time, place and date of the hearing;

2.5.2 A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Governing Board), at the hearing;

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

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

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

2.6 **Witness List**: At least (15) fifteen 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. The list of witnesses who will testify in support of the MEC recommendation (or the Governing Board action) will include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 2A. Settlements

At any time following receipt of notice of a recommendation or action which would entitle an affected practitioner to request a hearing under this Fair Hearing Plan, the affected practitioner may ask the MEC to discuss voluntary settlement or resolution of the matter. On such a request and subject to the affected practitioner's waiver of time requirements in order to allow such discussions to proceed, the MEC may authorize one or more of its members to conduct confidential discussions with the affected practitioner, provided that the MEC shall not be obligated to conduct such discussions if it concludes that the request is interposed primarily for delay or that a settlement is not feasible. If the affected practitioner and the MEC reach a written agreement which could settle the matter, the MEC shall promptly notify the CEO and the Governing Board. Any such written settlement agreement shall include an acknowledgment by the affected practitioner that he or she voluntarily waives his or her hearing and appeal rights under these Bylaws, that the settlement is entered into voluntarily, that he or she will waive all claims relating in any way to the matter against Hospital, the Medical Staff, and all Medical staff and Hospital personnel, and that the settlement will be reported to the National Practitioner's Data Bank and applicable State agencies if the settlement results in any limitations on the affected practitioner's membership or ability to exercise clinical privileges, or as may otherwise be required. Any such proposed settlement shall be subject to the approval of the Governing Board.

Section 3. Hearing Panel And Presiding Officer Or Hearing Officer

3.1 Hearing Panel:

3.1.1 When a hearing is requested, the CEO, acting for the Governing Board and after considering the recommendations of the Chief of Staff (and those of the chairperson of the Governing Board, if the hearing is occasioned by a Governing Board determination) shall appoint a hearing panel that shall be composed of not less than (3) three members chosen from the medical staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. The composition of the hearing panel must at all times be such as to qualify for the protections of any applicable New Mexico peer review laws.

3.1.2 Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing within (10) ten days of receipt of notice to the CEO who shall resolve the objection. While the individual who is the subject of the hearing may object to a panel member, he or she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CEO.

3.1.3 The hearing panel shall not include any individual who is in direct economic competition with the affected person, or who has acted as a fact-finder or investigator with respect to the matter, or who is professionally associated with or related to the affected individual. Such appointment shall include designation of the chairperson or the presiding officer.

3.2 **Presiding Officer**:

3.2.1 In lieu of a hearing panel chairperson, the CEO and Chief of Staff may appoint an attorney at law as presiding officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and be a legal advisor to it, but shall not be entitled to vote on its recommendation.

3.2.2 If no presiding officer has been appointed, a chairperson of the hearing panel shall be appointed by the CEO to serve as the presiding officer, and shall be entitled to one (1) vote.

3.2.3 The Presiding Officer (or Hearing Panel Chairperson) shall:

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, abusive or that causes undue delay;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points outside the presence of the hearing panel unless the panel wishes to be present; and

h. Legal counsel to the hospital may advise the presiding officer.

3.3 Hearing Officer:

3.3.1 As an alternative to the hearing panel described in Section 3.2 of this manual, the CEO, after consulting with the Chief of Staff (and chairperson of the Governing Board if the hearing was occasioned by a Governing Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.

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

Section 4. Pre-Hearing And Hearing Procedure

4.1 **Provision of Relevant Information**:

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

a. Copies of, or reasonable access to, all patient medical records supporting the MEC's recommendation, at his or her expense;

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee or service minutes, subject to denial or limitation to protect the peer review process, to the extent permitted by law;

d. Copies of any other documents relied upon by the MEC or the Governing Board;

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

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

4.1.2 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 in advance of the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

4.1.3 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 Governing Board) copies of any expert reports or other documents upon which the individual will rely at the hearing.

4.1.4 There shall be no contact by the individual who is the subject of the hearing with hospital employees 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 or her counsel.

4.2 **Pre-Hearing Conference**: The presiding officer may require a representative for the individual and for the hospital's MEC (or the Governing 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.

4.3 **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 Governing Board for final action.

4.4 **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 by such body and entitled to notarize documents in the State of New Mexico.

4.5 **Rights of Both Sides**:

4.5.1 At a 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. Representations by counsel who may call, examine, and cross examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least (10) ten days prior to the date of the hearing; and

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

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

4.5.3 The hearing panel may question the witnesses; call additional witnesses or request additional documentary evidence.

4.6 **Admissibility of Evidence**: The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute 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.

4.7 **Burden of Proof:** The hearing panel shall recommend in favor of the MEC (or the Governing Board) unless it finds that the individual who requested the hearing has proved by clear and convincing[6] evidence that the recommendation which prompted the hearing was arbitrary, capricious, or is unfounded or not supported by credible evidence. It is this individual's burden to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital policies.

4.8 **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.

4.9 **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.

4.10 **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.

4.11 **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 CEO or the Medical Staff President.

4.12 **Order of Presentation**: The Governing 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.

4.13 **Basis of Recommendation**: the hearing panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

4.14 **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.

4.15 **Deliberations and Recommendation of the Hearing Panel**: Within (20) twenty 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, which shall contain a concise statement of the reasons for the recommendation.

4.16 **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 Governing 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 5. Appeal To The Governing Board

5.1 **Time for Appeal**: Within (10) ten days after notice of the hearing panel's recommendation, either the member or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO 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) days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Governing Board for final action.

5.2 **Grounds for Appeal**: The grounds for appeal shall be limited to the following:

5.2.1 There was substantial failure to comply with fair hearing plan and/or the Hospital Medical Staff Bylaws prior to the hearing so as to deny a fair hearing; or

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

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

5.3 **Time, Place and Notice**: Whenever an appeal is requested as set forth in the preceding Services, the chairperson of the Governing 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 chairperson of the Governing Board for good cause may extend the time for appellate review.

5.4 **Nature of Appellate Review**:

5.4.1 The Chairperson of the Governing Board shall appoint a review panel composed of members of the Governing Board to consider the information upon which the recommendation before the Governing Board was made.

5.4.2 The review panel may accept additional oral or written evidence subject to the same of cross-examination or confrontation provided at the hearing panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that the party had good cause for not presenting it earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.[6]

5.4.3 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 (30) thirty-minute oral argument. The review panel shall recommend final action to the Governing Board.

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

5.5 **Final Decision of the Governing Board**: Within (30) thirty days after receipt of the review panel's recommendation, the Governing 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 chairpersons of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

5.6 **Further Review**: Except where the matter is referred for further action and recommendation, the final decision of the Governing Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Governing Board in accordance with the instructions given by the Governing Board. This further review process and the report back to the Governing Board shall in no event exceed (45) forty-five days in duration except as the parties may otherwise stipulate.

5.7 **Right to One Appeal Only**: No applicant or medical staff appointee shall be entitled as a matter of right to more than (1) one hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Governing Board ultimately determines to deny medical staff reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current appointee, that individual may not apply within (5) five years for medical staff appointment or for those clinical privileges at this hospital unless the Governing Board provides otherwise.

Part III: Credentials Procedure Manual

Section 1. Medical Staff Credentials Committee

1.1 **Composition**: Membership of the Medical Staff Credentials Committee shall consist of at least six (6) members of the active medical staff. The Chief of Staff elect will be a member of the committee, with the chairperson and the remaining members appointed by the Chief of Staff and Vice President of Medical Affairs. Each member, other than the Chief-Elect, will be appointed for two (2) year terms with the initial terms staggered such that approximately one half of the members will be appointed each year. The Chair and remaining members will be appointed for a two (2) year term. The Chair and members may be reappointed for additional terms without limit. Any member of the Medical Staff Credentials Committee, including the Chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the Medical Executive Committee, (MEC). The Medical Staff Credentials Committee may also invite, at its discretion, appropriate ex-officio (non-voting) members such as representatives from hospital administration and the Governing Board.

1.2 **Meetings:** The Medical Staff Credentials Committee shall meet on call of the Chair or Chief of Staff.

1.3 Responsibilities:

1.3.1 To review and recommend action on all applications and reapplications for membership and status on the Lovelace Medical Center medical staff.

1.3.2 To review and recommend action on all requests for privileges for practitioners granted privileges at Lovelace Medical Center.

1.3.3 To recommend criteria for the granting of medical staff membership and clinical privileges at Lovelace Medical Center.

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing activities at Lovelace Medical Center.

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

1.4 Confidentiality: This committee shall function as a peer review committee consistent with federal and state law. All members of the Medical Staff Credentials 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. ***See additional provisions for confidentiality, immunity and releases in Part IV of these Bylaws (the Organization and Functions Manual).***

Section 2. Qualifications for Membership

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

2.2 General qualifications for Medical Staff membership can be found in Part I of these Bylaws, Article II, Section 2.2. The following specific qualifications must be met by all applicants for appointment and reappointment to the medical staff before an application will be processed:

2.2.1 Demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, or podiatry, clinical psychology, or optometry;

2.2.2 Have a current license as required for the practice of his/her profession within New Mexico;

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

2.2.4 Provide evidence of skills to provide a type of service that the Governing Board has determined to be appropriate for the performance within the hospital and for which a need exists.

2.2.5 Provide evidence of professional liability insurance of a type and in an amount established by the Medical Staff and Governing Board.

2.2.6 Have a record that is free from current Medicare/Medicaid/CHAMPUS sanctions or felony convictions (within the last three (3) years), or occurrences that would raise questions of undesirable conduct.

2.2.7 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program of at least three (3) years, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or board admissible by an approved board of the American Board of Medical Specialties or the American Osteopathic Association in the specialty of application. If board admissible, the applicant must achieve full board certification within five (5) years of the date of board eligibility certification or recertification.[4]

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

2.2.9 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery.

2.2.10 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine or achieve such certification within five (5) years of the date of board eligibility certification or recertification.[4]

2.2.11 A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA).

2.3 Exceptions:

2.3.1 All practitioners who are current active staff members as of 11/01/2005 and who have met prior qualifications for membership shall be exempt from # 2.2.7 – 2.2.11 above.

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

2.4 It is the policy of Lovelace Medical Center to grant and maintain medical staff membership and clinical privileges only to individuals who continuously meet the following criteria:

2.4.1 Fulfill the criteria as identified in these Bylaws Part I, Article II, Section 2.2 and in Part III, Section 2.2 above.

2.4.2 Demonstrate his/her background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in his/her specialty for all privileges requested.

2.4.3 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.

2.4.4 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; and

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

2.4.5 Appropriate written and verbal communication skills.

2.4.6 Any member of the medical staff who may have occasion to admit an inpatient must demonstrate the capability to provide continuous care to his or her patients. Members of the medical staff will reside and maintain an office within a reasonable distance from the hospital in order to assure such continuous care. Alternatively, he or she may demonstrate that they have adequate patient coverage arrangements with other members of the medical staff with appropriate privileges to provide for the required continuous coverage. The Governing Board shall have discretion to determine a "reasonable" distance from the hospital. The applicant must provide evidence of acceptable patient coverage to the MEC.

Section 3. Application Request Procedure

3.1 All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the Central Verification Office.[5] Upon receipt of a written request for an application, the Central Verification Office[5] will provide the potential applicant with a Pre-Application package. The Pre-Application will ask the applicant to provide documentation of the following:

- An unrestricted license to practice in New Mexico;
- A current, unrestricted DEA registration, if applicable. The Governing Board may, upon recommendation of the MEC, waive the requirement for an unrestricted DEA registration, provided that any clinical privileges ultimately approved by the Governing Board with respect to an applicant will be subject to any such restrictions;
- Ability to provide services needed by the hospital and which are not covered by any closed department or any exclusive contract to which the Hospital is a party;
- Professional liability insurance in amounts established by these Bylaws or in Medical Staff policies approved by the Governing Board.
- Information necessary for the medical staff office to confirm that the applicant is not on the OIG list of Excluded Individuals

A request for an application from an individual not planning to affiliate with an existing member of the staff or an individual who has not been recruited by the hospital may be asked to complete an *Intended Practice* Plan if such a document is adopted by the MEC and Governing Board.

Additional requirements may be added to the Pre-Application package from time to time at the discretion of the Governing Board after consultation with the MEC.

If the applicant has met the requirements above, he/she will be provided an application package to complete. Failure to meet the pre-application requirements will not be considered an adverse action and will not entitle the applicant a right to any hearing or appeals under these Bylaws. As part of the application package the applicant will be provided a copy of a Medical Staff Bylaws overview document or a complete set of Medical Staff Bylaws and associated policies will be provided or made available to the applicant.

Section 4. Initial Appointment Procedure

4.1 Upon request, and after completion of a Pre-Application and pre-screening based on that document, the medical staff office will provide to prospective applicants an application package which will include the following:

- a blank application form
- a list of required supporting information
- a list of expectations of performance for individuals granted Medical Staff membership and/or Privileges,(if such a list of expectations has been formally adopted by the Medical Staff)
- a description of responsibilities for Medical Staff members
- a privilege delineation overview
- a privilege request form(s), including criteria for Privileges
- a detailed list of requirements for completion of the application

4.2 The applicant must sign the application form. This signature will signify the applicant's agreement to all of the following:

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

4.2.2 Consent to appear for any requested interviews in regard to his/her application.

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

4.2.4 Consent for hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, of his/her physical and mental health status to the extent relevant to the capacity to fulfill requested privileges, and of his/her professional and ethical qualifications.

4.2.5 Provider releases from liability, promises not to sue and grants immunity to the hospital, its medical staff, and its representatives for acts performed and statements made in connection with evaluation of the application and his/her credentials and qualifications (including queries and reports to the National Practitioner Data Bank) to the fullest extent permitted by the law.

4.2.6 Provider releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to Lovelace Medical Center (LMC) representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

4.2.7 Authorization of LMC medical staff and administrative representatives to release to other hospitals, medical associations, licensing boards, and other organizations concerned with this provider's performance and the quality and efficiency of this provider's patient care any information relevant to such matters that LMC may have concerning him/her and release of LMC representatives from liability for so doing. For the purposes of this provision, the term "Hospital representatives" includes the Governing Board, its directors and committees, the Chief Executive Officer (CEO), or his/her designee, registered nurses and other employees of LMC, the medical staff organization, and all medical staff appointees, clinical units, and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her application, and any authorized representative of any of the foregoing.

4.2.8 He/she has been oriented to the current medical staff bylaws, including its associated manuals, and all rules, regulations, policies and procedures of the Medical Staff and agrees to abide by their provisions. Such orientation will include at least one of the following: receiving a copy of the bylaws and associated manuals, or receiving a summary of the expectations of medical staff members and having the bylaws and manuals made available to the applicant.

4.2.9 Attests that he/she will promote the hospital's adoption of electronic health records by using the electronic health and medical records systems adopted by the hospital, with the knowledge that failure to do so may result in the initiation of corrective action under Part II of these Bylaws.[6]

4.2.10 Agrees to participate in the sharing of, and consents to the release of, peer review information, credentialing information, and quality review information among Lovelace Medical Center, Lovelace Women's Hospital, and Lovelace Westside Hospital via the Ardent Lovelace Albuquerque Credentials and Peer Review Sharing Committee.[6]

4.2.11 The provision of accurate answers to the following questions, and agreement to immediately notify the hospital in writing should any of the information regarding these items change during the period of their medical staff membership or privileges. If the applicant answers any of the following questions affirmatively/provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

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

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

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

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

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

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

g. Is your narcotics registration certificate currently being challenged?

h. Have you ever been named as a defendant in any criminal proceedings?

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

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

k. Have you ever been the subject of focused individual monitoring at any hospital or health care facility?

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

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

n. If no, do you intend to apply for the certification exam?

o. Have you ever been accepted to take the certification exam?

p. If yes, what dates are you scheduled to take the certification exam?

q. What are the date(s) of the next recertification examination (if applicable)?

r. Have any professional liability claims or suits ever been filed against you or are any presently pending?

s. Have any judgments or settlements been made against you in professional liability cases?

t. Have you ever been refused or denied coverage or had coverage cancelled by a malpractice liability carrier?

u. Are you currently taking, or have you in the last three (3) years taken, any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?

v. Are you aware of or have you ever been advised that you have or had any physical or mental limitations which have impaired or could impair your ability to provide patient care services for which you are seeking clinical privileges?
w. Have you been hospitalized, treated, counseled, or medicated at any time during the past three years for any conduct or condition which impaired or could have impaired your ability to provide patient care services for which you are seeking clinical privileges?
x. Has your right to participate in any managed care organization (e.g., HMO, PPO, EPO) ever been limited, suspended, diminished, denied, modified, revoked, voluntarily relinquished or limited, or otherwise adversely acted upon, based on quality of care or professional competence, or otherwise, or is any such action pending?
y. Have you ever been indicted for or convicted of a felony or misdemeanor (other than minor traffic offenses) or is any such action pending?
z. Have you ever discontinued practice for any reason (other than for routine vacation or formal education or training) for one month or more?

4.3 Procedure for processing applicants for initial staff appointment:

4.3.1 A completed application includes, at a minimum:

- a signed, dated application form
- request for privileges
- copies of all documents and information necessary to confirm applicant meets criteria for membership and privileges
- a complete list of all hospital medical staff memberships held within five yars prior to application[6]
- all applicable fees
- and receipt of all references

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed.

4.3.2 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 providing sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff Office within ninety (90) days of the receipt of the request letter, this will be deemed a voluntary withdrawal of the application.

4.3.3 Upon receipt of a completed application the CEO/CMO/Chair of the Medical Staff Credentials Committee or designee, in collaboration with the Medical Staff Office, will determine if the requirements of Section 2.2 are met. In the event the requirements of Section 2.2 are not met, the potential applicant will be notified that he/she is ineligible to apply for membership on the Lovelace Medical Center medical staff, and the application will not be processed. If the requirements of Section 2.2 are met, the application will be accepted for further processing.

4.3.4 Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgment by the Medical Staff Services Office. Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

4.3.5 Any applicant not meeting the minimum objective requirements for membership to the medical staff will not have his/her application processed and will not be entitled to a fair hearing.

4.3.6 Upon receipt of a completed application, the Medical Staff Office will verify its contents from acceptable sources, using primary sources where required, and collect additional information as follows:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past ten (10) years;

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

c. Licensure status in all current or past states of licensure;

d. Information from the AMA or AOA Physician Profile, Federation of State Medical boards, HHS/OIG list of excluded individuals, FACIS (Fraud and Abuse Control Information System), or other such data banks including criminal background check;

e. Completion of professional training programs including residency and fellowship programs;

f. Information from the National Practitioner Data Bank;

g. Other information about adverse credentialing and privileging decisions;

h. One or more peer recommendations addressing the applicant's current clinical competence, ethical character and ability to work with others;
(Note: a peer is defined as a practitioner in the same professional discipline as the applicant.)

i. Additional Information as may be requested to ensure applicant meets the criteria for medical staff membership; and

j. Recent photograph of the applicant to verify identity.

k. If available, the results of any drug testing and/or other health testing required by a health care institution or licensing Governing Board.

Note: In the event there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after (30) thirty days will be deemed a withdrawal of the application.

4.3.7 When the items identified in 4.3.6 above have been obtained, the file will then be reviewed by the Chair of Medical Staff Credentials Committee and the Medical Staff Office Service Professional (or designee), who will categorize the application as follows:

Category 1: A verified application[1]a) that does not raise concerns as identified in the criteria for category 2. Applicants in category 1 will be granted medical staff membership and privileges following approval by the following: Chairperson of the Medical Staff Credentials Committee acting on behalf of the Medical Staff Credentials Committee, the MEC* and a Governing Board Committee consisting of at least two individuals**
Note:

** The MEC may act on requests for expedited appointment, clinical privileges and reappointment only when a quorum as defined in the Bylaws is present.*

*** Governing Board Bylaws must delineate the composition and authority of this committee.*

Category 2: If one or more of the following criteria are identified in the course of review of a completed file, the application will be treated as category 2. The Medical Staff Credentials Committee, the MEC, and the Governing Board review applications in category 2. The Medical Staff Credentials Committee may request that an appropriate subject matter expert[2]a) assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he/she meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete.

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

c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

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

A5 "Verified application" – definition – indicates that the primary source verification has been completed and all items listed under Service 4.3.6 have been received and verified.

[2]a) Subject matter expert is an individual chosen by the Medical Staff Credentials Committee, Chief of Staff, or MEC to assist and advise them in evaluation of recommendations for clinical privileges for their peers.

e. Applicant has had two (2) or more malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of seventy-five thousand dollars ($75,000.).

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 found between information received from the applicant and references or verified information.

k. Applicant has an adverse National Practitioner Data Bank report.

l. The request for clinical privileges is not reasonable based upon applicant's experience, training, and 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 or mental health problems.

o. Other as determined by the service chair or other representative of the institution.

4.4 Applicant Interview:

4.4.1 All applicants may be required to participate in an interview as part of the application for appointment to the medical staff at the discretion of the Medical Staff Credentials Committee. The interview is to be conducted by one or more individuals selected by the Medical Staff Credentials Committee for this purpose. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community.

4.4.2 Procedure: the applicant will be notified when the verification process is complete and that he/she should contact the responsible individual to schedule an interview. It is the responsibility of the applicant to contact this individual to arrange the interview. Failure of the applicant to schedule an interview with the designated medical staff leader within thirty (30) days will be deemed a withdrawal of the application.

4.5 Medical Staff Credentials Committee Action:

4.5.1 If the Medical Staff Office Professional (or designee) and the Credentials Chair designate an application as category 1, it remains with the Credentials Chair for review and recommendation. The Credentials Chair reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The Credentials Chair has the opportunity to 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 votes for one of the following actions:

a. **Deferral**: Action by the Medical Staff Credentials Committee to defer the application for further consideration or gathering of information from the applicant or other sources must be followed within thirty (30) days, so long as all further requested information is received from the applicant or other sources, by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, service affiliations, and scope of clinical privileges.

b. **Favorable recommendation**: When the Medical Staff Credentials Committee's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together will all supporting documentation, to the MEC. The Medical Staff Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The Medical Staff Credentials Committee may also recommend that appointment be granted for a period of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions.

c. **Adverse recommendation**: When the Medical Staff Credentials Committee's recommendation is adverse to the applicant, the application shall be forwarded to the MEC.

4.6 Medical Executive Committee Action:

4.6.1 If the application is designated category 1, it is presented to the MEC, where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The Chief of Staff 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 MEC acts and the application is presented to the Governing Board. If designated as a category 2, the MEC reviews the application and votes for one of the following actions:

a. **Deferral:** Action by the MEC to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, service affiliations, and clinical privileges. The CEO shall promptly notify the applicant by special, written notice of the action to defer.

b. **Favorable recommendation:** When the MEC's recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the Governing Board.

c. **Adverse recommendation:** When the MEC's recommendation is adverse to the applicant, a special notice shall be sent to the applicant. No such adverse recommendation will be acted upon by the Governing Board until after the practitioner has exercised or has waived his/her right to a hearing as provided in the Investigation, Corrective Action, Hearing and Appeal Plan. A recommendation shall not be considered adverse to the applicant if clinical privileges not central and directly related to the applicant's prior training and practice are deferred until such time as the hospital has had sufficient opportunity (after initial appointment) to observe the applicant's practice and qualifications to exercise the deferred privileges.

4.7 Governing Board Action:

4.7.1 If the application is designated as category 1, it is presented to the Governing Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The CEO has the opportunity to determine whether the application is forwarded as a category 1 or may change the designation to a category 2. If designated as a category 2, the Governing Board reviews the application and votes for one of the following actions:

- A report is prepared for the Governing Board, identifying those practitioners who were appointed and granted clinical privileges as category 1 applicants. This report is for information only in the event that a Governing Board committee is authorized to act on behalf of the Governing Board for category 1 applicants. If there is no such Governing Board committee, the full Board acts with respect to category 1 applicants.

- If an application is designated as category 2, the Governing Board reviews the application and votes for one of the following actions.

a. **Favorable recommendation:** the Governing Board may adopt or reject in whole or in part a favorable recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Governing Board is effective as its final decision.

b. **Adverse recommendation:** if the Governing Board's action is adverse to the applicant, a special notice will be sent to him/her and he/she shall then be entitled to the procedural rights provided in the Part II of these Bylaws (the Investigation, Corrective Action, Hearing and Appeal Plan).

c. **After procedural rights:** In the case of an adverse MEC recommendation, the Governing Board shall take final action in the matter as provided in the Investigation, Corrective Action, Hearing and Appeal Plan.

d. All appointments to medical staff membership are subject to the Provisional Status Rules & Regulations #1 approved June 2007. In addition, Active Provisional Staff must document seven (7) encounters at a Lovelace hospital before a determination can be made. Active Provisional Staff without this minimum number of encounters will have their provisional period extended in keeping with 1.3 of the Rules & Regulations.[4] All appointments to medical staff membership and the granting of privileges are for a period not to exceed twenty-four (24) months.

4.8 **Basis for recommendation and action:** The report of each individual or group required to act on an application, including the Governing Board, must state in writing the reasons for any adverse recommendation or action taken, with specific reference to the completed application and all other documented considered.

4.9 **Notice of final decision:** Notice of the Governing Board's final decision shall be given, through the CEO to the MEC and to the chair of each service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions. A decision and notice of appointment includes the staff category to which the applicant is appointed, the service to which he/she is assigned, the clinical privileges he/she may exercise, and any special conditions attached to the appointment.

4.10 **Time periods for processing:** All individual and groups required to act on an application for staff appointment must do so in a timely and good faith manner, and, except for good cause, each application will be processed within the following time periods once the application is complete:

- ✡ Medical Staff Office (to collect, verify, and summarize) 60 days
- ✡ Medical Staff Credentials Committee (analyze and recommend) 30 days
- ✡ Medical Executive Committee (to reach final recommendation) 30 days

- Governing Board (to make an offer of appointment or reject an applicant's request for appointment or privileges) — 30 days
- Governing Board (offer of appointment will expire if the applicant does not respond in 30 thirty days) — 30 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 the Investigation, Corrective Action, Hearing and Appeal Plan are activated, the time requirements provided therein govern the continued processing of the application.

4.11 Provisional Status6

4.11.1 **Initial Appointments.** Except as otherwise determined by the Board, all initial appointments to any category of the Medical Staff shall be provisional. Each provisional appointee's performance shall be evaluated by the *Chief Medical Officer* and either the Section Chair or Service Chief, to determine his/her eligibility for regular staff membership in the staff category for which he/she was provisionally granted. Any initial appointment and renewals thereof shall remain provisional until the *CMO* and Section Chair or Service Chief makes a determination that:

a. the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the staff category to which he/she was provisionally appointed; and

b. the appointee has demonstrated his/her ability to exercise the clinical privileges provisionally granted to him/her.

4.11.2 **Modification in Staff Category and Privileges.** The Medical Executive Committee may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member pursuant to Part III, Section 8.3 of the Bylaws be made provisional according to the procedures provided in Part III, Section 3.1 for initial appointments.

4.11.3 **Duration and Renewal of Provisional Status.** Initial appointments to Provisional status shall be for at least a six-month period. Provisional status shall not extend for more than two (2) years. If the CMO and Section Chair/Service Chief fail within that period to make the determination required in Section 4.11.1, his/her staff status or particular clinical privileges, as applicable, shall automatically terminate. The appointee so affected

shall be given Special Notice of such termination and shall be entitled to the procedural rights afforded in Part II of the Medical Staff Bylaws.

4.11.4 **Evaluation of Provisional Appointees.** The persons responsible for evaluation of the provisional appointee shall review all pertinent information, including, but not be limited to, an assessment of patient care, documentation skills, and interpersonal relationships with peers demonstrated by the appointee during the provisional period. The persons responsible for evaluation of the appointee shall make a written report and recommendation to the Chief of Staff or to his/her designee before the expiration of any provisional appointment or reappointment.

4.11.5 **Restricted from Holding Office.** Provisional appointees may not hold office in any department unless the restriction is waived by the Board after recommendation of the Medical Executive Committee.

Section 5. Reappointment

5.1 All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 4 above concerning the initial granting of new clinical privileges.

5.2 Information collection and verification:

5.2.1 **From appointee**: On or before four (4) months prior to the date of expiration of a medical staff appointment, a representative from the Medical Staff Office notifies the appointee, of the date of expiration and supplies him/her with an application for reappointment. At least sixty (60) days prior to this date the appointee furnishes, in writing:

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. Specific requests for clinical privileges sought on reappointment, with any basis for changes.

d. By signing the reapplication form the appointee agrees to the same terms as identified in Section 4.2 above.

5.2.2 Failure, without good cause, to provide any requested information, at least thirty (30) days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment and such cessation will not entitle applicant to a hearing or appeal. Once the information is received, the Medical Staff Office verifies, where appropriate, this additional information and notifies the staff appointee of any information inadequacies of adequate information and resolving any doubts about this data.

5.2.3 From internal and/or external sources: The Medical Staff Office collects information regarding each staff appointee's professional and collegial activities to include those items listed in Section 4.2.11, items a.-s.

5.2.4 The following information is also collected:

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

b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided clinical care since the last reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, his/her clinical judgment and skills in the treatment of patients, loss or restriction of clinical privileges at any health care institution, and his/her behavior and cooperation with hospital personal, patients, and visitors.

c. Substantiation of the required hours, if any, of category one continuing medical education activities.

d. Service on medical staff, clinical service and hospital committees.

e. Timely and accurate completion of medical records.

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

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

h. National Practitioner Data Bank query.

i. A peer recommendation, at the discretion of the Credentials Committee or MEC, when insufficient peer review data are available to evaluate current competence, ethical character, and ability to work with others. Note: a peer is defined as a practitioner in the same professional discipline as the applicant.

j. Malpractice history for the past two (2) years which is primary source verified by the malpractice carrier(s).

k. Evidence of current unrestricted professional license in New Mexico, DEA registration, and liability insurance coverage in amounts required under these Bylaws or medical staff policies.

l. Evidence of physical and mental capacity to perform requested privileges.

5.3 Procedure for processing applications for staff reappointment: When the items identified in 5.2.1, 5.2.3, and 5.2.4 above have been obtained, the file will then be reviewed by the Chair of the Credentials Committee who, in consultation with the Medical Staff Office Service Professional (or designee), will categorize the reapplication as follows:

5.3.1 Category 1: A completed reapplication that does not raise concerns as identified in the criteria for category 2. Re-applicants in category 1 will be reviewed through the same process as for category 1 initial applicants as described in Section 4.3.7.

5.3.2 Category 2: If one or more of the following criteria is identified in the course of review of a completed reapplication, the reapplication will be treated as category 2. Reapplications in category 2 approved through the same procedure as category 2 initial applications. Criteria for category 2 reapplications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete.

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

c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

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

e. Applicant has had two (2) or more malpractice cases filed within the past five (5) years or on final adverse judgment in a professional liability action in excess of seventy-five thousand dollars ($75,000.).

f. Applicant has gaps in practice since the most recent re-credentialing.

g. Applicant has one or more reference responses, which raise concern or questions.

h. Discrepancy found between information received from the applicant and references or verified information.

i. Applicant has a National Practitioner Data Bank report with adverse information entered since the time of the applicant's previous appointment or reappointment.

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

k. Removal from managed care panel for reasons of professional conduct or quality.

l. Potentially relevant physical or mental health problems.

m. Information from the quality monitoring and improvement program at Lovelace Medical Center or any health care institution raises possible concerns with the applicant's quality of care or capacity to fulfill the responsibilities of medical staff membership and the requested privileges.

5.4 All applications for reappointment will be processed through the same procedure described in Section 4 above for initial appointment. In addition, as part of the assessment of the appointee's performance, one or more disinterested subject matter experts who qualify for any applicable peer review protections under New Mexico law may be asked to provide relevant information concerning provider's clinical and professional qualifications for reappointment for staff category and clinical privileges and to evaluate the credentials application. Such evaluation will include providing information as to whether or not he/she knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and medical staff duties appropriately, as well as relevant information concerning provider's clinical and professional qualifications for reappointment for staff category and clinical privileges.

5.5 For the purpose of reappointment, an "adverse recommendation" by the Governing Board as used in Section 4 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant for reappointment to a Fair Hearing under Part II of the Medical Staff Bylaws. The terms "applicant" and "appointment" as used in these Services shall be read respectively, as "staff appointee" and "reappointment".

5.6 **Criteria for reappointment**. It is the policy of Lovelace Medical Center to approve for reappointment only those individuals who meet the criteria for initial appointment as identified in Section 2 and been determined by the MEC to be providers of effective care that is consistent with Lovelace Medical Center standards of quality as determined by the MEC and hospital performance improvement program, and practitioners who have also fulfilled their commitment to the Lovelace Medical Center as outlined in any Intended Practice Plan adopted by the hospital Governing Board.

Section 6. Clinical Privileges

6.1 Exercise of privileges: A practitioner providing clinical services at Lovelace Medical Center may exercise only those privileges granted to him/her by the Governing Board or emergency and disaster privileges as described herein. All licensed independent practitioners working at the hospital must be granted privileges in accordance with these bylaws. Licensed dependent practitioners may be required to obtain privileges as determined by the Governing Board.

6.2 Requests: Each application for appointment or reappointment to the medical staff must contain a request for setting specific clinical privileges desired by the applicant. Setting specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals. “Setting specific” refers to privileges which may be exercised on an identified hospital campus unless otherwise specified in the delineation of privileges form.

6.3 Basis for privileges determination:

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

6.3.2 Privileges for which no criteria have been established:[5]

Requests for clinical privileges will be processed only when the potential applicant meets the board's current minimum threshold criteria. Potential applicants who do not meet these criteria will not have their applications submitted to the medical staff credentials committee and the department chair(s) for evaluation. In the event there is a request for which there are no approved criteria, the board must determine whether it will allow the privilege. If the board allows the privilege, it will use the following procedure to develop criteria.[5]

Procedure for developing privilege criteria

Whenever a privileging question arises for which there is no policy or privileging criteria, the credentials committee will follow these steps to coordinate the development of a policy and applicable criteria:

6.3.2.a If the issue pertains to the use of new technology or a new treatment protocol, the burden is on the interested practitioner to provide information about the device, technology or protocol. The practitioner should be requested to provide a full briefing concerning the new technique or procedure. This briefing should include information concerning the development of the new technology, the names of other hospitals in which it is used, any peer reviewed research demonstrating the risks and benefits of this technology, any product literature or educational syllabus addressing the technology and the names of any residency training directors responsible for providing training in this area (see attached form).[5]

6.3.2.b The credentials committee will review the issue and will determine if the technology will be permitted within the institution at all. When making this determination, the credentials committee should discuss the institution's current plan of care, whether or not the new technology/procedure is of proven clinical efficacy and effectiveness, if the new procedure/technology carries a greater risk than existing conventional therapy. Remember, the first question which must be answered is, "Should this technology be permitted at all? If the answer is no, there is no credentialing issue.[5]

6.3.2.c If it is determined that criteria for reviewing requests for clinical privileges are necessary, the credentials committee will assign a task force that will consist of at least the Chief Medical

Officer, one (1) member of the Credentialing Committee in a specialty related to the technology, and one (1) physician who is likely to use the technology (who can be the same as the requesting provider) The task force will seek credentialing criteria from at least two (2) sources where the technology is used and credential granted, preferably with at least one facility being in geographic proximity to Lovelace Medical Center. The task force will use this information to draft a policy for Lovelace Medical Center.[5]

6.3.2.d The credentials committee will submit the results of its proposed policy to, and seek the opinion of subject matter experts. One of the following mechanisms may be used:[5]

- A representative of the credentials committee will facilitate a multi-specialty task force with a true interest (and knowledge of) the issue
- The credentials committee will request each individual department/ subspecialty to provide it with advice concerning the clinical issue.

6.3.2.e The task force or specialty shall advise the credentials committee concerning the specific issue:

- The type of basic education and, if necessary, continuing education required to exercise the privileges safely and effectively
- The number of years of formal training, and in what field(s) (and, if applicable, continuing training-either didactic or hands-on).

Note: The required number of years of basic residency training may vary by specialty as might the need for post-graduate continuing medical education/training.

- Whether some years of fellowship should follow completion of an approved residency program
- Whether completion of an approved residency training program should be followed by at least _____hours of approved post-graduate training in a university or other educational setting.
- Whether prior experience is required and, if so, the amount of recent, direct or indirect (but applicable) experience (evidence of prior experience may include general hospital experience in the specialty during the past 12 months; and/or specific experience in the diagnosis/procedure during the past 12 months. (There should be very few exceptions to the creation of an objective requirement concerning past experience. It is not reasonable for a hospital to grant clinical privileges without evidence demonstrating that the practitioner has actually provided relevant related care during the recent past. If experience is not required the task force should indicate the type of required continuing education.)[5]

6.3.2.f The recommendations of the specialty(ties)/task force will be reviewed by the credentials committee. If there is general agreement concerning the proposed privileging criteria the credentials committee will determine if the rule is acceptable. If the specialties have been unable to agree on the amount of education, training or experience necessary the credentials committee

will draft a proposed rule. Such rule will be submitted to the involved specialties with a request that each group review and comment on the proposed rule.[5]

6.3.2.g The proposed rule will then be submitted to the medical executive committee for final review and recommendation to the board.[5]

6.3.2.h Once approved the rule will be incorporated in the credentials policy and procedure manual and will, until changed, guide the institution in the processing of any requests for the privilege in question.[5]

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

6.5 **Special conditions for licensed independent practitioners not qualified for medical staff appointment but practicing pursuant to medical staff privileges per hospital policy**: Requests for privileges from such individuals, including but not limited to CNP, CRNA, hereinafter referred to as "MidLevel" providers, as provided for by the New Mexico Medical Board guidelines, are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the Lovelace Medical Center medical staff and do not have the rights and privileges of such membership Only those types of practitioners approved by the Governing Board for providing services pursuant to Medical staff privileges at Lovelace Medical Center are eligible to apply for privileges.

6.5.1 **Requests for privileges from such individuals, including but not limited to Certified Physician Assistant practitioners and Pharmacist Clinicians**, hereinafter referred to as "Allied Health professionals," as provided for by the New Mexico Medical Board guidelines, are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on Lovelace Medical Center medical staff and do not have the rights and privileges of such membership. Certified Physician Assistants are not required to obtain co-signatures on orders, based on legal review and community standards. It is the responsibility of the Physician Sponsor to provide appropriate oversight and supervision of such practitioners and to provide the documentation evidencing oversight and competency.

6.6 **Special conditions for podiatric privileges**: Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the medical staff that will be recorded in the medical record.[6]

6.7 **Special conditions for residents or fellows in training:** Residents or fellows in training in the hospital shall not hold membership on the medical staff and shall not be granted specific clinical privileges or be entitled to any rights afforded by these Bylaws. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the CMO or designee, an MEC approved professional graduate education committee, or the MEC in conjunction with an applicable Residency Training Program authorized by the MEC and Governing Board to have residents/fellows train at the hospital. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances and when they may do so, and what entries a supervising physician must countersign. The protocol(s) must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care. Residents and fellows shall be responsible and accountable at all times to a medical staff member possessing appropriate clinical privileges. They shall follow hospital and medical staff policies at all times, including the provisions of these Bylaws where appropriate.

All relevant post-graduate education program director(s) or committee(s) must communicate periodically with the MEC and the Governing Board about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.8 **Telemedicine Privileges:** Practitioners providing telemedicine services must be granted privileges at this hospital if, and only if, these services include prescribing care or otherwise treating patients. Practitioners providing telemedicine services limited to interpretation and second opinions do not require privileges at this hospital. Practitioners providing official readings of images, tracings or specimens through a telemedicine mechanism must do so under one of the following arrangements:

- The practitioner is granted clinical privileges at the originating site or distant site* that include these services; or
- The hospital contracts for the provision of these services by the provider. If the hospital contracts for the provision of these services, they must be provided consistent with the terms described in Part III, Section 10 of these Bylaws addressing contracted services.

(*The originating site is the site at which the patient is receiving care and the distant site is the site from which the prescribing or treating services are provided.)

6.8.1 In order for a practitioner to be eligible to request telemedicine privileges, the following requirements must be met:

- The MEC has recommended that the scope of telemedicine services provided at Lovelace Medical Center (LMC) and the distant site hospital include the privileges requested by the practitioner. Both the originating site MEC and the distant site MEC must approve this scope of services.
- The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant site hospital as he or she is requesting at the Lovelace Medical Center.

6.8.2 Requests for telemedicine privileges at LMC will be processed through its established procedure for reviewing and granting privileges. Information included in the completed practitioner application for telemedicine privileges at LMC may be collected in the usual manner or may be collected from the distant site hospital.

6.8.3 In order for the originating site to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following three conditions must be fulfilled:

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

6.9 **Temporary Privileges:** temporary privileges may be granted by the CEO (or designee) acting on behalf of the Governing Board, upon concurrence of the Chief of Staff (or designee), a Clinical Service Chief, or the MEC, provided there is verification of current licensure and current competence and, in the case of circumstances covered in section 6.9.2 below, such other credentials as may be required under Section 6.9.2 below. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care need, and 2) when an initial applicant with a complete, clean application is awaiting review and approval of the MEC and the Governing Board.

6.9.1 **Important Patient Care Need**: Temporary privileges may be granted on a case by case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. For the purposes of granting temporary privileges, an important patient care need is defined as including the following:

a. A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted, (i.e., a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner);

b. A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care from the institution if the temporary privileges under consideration are not granted (i.e., the institution will not be able to provide adequate emergency room coverage in the providers specialty, or the Governing Board has granted privileges involving new technology to a physician on your staff provided the physician is precepted for a specific number of initial cases and the precepting physician, who is not seeking medical staff membership, requires temporary privileges to serve as a preceptor, and;

c. A circumstance in which a group of patients in the community will be placed at risk of not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted, (i.e., a physician who has a large practice in the community for which adequate coverage of hospital care for those patients cannot be arranged.)

6.9.2 **Clean Application Awaiting Approval**: Temporary privileges may be granted for up to one hundred and twenty (120) days when the new applicant for medical staff membership or privileges is waiting for review and recommendation by the MEC and approval by the Governing Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the Lovelace Medical Center: current licensure*; education*; training and experience*; current competence*; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer*; and ability to perform the privileges requested*; and results from a query to the National Practitioner Data Bank*, *(* denote TJC required criteria)*. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 4 of this manual.

6.9.3 **Temporary privileges at reappointment**: Temporary privileges are not to be used at reappointment for other administrative purposes such as the following situations.

a. The LIP fails to provide all information necessary to the processing of his/her reappointment in a timely manner; or

b. Failure of the staff to verify performance data and information in a timely manner.

6.9.4 **Special requirements:** of consultation and reporting may be imposed as part of the granting of temporary privileges and shall not entitle any individual subject to such requirements to hearing or appeals rights under these Bylaws. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the medical staff and Lovelace Medical Center in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

6.9.5 **Termination of temporary privileges:** The CEO, acting on behalf of the Governing Board and after consultation with the Chief of Staff (or designee), may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. Where the life or well being of a patient is determined to be endangered, any person entitled to impose summary suspension under the medical staff bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.9.6 **Rights of the practitioner with temporary privileges:** A practitioner is not entitled to the procedural rights afforded by the Investigation, Corrective Action, Hearing and Appeal Plan procedures outlined in the Medical Staff Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended prior to the specified expiration of such privileges unless such termination or suspension is related to the competence or professional conduct of the affected practitioner.

6.9.7 **Emergency Privileges**: During a medical emergency, any medical staff appointee 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 appointee's license, but regardless of service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.9.8 Disaster Privileges:

a. If the institution's Emergency Management Plan has been activated, the CEO and such other individuals as identified in the institution's Emergency Management Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected practitioners provided at least one of the following requirements has been met by the practitioner:

1) Presentation of a current hospital photo identification (ID) card;
2) Presentation of a current medical license with photo identification (ID) card issued by a state, federal or regulatory agency;
3) Presentation of a photo identification (ID) card that certifies the practitioner is a Licensed Independent Practitioner (LIP) indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;[6]
4) Presentation of an (ID) card that certifies the practitioner is an (LIP) who has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies; and
5) Presentation by a current hospital or medical staff member (s) who can vouch for the practitioner's identity.

b. Each practitioner granted disaster privileges will be required to practice under the supervision of a designated member of the medical staff whose privileges at a minimum include the disaster privileges granted to the practitioner.

c. As soon as feasible while a practitioner is practicing under disaster privileges, but not later than seventy-two (72) hours after disaster privileges are granted, the hospital will seek to verify the practitioner's current license and current competency in the same manner as for individuals granted temporary privileges. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible.[6]

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

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

f. Each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges.[6]

6.9.9 Time-Limited Situational Permission to Observe or Perform Procedures under Proctoring Environment

Lovelace Medical Center has established a policy to process and approve requests for qualified practitioners to observe and/or participate in specific surgical or other procedures performed by a member in good standing of the Lovelace Health System ("LHS") Medical Staff while under a proctoring environment for a time-limited period.

b. At the time of application and throughout the time period that the applicant has a Time-Limited Situational Permission to Observe or Perform Procedures under Proctoring Environment, the applicant must:

1) Demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, or podiatry, clinical psychology, or optometry.
2) Have and maintain a current Temporary Teaching, Research, and Specialized Diagnostic and Treatment Privileges License approved by the New Mexico Board of Medicine as required for the practice of his/her profession within New Mexico.
3) Provide evidence of skills to provide a type of as delineated in the protocol.
4) Provide evidence of professional liability insurance of a type and in an amount established by the Medical Staff and Governing Board.
5) Have a record that is free from current Medicare/Medicaid/CHAMPUS sanctions or felony convictions (within the last three (3) years), or occurrences that would raise questions of undesirable conduct.

6) Act only under the direct supervision of the sponsoring physician who has active medical staff privileges in good standing at LHS.

c. No practitioner shall be entitled to membership on the medical staff, the rights or privileges provided to members of the medical staff, or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

d. Issuance of permission to participate is not guaranteed. No rights to appeal or other due process shall be given under this protocol.

6.10.1 History and physical examinations completed within 30 days prior to the patient's hospital admission or registration by a physician or other qualified licensed individual who may not be a member of the hospital's medical staff or who does not practice at LMC but is acting within his/her scope of practice under New Mexico law or regulations may be accepted. There must be an update to this H&P by a licensed and privileged physician, oral/maxillofacial surgeon, or other licensed individual approved by LMC to perform H&Ps within 24 hours after patient admission or registration or prior to surgery listing any changes in the patient's condition, as required by Part I, article II, section 6.8 of these Bylaws.[2]

6.10.2 More than one qualified practitioner can participate in performing, documenting, and authenticating a history and physical for a single patient. When performance, documentation, and authentication are split among qualified practitioners, the practitioner who authenticates the history and physical will be held responsible for its contents. Therefore LMC permits contribution to the history and physical by anesthesia providers and other licensed individuals privileged to perform history and physicals. [2]

6.11 **Consultations:** The medical staff through its Clinical Service Chiefs shall assure that appropriate consultations will be requested. Any member of the medical staff may be requested to provide consultation within his/her area of expertise. Consultation is required for the following situations: [2]

6.11.1 In unusually complicated situations where specific skills of other practitioners may be helpful; [2]

6.11.2 Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed; [2]

6.11.3 Where there are significant differences of opinion as to the best choice of therapy; [2]

6.11.4 When specifically requested by the patient or his/her family and with concurrence by the attending physician. [2]

Section 7. Preceptorship

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

7.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the Medical Staff Credentials Committee and MEC. At a minimum, the preceptorship program description must include the following:

7.2.1 The scope and intensity of required preceptorship activities; and

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.

7.3 Upon receipt of a report from the preceptor, the practitioner's request for privileges will be processed in accordance with the requirements of the Credential Procedure Manual (Part III of the Bylaws.

Section 8. Reapplication and 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 Governing Board in light of exceptional circumstances, a practitioner who has received a final adverse decision regarding medical staff membership is not eligible to reapply to the medical staff for a period of five years from the date of the notice of the final adverse decision. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Governing Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

8.2 **Reapplication after administrative revocation**: A practitioner who has had his/her appointment or clinical privileges administratively revoked for failure to maintain current professional liability insurance in the specified amount, failure to maintain and complete medical records, or failure to meet other administrative requirements enumerated in these Bylaws, will be reinstated for appointment and appropriate privileges upon submission of documentation that he/she has resolved the reason for the revocation.

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

8.4 **Resignation of staff appointment:** A practitioner may resign his/her staff appointment and/or clinical privileges by providing written notice to the Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

8.5 **Exhaustion of administrative remedies:** Every practitioner agrees that he/she will exhaust all the administrative remedies afforded in the various Services of this manual, the Bylaws and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

8.6 **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 (HCQIA) and its successor statutes, as well as any implementing regulations, and under any applicable state law and its accompanying regulations. Actions that must be reported include those that must be reported to the National Practitioner Data Bank (NPDB) under HCQIA, as well as those that must be reported under any applicable state law. All such reports made to the NPDB or to any other entity pursuant to the requirements of law are covered by the confidentiality and immunity provisions of Section 4 of Part IV of these Bylaws.

Section 9. Leave of Absence

9.1 **Leave request**: A staff appointee may obtain a voluntary leave of absence by providing written notice to the Chief of Staff. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed the remainder of the appointee's current appointment cycle. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Governing Board. During the period of time of the leave, the staff appointee may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities.

9.2 **Termination of leave**: At least thirty (30) days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement by sending a written notice to the Chief of Staff. The staff appointee must submit a written summary of relevant activities during the leave if the MEC or Governing Board so requests. The MEC makes a recommendation to the Governing Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed.

9.3 Decision to Deny Reinstatement: If a denial of reinstatement is determined on the basis of competence or professional conduct the practitioner is eligible for a fair hearing under the provisions of Part II of these bylaws.

Section 10. Practitioners Providing Contracted Services

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

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

10.3 **Exclusivity policy**: Whenever hospital policy specifies that certain hospital facilities or services may be provided on a an exclusive basis in accordance with contracts or letters of agreement between Lovelace Medical Center and qualified practitioners, then other staff appointees must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to Lovelace Medical Center facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Members of the medical staff who have been granted privileges which are subsequently covered by an exclusive contract will not be able to exercise those privileges unless they become a party to the contract. No hearing rights under the Fair Hearing Plan or under any other section of these Bylaws applies to such a loss of exercise of privileges. Providers ineligible for privileges due to an exclusive contract may be granted limited privileges to "follow" their patients in the hospital while under the care of an exclusive provider. This would allow such provider to still have limited privileges to review and recommend care and to be available for consultation at the request of the exclusive provider.[1]

10.4 Effect of disciplinary or corrective action recommended by the MEC: The terms of the Medical Staff Bylaws will govern disciplinary action taken or recommended by the MEC, unless otherwise provided in the practitioner's contract with the Hospital.

10.5 When the hospital contracts for patient care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a TJC accredited organization, all of Sections 10.1 through 10.4 above will apply, and, in addition, one of the following mechanism(s) will be implemented:

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

10.6 When the hospital contracts for care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a TJC accredited organization, all of Sections 10.1 through 10.4 above will apply, and, in addition, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in Part III of these Bylaws

Section 11. Medical Administrative Officers

11.1 A medical administrative officer is a practitioner engaged by the hospital either full or parttime 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 must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

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

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

b. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Governing Board after requesting and considering the recommendation of relevant components and officials of the staff.

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

Section 12. Review, Revision, Adoption, and Amendment

This medical staff Credentials Procedure Manual may be amended or repealed, in whole or in part in accordance with Part I of these Bylaws, Article XI, Section 2.

Adopted by:

Chief of Staff	Date:
Chief Executive Officer	Date:
Chairman, Governing Board	Date:

Part IV: Organization and Functions Manual

Section 1. Organization And Functions Of The Staff

1.1 Organization of the Medical Staff

The medical staff of Lovelace Medical Center shall be organized as a non-departmentalized staff. The following are the currently recognized Clinical Services: Medicine and Surgery. A Clinical Service Chief shall head each clinical service with overall responsibility for the coordination of clinical service activities. Individual Clinical Services are advisory only, with no binding authority, but may adopt internal policies to facilitate their work, subject to the authority of the MEC.

1.2 Responsibilities for Medical Staff Functions

The ultimate responsibility and authority for the medical staff functions outlined in Section 1.3 lies with the MEC. The Medical Staff Officers, Clinical Service Chiefs, Hospital and medical staff committee Chairs, are responsible for working collaboratively to develop a process for communication of medical staff function activities by providing periodic reports as appropriate to the medical staff and any Clinical Services and to elevate issues of concern to MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care. Activities of the medical staff are intended to improve the quality of patient care by encouraging peer collaboration and are entitled to peer review protections to the extent permitted by law.
The Chief of Staff and the Chief Medical Officer will appoint physician advisors to act as liaisons with hospital personnel and committees to facilitate important medical staff performance improvement activities.

1.3 Description of medical staff functions:

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

1.3.1 Governance, direction, coordination, and action:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from Clinical Services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC and medical staff committee(s));

b. Account to the Governing Board and to the staff by written recommendations for the overall quality and efficiency of patient care at Lovelace Medical Center (Chief of Staff and MEC);

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

d. Make recommendations on medico-administrative and hospital clinical and operational matters (Chief of Staff and MEC);

e. Inform the medical staff of the accreditation program and the accreditation and state licensure status of Lovelace Medical Center (Chief of Staff and MEC);

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

g. Oversee, develop and plan 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 (MEC);

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 (MEC, Bioethics Physician Liaison or Subject Matter Expert);

i. Provide oversight concerning the quality of care provided by any residents, interns, or students who may work at the hospital, and ensure that the same act within approved guidelines established by the medical staff and governing body (MEC); and

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 Governing Board. (Medical Staff Officers and MEC)

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities (MEC, Medical Staff Peer Review Committee,)

a. Set expectations, develop plans, educate members, and manage processes to measure, assess, and improve the quality of clinical activities;

b. Understand the adopted approach to and methods of performance improvement;

c. Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the hospital;

d. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body, and define in writing responsibility for acting on recommendations for improvement;

e. Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis;

f. Ensure implementation of an integrated patient safety program throughout the hospital;

g. Ensure that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors are defined and implemented;

h. Provide for mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety; and

i. Measure and assess the effectiveness of contributions to improving performance and patient safety.

1.3.3 Monitoring activities should include but not be limited to the following (MEC, Medical Staff Peer Review Committee):

a. Medical assessment and treatment of patients;

b. Use of medications;

c. Use of blood and blood components;

d. Use of operative and other procedures;

e. Education of patients and families;

f. Coordination of care with other practitioners and hospital personnel;

g. Accurate, timely, and legible completion of patients' medical records;

h. Appropriateness of clinical practice patterns;

i. Significant departures from established patterns of clinical practice;

k. Use of developed criteria for autopsies;

l. Sentinel event data;

m. Patient safety data;

n. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient; and

o. Findings of the assessment process relevant to individual performance.

1.3.4 Credentials review (see Credentials Procedure Manual)

1.3.5 Information Management (MEC, Medical Records Physician Liaison)

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

1. Properly describe the condition and progress of the patient, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

2. 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. (MEC, Medical Record Physician Liaison, Peer Review Committee for review and enforcement of timeliness rules, forms, policy, etc.); and

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 a crisis management program that addresses disasters both external and internal to the hospital (MEC).

1.3.7 Planning (Chief of Staff, MEC)

a. Advise the hospital by participating in the evaluation of existing programs, services, and facilities of the hospital and medical staff and recommending continuation, expansion, abridgment, or termination of each;

b. Advise the hospital by participating in the evaluation of 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; and

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

1.3.8 Bylaws review (MEC)

a. Conduct periodic review of the Medical Staff Bylaws, Organization and Functions Manual, Credentials Procedure Manual, and medical staff rules and regulations;

b. Conduct periodic review of the clinical policies and rules; and

c. Submit written recommendations to the MEC and to the Governing Board for amendments to the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual, and rules and regulations.

1.3.9 Nominating (MEC, Nominating Committee)

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

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 (MEC, Medical Staff Peer Review Committee, Infection Control Physician Liaison)

a. The medical staff oversees 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 nosocomial infections;
- Review of prevalence and incidence studies, as appropriate; and
- Collection of additional data as needed;

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

d. Evaluate and revise the type and scope of surveillance annually;

e. Develop a surveillance plan for sampling of personnel and environments;

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

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

h. Report nosocomial infection findings on a day-to-day basis to the attending physician and appropriate clinical or administrative leader; and

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

1.3.11 Pharmacy and Therapeutics functions (MEC, Pharmacy & Therapeutics Physician Liaison, and Medical Staff Peer Review Committee)

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;

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 on Accreditation of Healthcare Organizations (TJC);

f. Perform blinded practitioner profile analysis related to medication use;

g. Approve policies and procedures related to the TJC 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 health system;

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; and
   - 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 health system and medical staffs pertaining to the choice of available medications; and

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

1.3.12 All quality, patient safety and performance related functions mentioned above shall be reported through the Medical Staff Peer Review Committee to the MEC or directly to the MEC. All minutes and records reviewed will be maintained as a permanent record and will be kept in compliance with the confidentiality policies of the medical staff and Lovelace Medical Center.

1.4 Responsibilities of Chief of Staff:

Note: The Duties of Officers and of Chief of Staff are listed in Part I of the Medical Staff Bylaws, Article V, Section 6, Duties of Officers.

1.4.1 The Chief of Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Governing Board and the administration of the hospital. The Chief of 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, Credentials Procedure Manual, Organization and Functions Manual, and the medical staff rules and regulations. 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 Governing Board and the hospital administrator on hospital or Governing Board committees;

c. Enforce the Medical Staff Bylaws (Parts I through IV) and medical staff and hospital policies;

d. Unless as provided for elsewhere in the Bylaws, appoint committee chairpersons and all members of the medical staff standing and ad hoc committees; appoint Physician Liaisons/Advisors; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees; and in consultation with the chair of the Governing Board, appoint medical staff members to appropriate Governing Board committees when those are not designated by position or by specific direction of the Governing Board or otherwise prohibited by state law;

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

f. Report to the Governing Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical 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 Governing 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 Governing 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 Governing Board;

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

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

l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

1.5 Responsibilities of Clinical Service Chiefs: All of the following functions shall be performed in an advisory capacity to the MEC only, and the MEC shall not be required to wait for any particular reports or recommendations from Clinical Services or Clinical Service Chiefs prior to taking action:

a. Formulate continuing education as desired by the membership of the Clinical Service and encourage discussion of patient care issues pertinent to that clinical specialty or specialties;

b. Conduct Grand rounds as desired by physicians in the Clinical Service;

c. Discuss policies and procedures and make recommendations to the MEC as desired by the members of the Clinical Service;

d. Discuss equipment needs pertinent to that Clinical Service, if requested by the members of the Service, and make recommendations to appropriate hospital parties;

e. Develop recommendations on a specific issue at the request of the MEC;

f. Encourage participation in the development of criteria for clinical privileges and give input on an application or reapplication, when requested by the Credentials Committee or MEC; and

g. Submit a written annual report detailing the Clinical Service activities to the MEC is requested by the MEC or Chief of Staff.

Section 2. Medical Staff Committees And Physician Liaisons/Advisors

All physician advisors/liaisons and committees other than the MEC act solely in an advisory capacity to the MEC.

2.1. **Medical Executive Committee:** Description of the MEC is in Article VII, Section 2 of Part I of the Medical Staff Bylaws.

2.2. **Credentials Committee:** Description of the Credentials Committee is in Section I of Part III of the Medical Staff Bylaws (Credentials Procedure Manual)

2.3. Medical Staff Peer Review Committee:

2.3.1. **Composition:** the Medical Staff Peer Review Committee includes:

2.3.1.a. A minimum of seven (7) active members of the medical staff; and

2.3.1.b. Other hospital staff without vote to present data or reports, as requested by the chair.

2.3.2. **Responsibilities:** The Medical Staff Peer Review Committee is responsible to:

2.3.2.a. Perform initial review of all cases which meet the criteria for case review under the hospital and medical staff performance improvement policies;

2.3.2.b. Obtain case reviews and recommendations from specialists/subject matter experts when deemed appropriate and make recommendations to the MEC regarding the need for external peer review;

2.3.2.c. Regular review of aggregated results of physician performance representing all dimensions of care to identify individual or system opportunities for improvement;

2.3.2.d. Communicate individual improvement opportunities to the appropriate medical

staff leader and the member involved;

2.3.2.e. Communicate system improvement opportunities to the Quality Council;

2.3.2.f. Track staff member responses to recommendations for improvement and compliance with all improvement plans;

2.3.2.g. Report to the MEC regularly regarding recommendations to improve care;

2.3.2.h. Communicate and collaborate with any hospital Quality Committee to address system issues at LMC.

2.4. Cancer Committee

2.4.1. **Composition:** The Cancer Committee shall be multidisciplinary with required members as appropriate to maintain certification by the American College of Surgeons Commission on Cancer as a Community Hospital Cancer Program.

2.4.2. **Responsibilities:** The Cancer Committee provides program leadership with duties as described in the Standards of the ACS Commission on Cancer.

2.5. Pharmacy and Therapeutics Physician Liaison:

2.5.1. **Responsibilities:** The Pharmacy & Therapeutics Physician Liaison shall be responsible for assisting in the development and surveillance of all drug utilization policies and practices within the hospital in collaboration with the hospital's director of pharmacy and the pharmacy staff. The Physician Liaison shall assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, procedures, and all other matters relating to drugs in the hospital. The Physician Liaison, in collaboration with the Director of Pharmacy, shall be charged with implementation of a regular review of the clinical use of antibiotics, including prophylactic use of antibiotics.

2.6. Infection Control Physician Liaison:

2.6.1. **Responsibilities:** The Physician Liaison for Infection Control shall collaborate with the hospital infection control nurse and other appropriate hospital personnel to develop and maintain protocols that will insure constant surveillance of all potential sources of hospital infections. In collaboration with hospital personnel and appropriate clinical experts, the Physician Liaison will review and analyze infections occurring in the hospital. A report of infections, their outcomes and recommendations shall be made to the MEC through the Quality Council and/or the Medical Staff Peer Review Committee.

2.7. Medical Records Physician Liaison:

2.7.1. **Responsibilities:** The Physician Liaison will work with the staff of the medical records or HIM department to assure that all medical records reflect realistic documentation of medical events. The Physician Liaison, or designee, shall participate in a monthly

review of currently maintained medical records which shall be conducted to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criteria of medical comprehension of the case in the event of transfer of physician responsibility for patient care. The Physician Liaison, or designee, shall also participate in the review of records of discharged patients conducted to determine the promptness, pertinence, adequacy and completeness of each record's documentation. The Physician Liaison can call upon the expertise of multidisciplinary members of the staff to assist in carrying out this work.

2.8. Biomedical Ethics Physician Liaison:

2.8.1. **Composition:** The Biomedical Ethics function shall be conducted by the division-wide Biomedical Ethics Committee.

2.8.2. **Responsibilities:** The Physician Liaison will work with any established hospital ethics committee or any system-wide Biomedical Ethics Committee to establish policies relating to issues of medical ethics, engage in case reviews or solicit appropriate members of the medical staff for such involvement, promote educational programs relating to medical ethics, and serve as a resource to members of the medical staff facing challenging medical ethics dilemmas.

2.9. Practitioner Health Committee:

2.9.1. **Composition:** The Practitioner Health Committee shall be comprised of members selected by the Medical Executive Committee.

2.9.2. **General Description:** This function shall be responsible for addressing problems dealing with impaired professional performance among practitioners. Issues related to impaired practitioners shall be referred to the Chief of Staff, who will determine the need for referral to the MEC.

2.9.3. **Responsibilities:** This committee shall be responsible for addressing problems dealing with impaired professional performance among practitioners at LMC. In particular, the committee will focus on clinical performance adversely affected by a practitioner's substance abuse, physical or mental health. The committee will seek to find ways to assist practitioners that provide an alternative to the corrective action mechanisms articulated elsewhere in these bylaws. The committee will collaborate with organizations recognized by the state medical board to assist physicians with health or substance abuse problems. The committee is charged with the following tasks:

2.9.3.a. To recommend a program for identifying and contacting practitioners who have become professionally impaired in varying degrees because of drug dependence including alcoholism or because of mental, physical or aging problems. The committee is to offer rehabilitative help to such practitioners to the extent of its ability;

2.9.3.b. To establish programs for educating staff practitioners to prevent substance dependence;

2.9.3.c. To notify the impaired practitioner's Clinical Service Chief and the hospital CEO if the committee believes that an impaired practitioner's actions could endanger patients;

2.9.3.d. To create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible.

2.9.4. **Operations:** Deliberations of the Practitioner's Health Committee are to remain confidential subject only to the reporting mechanisms outlined in 2.9.3 above.

2.9.5. **Patient Safety:** If at any time during the process described in this section it is determined that a medical staff member cannot safely perform the clinical privileges that he or she has been granted, regardless of whether he or she is participating in a program sponsored by the Practitioner's Health Committee, the matter shall be taken up by the MEC for appropriate corrective action in accordance with the medical staff bylaws. The MEC shall also strictly comply with any applicable federal or state reporting requirements. Nothing in this section shall be deemed to limit any of the provisions in the medical staff bylaws for corrective action or disciplinary action against a medical staff member or for the suspension of that medical staff member's clinical privileges.

2.10. **Ardent Lovelace Albuquerque Credentials and Peer Review Sharing Committee:**
Composition: The Ardent Lovelace Albuquerque Credentials and Peer Review Sharing Committee shall be composed of one member of the Governing Body and either one member of the MEC or one member of the Credentials Committee of each of Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital.
General Description: The purpose of the committee shall be to facilitate the sharing of credentialing, peer review, and quality review information among three facilities under common ownership: Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital. Any credentialing and peer review information may be shared among these facilities upon request of the CEO, Chief of Staff, or Credentials Committee chair of these facilities. Additionally, any reports generated by the peer review or quality review processes at any of these hospitals shall promptly be forwarded to the Ardent Lovelace Albuquerque Credentials and Peer Review Sharing Committee. The disclosure of information via this committee is not intended to waive any applicable privilege.
Responsibilities:

a. To promote the sharing of credentialing, peer review, and quality review information among Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital.

b. To perform the committee's functions in strict compliance with HIPAA regulations.[6]

Section 3. Confidentiality, Immunity, And Releases

3.1 **Confidentiality of Information**: Information submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of: assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of health care provided; evaluating current clinical competence and qualifications for staff appointment/affiliation, or clinical privileges or specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, confidential. This information will not be disseminated to anyone other than a representative of the hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each practitioner expressly acknowledges that violations of the confidentiality provided here are grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services or other disciplinary or corrective action as the MEC might recommend.

3.2 **Immunity From Liability**: No representative 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 for providing information, opinion, counsel, or services to a representative or to any health care facility or organization of health professionals concerning said practitioner. Immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

3.3 **Activities:** The confidentiality and immunity provided by this article applies to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- 3.3.1 Applications for appointment/affiliation, clinical privileges, or specified services;
- 3.3.2 Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- 3.3.3 Corrective or disciplinary actions;
- 3.3.4 Hearings and appellate reviews;
- 3.3.5 Quality assessment and performance improvement activities;
- 3.3.6 Utilization review and improvement activities;
- 3.3.7 Claims reviews;
- 3.3.8 Risk management and liability prevention activities; and

3.3.9 Other hospital, committee, [service/clinical service], or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

Section 4. Review, Revision, Adoption, And Amendment

This medical staff Organization and Functions Manual may be amended or repealed in accordance with the procedure outlined in Article XI, Section 2 of Part I of these Bylaws.

Lovelace

Site: Lovelace Medical Center	**Title:** MEDICAL STAFF - Medical Staff Bylaws - LMC	
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Approved: Document Control Committee, LMC Governing Board, MEC Committee, Vesta Sandoval (Division CMO)	**Supersedes:** v.2 MEDICAL STAFF - Medical Staff Bylaws - LMC	

Adopted by:

Chief of Staff	Date:
Chief Executive Officer of Lovelace Medical Center	Date:
Chairman, Governing Board	Date:

Endnotes

Summary of Document Revisions/Edits	Date: 04/25/2017
Amended and approved October 20, 2016	

[i] These bylaw revisions were voted upon and approved by the Medical Staff, Medical Executive Committee, and Board in July 2007.
[2] These bylaw revisions were voted upon and approved by the Medical Executive Committee and Board in August 2008.
[3] These bylaw revisions were voted upon and approved by the Medical Executive Committee and Board in December 2008.
[4] These bylaw revisions were voted upon and approved by the Medical Executive Committee and Board in November 2009.
[5]These bylaw revisions were voted upon and approved by the Medical Executive Committee and Board in February 2011.
[6] These Bylaws revisions were voted upon and approved by the Medical Executive Committee and Board in May, 2012.
These Bylaws revisions were voted upon and approved by the Medical Executive Committee and Board in June, 2015.