Lovelace

Medical Staff Bylaws

Lovelace Regional Hospital –Roswell

Approved August 2011
Revised May 2013
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Medical Staff Bylaws
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MEDICAL STAFF BYLAWS
OF
LOVELACE REGIONAL HOSPITAL - ROSWELL

RESOLUTION

WHEREAS,- Lovelace Regional Hospital - Roswell, hereinafter referred to as "Hospital", is operated by Lovelace Health Systems, a private corporation organized under the laws of the State of New Mexico and is lawfully doing business in New Mexico, and is not an agency or instrumentality of any state, county, or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the hospital; and

WHEREAS, the cooperative efforts of the Medical Staff, management, and the Board of Trustees are necessary to fulfill these goals.

NOW, THEREFORE, the practitioners practicing in Lovelace Regional Hospital – Roswell hereby organize themselves into a Medical Staff conforming to these bylaws.

PREAMBLE

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body of Lovelace Regional Hospital – Roswell to enhance the quality, safety of care, and treatment provided in the Hospital and to assure the competency of the Hospital's Medical Staff. The Medical Staff Bylaws, Rules and Regulations, Policies and the Governing Body's bylaws do not conflict. The Bylaws provide a framework of self-governance, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issue and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure of Medical Staff operations, organized medical staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria for Medical Staff membership and privileges. These bylaws enforce those criteria's and standards and establish clinical criteria's and standards that oversee the management of quality assurance/improvement, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments; review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff Officers; and they address the respective rights and responsibilities of the Medical Staff and Governing Body.

ARTICLE I

1. Definitions

The following terms shall have the meaning set forth in this Article, unless the context clearly indicates otherwise. NOTE: Some of the terms defined in the Article I are not capitalized when used throughout these bylaws.

1.1 **Active Staff**: members shall be those physicians (D.O.'s and M.D.'s) licensed in the State of New Mexico that have the privilege of admitting patients, holding office, and voting.

1.2 **Administration:** executive members of the administration of the Hospital, including the CEO.

1.3 **Adult Patient:** for admitting purposes, a patient identified as eighteen (18) years of age or above.

1.4 **Allied Health Professional or "AHP":** means an individual, other than the practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in Hospital. The authority of an AHP to provide specified care services is established by the Medical Staff based on the professional's qualifications.

1.5 **Attending Physician:** A Medical Staff member, with admitting privileges; who is legally responsible for the care and treatment of a patient in a particular case; such as a doctor of medicine or osteopathy (as defined by the Center for Medicare and Medicaid Services in Section 1861® (42 USC1395x) who is fully knowledgeable about the patient's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the patient's specific medical problem.

1.6 **Board:** the Board of Trustees of the hospital.

1.7 **Chief Executive Officer or CEO:** the Administrator of the hospital; means the individual appointed by the Hospital Board of Trustees to provide for the overall management of the Hospital or his/her designee.

1.8 **Chief of Service/Department:** The Chief or Acting Chief of each Department of the Medical Staff is a physician who is the head of a clinical department at the Hospital.

1.9 **Chief of Staff**: means the member of the Active Medical Staff who is duly elected in accordance with these bylaws to serve as chief officer of the Medical Staff of this hospital or his/her designee.

1.10 **Clinical Privileges:** the permission granted to a practitioner by the Hospital to render specific professional, diagnostic, therapeutic, medical, dental or surgical services. It reflects the Board's recognition of the practitioner's competence and qualifications to render specific care.

1.11 **Data Bank:** means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

1.12 **Day:** A day is defined as a calendar day unless otherwise specified herein.

1.13 **Designee:** means one selected by the CEO, Chief of Staff, or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.

1.14 **Direct Supervision:** The physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

1.15 **Emergency:** A condition in which serious harm could result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that harm or danger.

1.16 **Ex Officio:** means one selected by the CEO, Chief of Staff, or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.

1.17 **Fair Hearing Plan:** means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a practitioner's clinical privileges are adversely affected by a determination based on the practitioner's professional conduct or competence. The Fair Hearing Plan is incorporated into these bylaws and contained in Appendix "A" hereto.

1.18 **Good Standing:** status indicating the Staff member has met the attendance requirements during the medical staff year, is not in arrears in dues payment, if applicable, and is not under a suspension of his/her appointment or admitting privileges.

1.19 **HCQIA:** the Health Care Quality Improvement Act of 1986,42 U.S.C.A. Sect.ion 11101 et seq.

1.20 **Hospital:** Lovelace Regional Hospital – Roswell, 117 East 19th Street, Roswell, NM 88201, which is owned and operated by Lovelace Health System.

1.21 **Hospital Representative:** includes (a) The Board of Managers and its directors and committees; (b) the CEO or his or her designee; (c) Registered Nurses and other employees of the Hospital; (d) the Medical Staff organization and all Medical Staff appointees; (e) clinical units and committees that have responsibility for collecting and evaluating the applicant's credentials or acting upon his or her application; and (f) any authorized representative of any of the foregoing.

1.22 **Investigation:** means a process specifically instigated by the MEC to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Physician Advisory Committee.

1.23 **Licensed Independent Practitioner:** means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

1.24 **Medical Executive Committee or "MEC":** means the Executive Committee of the Medical Staff. The Medical Executive Committee is the governing body of the organized medical staff. Its duties include representing and acting on behalf of the Medical Staff, making recommendations for staff membership, delineation of clinical privileges, and assuring professionally ethical conduct and competent clinical performance of medical staff members.

1.25 **Medical Staff** means the formal organization of practitioners who have been granted privileges by the Board to attend patients in the hospital.

1.26 **Medical Staff Bylaws:** means the Bylaws of the Medical Staff and the accompanying Rules and Regulations, Fair Hearing Plan, and such other departmental rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

1.27 **Medical Staff Year:** means calendar year.

1.28 **Member:** means a practitioner who has been granted Medical Staff membership and clinical privileges pursuant to these bylaws.

1.29 **Peer**: One that has the same professional rank as another

1.30 **Peer Review Policy:** means the policy and procedure adopted by the Medical Staff via the MEC's approval with approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards.

1.31 **Physician:** an individual who has received a doctor of medicine or doctor of osteopathy degree and is currently licensed to practice medicine in the state of New Mexico.

1.32 **Podiatrist:** a Podiatrist holding a DPM degree, or its equivalent, and a valid, unrestricted license to practice podiatry in the State of New Mexico.

1.33 **Practitioner:** means a physician who has been granted clinical privileges in the hospital.

1.34 **Prerogative:** means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.

1.35 **Privileges or Clinical Privileges:** the permission granted by the Governing Body to a practitioner to provide specific patient care services within defined limits, based on the individual practitioner's license, education, training, experience, competence, health status and judgment. Privileges are granted for a period not to exceed two (2) years.

1.36 **Proctoring:** the method by which the Medical Staff members may be evaluated for clinical competence in the areas in which they are privileged or are requesting privileges.

1.37 **Rules and Regulations:** the rules and regulations of the Staff attached to these bylaws.

1.38 **Special Notice**: means a written notice sent by mail with return receipt requested or delivered by hand with a written acknowledgement of receipt or delivery by the person delivering the special notice.

1.39 **Staff:** the single organized Medical Staff which includes physicians and other licensed individuals permitted by law and these bylaws to provide patient care services independently in the Hospital and who may be granted clinical privileges to attend patients in the Hospital. The Staff is an integral part of the Hospital and is not a separate legal entity.

1.40 **Staff Officer:** any medical staff member of the Medical Executive Committee.

1.41 **Telemedicine:** means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from the hospital.

1.42 **Vice Chief of Staff:-**an elected physician officer of the medical staff, who, upon completion of the two (2) year term of office, shall succeed to the office of Chief of Staff.

1.43 **Voluntary Relinquishment:** means to avoid an investigation or adverse action; this shall not include voluntary non-renewal without cause.

ARTICLE II

Name, Purpose, Responsibilities

2.1 **Name-** The name of the Staff shall be the "Medical Staff of Lovelace Regional Hospital-Roswell."

2.2 **Purposes-** The purposes of the Staff are:

2.2.1 To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;

2.2.2 To foster cooperation with administration with the board while allowing staff members to function with relative freedom in the care and treatment of their patients;

2.2.3 To provide an educational setting that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skill;

2.2.4 To adopt rules and regulations for the proper function of the Staff;

2.2.5 To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs. LIPs authorized to practice in the hospital through delineation of clinical privileges, ongoing review and evaluation of each practitioner's performance in the hospital, and supervision, review, evaluation and delineation of duties and prerogative of LIPs;

2.2.6 To assist the Board by serving as a professional review body in conducting professional review activities;

2.2.7 To participate in educational activities and scientific research with approved colleges of medicine as may be justified by the facilities, personnel, funds or other equipment that are or can be made available; and

2.2.8 To maintain the accreditation status of the hospital.

2.3 **Responsibilities:** The Staff shall account and report to the Board and Administration regarding quality improvement activities in the Hospital by means of:

2.3.1 Identifying community health needs and establishing appropriate institutional goals;

2.3.2 Ensuring that practitioners cooperate with each other in caring for patients in the hospital; and

2.3.3 Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and LIP**s** authorized to practice in the hospital, by taking action to:

a. Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

b. Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

c Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the hospital; and require documentation of individual participation in such programs by all individuals with clinical privileges;

d. Implement a utilization review program, based on the requirements of the hospital's utilization review plan;

e. Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of LIPs;

f. Initiate and pursue corrective action with respect to practitioners and LIPs, when warranted;
g. Develop, administer, and enforce these bylaws, the rules and regulations of staff and other hospital policies related to medical care;
h. Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;
i. Ensure that the functions delineated in these bylaws are performed by appropriate standing or ad hoc committee of the Medical Staff; and
j. Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix "B" hereto;
k. Maintain confidentiality with respect to the records and affairs of the hospital, except as disclosure is authorized by the Board or required by law.
l. Professional Liability Insurance. Each practitioner and other individuals granted clinical privileges or approved to render specified services in the Hospital shall continuously maintain in force professional liability insurance not less than the minimum amounts required by the New Mexico Malpractice Act or as may from time to time be determined by the Board. Policy coverage shall be applicable to the entire tenure of appointment. Upon request, each practitioner shall provide satisfactory evidence of such coverage. Each staff member is required to notify the Hospital immediately of any changes in his or her professional liability insurance.

2.4 **Reporting:** The Staff shall comply with the reporting requirements of the law, including HCQIA (including the National Practitioner Data Bank program), governing professional review actions. The Staff shall, as required by law, report to the appropriate licensing boards and to the Department of Health and Human Services any professional review actions, as defined in HCQIA, involving:

2.4.1 Competence or professional conduct that adversely affect the Staff membership or clinical privileges of a practitioner at the Hospital for a period longer than 30 days, or

2.4.2 The surrender or relinquishment of Staff membership or clinical privileges of any practitioner at the Hospital while an investigation or proceeding related to competence or professional conduct is underway, or the surrender or relinquishment of Staff membership or clinical privileges by practitioner in order to induce the hospital not to conduct such an investigation or proceeding.

2.5 **Professional Review Action:** A professional review action will be considered to adversely affect a practitioner or other person if it is considered adverse in the Fair Hearing Plan. Reports shall contain such information as may be required by law, including the name of the practitioner involved; a description of the acts or omissions or other reasons for the action or, if known, for the surrender; and other information respecting the circumstances of the action or surrender.

2.6 **Obtaining Reported Information:** The Staff shall request from the Department of Health and Human Services or from the appropriate agency designated by the Secretary of Health and Human Services information reported under the Health Care Quality Improvement Act of 1986 (National Practitioner Data Bank program) concerning any practitioner or other person:

2.6.1. At the time he or she applies f or Staff membership or clinical privileges at the hospital;

2.6.2 At least once every two years for each such practitioner or person who is on the Staff

or has been granted clinical privileges at the Hospital; and

2.6.3 During the term of appointment, whenever the physician or practitioner requests for an increase in privileges.

2.7 **Participation in Organized Health Care Arrangement:** Patient information will be collected, stored, and maintained so that privacy and confidentiality are preserved. The hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. The OHCA allows the hospital and the Medical Staff members to share information for purposes of treatment, payment, or health care operations. Under the OHCA, at the time or admission, a patient will receive the hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the hospital and the Medical Staff.

ARTICLE III

Staff Membership

3.1 **Nature of Membership-** Staff membership is a privilege extended by the Hospital, and not a right of any practitioner or other person. Membership and the exercise of privileges shall be extended only to practitioners who continuously meet the requirements of these bylaws. No person shall admit or provide services to Hospital patients unless he or she is appointed to the Staff or has been granted privileges. Appointment to the Staff shall confer on the appointee only such clinical privileges as are granted by the Board. For purposes of these bylaws, "membership in" is used synonymously with "appointment to" the Staff, accepts that the granting of clinical privileges does not automatically confer Staff membership or appointment. A person may be granted clinical privileges without Staff membership or appointment.

3.2 **Qualifications.** Only practitioners duly licensed to practice in the State of New Mexico shall be eligible for appointment to the Staff. Each practitioner must:

3.2.1 Document his or her experience, background, training, demonstrated ability and physical and mental health condition, with sufficient adequacy to demonstrate that patients treated by him or her will receive care of the recognized professional level established by the Hospital and that he or she is able to provide a needed service to the Hospital;

3.2.2 Be determined, on the basis of documented references, to adhere strictly to the ethics of his or her profession, to work cooperatively with others, and to be willing to participate in the discharge of Staff responsibilities; and

3.2.3 Comply and have complied with federal, state, and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the hospital

3.3 **Staff Membership Entitlement:** No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he or she is licensed to practice, is a member of any professional organization, is certified by any board, or had or has staff membership or clinical privileges in the Hospital or any other health care facility.

3.4 Adequate Facilities and Supportive Services*:* No person shall be appointed to the Staff or granted clinical privileges if the Hospital is unable to provide adequate facilities and supportive services for the applicant and his or her patients.

3.5 **Non-discrimination:** No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the hospital, to professional ability and judgment, or to the community need.

3.6 **Ethics:** The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past, and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of

ethics; abide by the ethical principles of his or her profession, including, but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing for continuing care for his or her patients; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility and who is not adequately supervised; seeking consultation whenever necessary; and refraining from providing fictitious surgical or medical services. Acceptance of Staff membership or exercise of clinical privileges shall constitute an agreement to strictly abide by these bylaws, the Rules and Regulations, and policies therein.

3.7 **Basic Responsibilities:** Except as otherwise provided in these bylaws, each Staff member shall:

3.7.1. Provides continuous care of his or her patients at the generally recognized professional level of quality and efficiency;

3.7.2 abides by these bylaws, the Rules and Regulations and other rules, policies and regulations of the Hospital;

3.7.3 Discharge such Staff, department, committee and Hospital functions for which he or she is responsible, by election, appointment or otherwise;

3.7.4 Prepare and complete in a timely manner the medical and other required records for patients as provided in the Rules and Regulations;

3.7.4 Comply and have complied with federal, state, and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the hospital

3.7.5 Maintains a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession

3.7.6 Maintain continuing medical education as required to gain and retain licensure

3.7.7 Practice in such a manner as not to interfere with orderly and efficient rendering of services by the hospital or by other practitioners within the hospital

3.7.8 Notifies the CEO and Chief of Staff immediately if:

a. His/her professional licensure in any state is suspended or revoked
b. His/her professional liability insurance is modified or terminated
c, S/he is named as a defendant, or is subject to a final judgment: or settlement in any court proceeding alleging that he/she committed professional judgment or fraud
d, S/he has been excluded from any federal or state health program, including Medicare and Medicaid, or
e, S/he has either voluntarily or involuntarily participated or is currently participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion

3.7.9 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.

3.7.10 Professional Liability Insurance- Each practitioner and other individuals granted clinical privileges or approved to render specified services in the Hospital shall continuously maintain in force professional liability insurance not less than the minimum amounts required by the New Mexico Malpractice Act or as may from time to time be determined by the Board. Policy coverage shall be applicable to the entire tenure of appointment. Upon request, each practitioner shall provide satisfactory evidence of such coverage. Each staff member is required to notify the Hospital immediately of any changes in his or her professional liability insurance.

3.7.11 Program Participation- Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion shall be provided to the CEO. In addition, the practitioner shall have a continuing duty to notify the Medical Executive Committee through the CEO or his/her designee of the initiation of participation in any rehabilitation or impairment program. The CEO or his/her designee shall be responsible for notifying the executive committee of all such actions.

3.8 **Terms-** Initial appointments and reappointments shall be made by the Board upon the recommendation of the Staff. Reappointments shall be made by the Board upon the recommendation of the Staff. Reappointments will be for a period of two (2) years and shall be considered on each anniversary date of the initial appointment.

3.9 **Contract Practitioner.** Any practitioner employed by the Hospital who wishes to exercise clinical privileges must apply for and maintain Staff membership in the same manner as, other privileges of any staff member who has a contractual relationship with the hospital, or is either an independent contractor, employee, partner, or principal of, or in, an entity that has a contractual relationship with the hospital, relating to providing services to patients at the hospital, shall terminate automatically and immediately upon:

3.9.1 The expiration or other termination of the contractual relationship with the hospital or

3.9.2 The expiration or other termination of the relationship of the staff member with the entity that has a contractual relationship with the hospital.

3.9.3 In the event of such a termination of staff appointment, no rights to a hearing or appellate review provided in these bylaws, including those provided in the Fair Hearing Plan and Article VII, shall apply.

3.9.4 Such termination of Medical Staff privileges described above shall not be reportable to the National Practitioner Data Bank or licensing agency.

3.10 **Leave of Absence -** A Staff member may obtain a voluntary leave of absence for a period not to exceed one year by submitting written notice to the Chairperson of the department to which he or she is assigned and to the Chief of Staff. During such leave, the member's privileges and prerogatives shall be suspended. At least fifteen (15) days prior to the termination of the leave, the Staff member may request reinstatement by written request to the Chief of Staff, who shall include a summary of his or her activities during the leave. The Chief of Staff shall forward the request to the Executive Committee, which shall then make a recommendation to the Board as to reinstatement. Failure to request reinstatement shall result in automatic termination of Staff member.

ARTICLE IV

Categories of the Staff

4.1 The Active Category

Qualifications: Appointees to this category shall:

4.1.1 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 Regional Hospital, 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.

4.1.2 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.

Prerogatives: Appointees to this category may:

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

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

4.1.5 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.

Responsibilities: Appointees to this category shall:

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

4.1.7 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 a activities and in the discharge of other staff functions as may be required**.**

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

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

4.2 The Associate Category

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.

Prerogatives: Appointees to this category may:

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

4.2.2 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, unless a resident of Chavez County. Members of the Associate Category may serve on Medical Staff Committees other than the Medical Executive Committee, unless a resident of Chavez County, and may serve and vote on matters that come before such committees.

Responsibilities: Appointees to this category shall:

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

4.2.4 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**.**

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

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

4.3 The Refer & Follow Category

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.

Prerogatives: Appointees to this category may:

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

4.3.2 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.

4.3.3 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.

4.4 Administrative Privileges Category

Qualifications: The Administrative category is reserved for Medical staff members who:

4.4.1 Have no patient care or clinical responsibilities and

4.4.2 By nature of their relationship to the LRH Medical Staff, regularly attend LRH 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 Division or Facility based Chief Medical Officers, but can be granted to other practitioners at the Medical Executive Committee's discretion.

Prerogatives: Appointees to this category:

4.4.3 Do not hold any clinical privileges

4.4.4 Are exempt from having to carry medical malpractice insurance

4.4.5 Are exempt from any ED "call" requirements

4.4.6 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.

Responsibilities: Appointees to this category shall:

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

4.4.8 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**.**

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

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

ARTICLE V

Allied Health Professionals

5.1 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)

5.2 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:

5.2.1 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;

5.2.2 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;

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

5.2.4 Provide a needed service within the Hospital; and

5.2.5 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.

5.3 Prerogatives

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

5.3.1 To exercise judgment within the AHP's area of competence

5.3.2 To participate directly, including writing orders to the extent permitted by law, in the management of patients

5.3.3 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.

5.4 Conditions of Appointment

5.4.1 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 nonappealable, except as specifically and expressly provided in these bylaws.

5.4.2 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.

5.4.3 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.

5.4.4 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.

54.5 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.

5.5 Responsibilities: Each AHP shall:

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

5.5.2 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;

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

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

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

5.5.6 Participate in performance improvement activities and in continuing professional

education;

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

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

a. His/Her professional license in any state is suspended or revoked;
b. His/Her professional liability insurance is modified or terminated;
c. 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
d. 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 VI

Initial Appointment Procedure

6.1 Upon request, and after completion of Pre- Application and Pre-screening, the medical staff office will provide to prospective applicants and 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 as 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

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

6.2.1 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.

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

6.2.3 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.

6.2.4 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.

6.2.5 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.

6.2.6 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 provide information to the hospital or the medical staff, including otherwise privileges or confidential information to Lovelace Regional Hospital (LRH) 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.

6.2.7 Authorization of LRH medical staff and administrative representatives to release to other hospitals, medical associations, licensing boards, and other organizations concerned with this providers' performance and the quality and efficiency of this provider's patient care any information relevant to such matters that LRH may have concerning him/her and release of LRH 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 LRH< 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.

6.2.8 He/she has been oriented to the current medical staff bylaws, including its associated manuals, and all rules, regulations, policies and procedures of the Medial 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.

6.2.9 Agrees to participate in the sharing of, and consents to the release of, peer review information, credentialing information and quality review information among Lovelace Health System, where appropriate.

6.2.10 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 involuntary?
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, or 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 case?
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?

6.3 **Procedure for processing applicants for initial staff appointment:**

6.3.1 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 years prior to application
- 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.

6.3.2 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. 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.

6.3.3 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 are met. In the event that they are not met, the potential applicant will be notified that he/she is ineligible to apply for membership on the Lovelace Regional Hospital medical staff, and the application will not be processed. If requirements are met, the application will be accepted for further processing.

6.3.4 Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgement 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.

6.3.5 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.

6.3.6 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. Three 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 result 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.

6.3.7 When items identified in 6.3.6 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 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 request 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 expert2a) 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.
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.

6.4 **Applicant Interview**

6.4.1 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.

6.4.2 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.

6.5 **Medical Staff Credentials Committee Action:**

6.5.1 If the Medical Staff Office Professional (or designee) and the Credentials Chair designate an application as category 1, it remains with the Credentials Chari for review and recommendation. The Credentials Chair has the opportunity to change the designation to a category 2. If forwarded as a category 1, the Credentials Chari 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 with 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 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.

6.6 **Medical Executive Committee Action:**

6.6.1 If the application is designated category 1, it is presented to 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 as exercised or has waived his/her right to hearing as provided in the Investigation, Corrective Action, Fair 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.

6.7 **Governing Board Action:**

6.7.1 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. A report is prepared for the Governing Board, identifying those practioners 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 applicant's.
b. If an application is designated as category 2, the Governing Board reviews the application and votes for one of the following actions.
c. **Favorable recommendation:** the Governing Board my 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.
d. **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 procedural rights provided in the these Bylaws (Fair Hearing Plan)
e. **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 Fair Hearing Plan.
f. All appointments to medical staff membership are subject to the Provisional Status. In addition Active Provisional Staff, must document seven (7) encounters at Lovelace Regional Hospital before a determination can be made. Active Provisional Staff without this minimum number of encounters will have their privileges extended keeping with the

Provisional Staff requirements. All appointments to medical staff membership and the granting of privileges are for a period not to exceed twenty-four (24) months.

6.8 **Basis for recommendation and action:** The report of each individual or group require 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.

6.9 **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 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.

6.10 **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 Credential Committee (analyze and recommended) 30 days
- Medical Executive Committee (to reach final recommendation) 30 days
- Governing Board (to make an offer of appointment or rejection An applicant's request for appointment or privileges) 30 days
- Governing Board (offer of appointment will expire if the applicant does not respond in thirty (30) days) 30 days

These times are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of the Fair Hearing plan are activated, the time requirements provided therein govern the continued processing of the application.

6.11 **Provisional Status**

6.11.1 **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 of Staff 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 Chief of Staff 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.

6.11.2 **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 the Bylaws be made provisional.

6.11.3 **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 COS and Section Chair/Service Chief fail within that period to make the determination required in Section 6.11.1, 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 entailed to the procedural rights afforded in the Fair Hearing Plan.

6.11.4 **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.

6.11.5 **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.

Reappointment Procedure

6.12 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 6 above concerning the initial granting of new clinical privileges.

6.12 **Information collection and verification:**

6.12.1 **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 6.2 above.

6.12.2 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.

6.12.3 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 6.2.11, items a.-s.

6.12.4. 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. National Practitioner Data Bank query.
h. Two peer recommendations, 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.
i. Malpractice history for the past two (2) years which is primary source verified by the malpractice carrier(s).
j. 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.
k. Evidence of physical and mental capacity to perform requested privileges.

6.13 Procedure for processing applications for staff reappointment: When the items identified in 6.2.1, 6.2.3, and 6.2.4 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:

6.13.1 **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 6.3.7.

6.13.2 **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.

6.14 All applications for reappointment will be processed through the same procedure described in Section 6 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.

6.15 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".

6.16 **Criteria for reappointment**. It is the policy of Lovelace Regional Hospital to approve for reappointment only those individuals who meet the criteria for initial appointment as identified in Section 6 and been determined by the MEC to be providers of effective care that is consistent with Lovelace Regional Hospital standards of quality as determined by the MEC and hospital performance improvement program, and practitioners who have also fulfilled their commitment to the Lovelace Regional Hospital as outlined in any Intended Practice Plan adopted by the hospital Governing Board outlined in any Intended Practice Plan adopted by the hospital Governing Board.

Other

6.17 **Modifications of Appointment** - A Staff appointee may, either in connection with reappointment or at any other time, request modification of his or her Staff category, department assignment or clinical privileges by submitting a request in writing to the CEO. Such requests shall be processed in substantially the same manner as requests for appointment or clinical privileges. If new or additional privileges are granted, they shall be considered provisional in nature, as in the case in initial privileges granted.

6.18 **Notices-** Any notices of adverse decisions on appointments, reappointments or other requests in this Article shall be deemed to have been properly given to the applicant or appointee if in writing and personally delivered with a receipt requested or deposited in the United States certified or registered mail, postpaid, to the address of the applicant or appointee on his or her application or his or her or her last known address.

6.19 **Time.** The time and date deadlines set forth in this Article are not exact, but are guidelines for use. All persons or groups shall act promptly.

6.20 **Practitioners Providing Contractual Professional Services**

6.20.1 A practitioner who is providing contract services to the hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff bylaws and rules and regulations and must fulfill all the obligations for his/her membership category as any other applicant or staff member. In approving any such practitioners for Medical Staff membership, the Medical Staff must require that the services provided meet The Medicare requirements, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assessment and improvement program.

6.20.2 In the event a practitioner or entity (the "Contractor") has entered into a written contract with the Hospital to render services within a specified area of practice, and such contract terminates or expires, full effect shall be given to any specific provisions in the contract regarding the effect of such termination or expiration on the medical staff membership and clinical privileges of the Contractor and those providing services for or through the Contractor.

a. If the exclusive contract provides that the medical staff membership and clinical privileges of all practitioners providing service pursuant to the contract shall automatically be terminated or reduced upon termination or expiration of the exclusive Contract, the practitioners shall not be afforded the procedural rights under the Fair Hearing Plan.
b. If, however, the contract is silent regarding the effect of its termination or expiration on the medical staff membership and clinical privileges of practitioners providing services under the contract shall not automatically result in the termination, suspension or modification of such practitioner's medical staff membership and clinical privileges, unless the Hospital enters into an exclusive contract with another practitioner or entity to render services within the same area of practice.
c. Nevertheless, in such event, the underlying grounds for termination of the contract may be grounds for initiating an investigation and taking action under this Article.
d. When any such practitioner is granted staff membership or clinical privileges, he or she shall be advised in writing by the Hospital as to the effect of termination of the contract on his or her medical staff membership and clinical privileges, but the failure to give such written advice shall not affect the rights or authority of the Hospital under these bylaws, nor shall it impair the right of the Hospital to terminate such contract, Staff membership or clinical privileges. Practitioners employed by the Hospital shall be subject to the provisions of Article III, Section 5.

6.20.3 The CEO may refuse to accept an application for appointment or reappointment on the basis of an exclusive professional contract which the Hospital has entered into for the rendition of services within a department. The CEO shall promptly notify the applicant in writing that the application cannot be processed because of the existence of such an exclusive contract. No applicant whose application is denied on such a basis shall be afforded any of the procedural rights provided in the Fair Hearing Plan.

6.20.4 When the hospital contracts for patient care services with practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are the accrediting body expanded guidelines one of the following mechanism(s) will be implemented:

a. 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 independent practitioners will be within the scope of those individual's privileges at the contracting entity; or
b. The hospital will verify that all individuals who are practitioners and providing services under the contract have privileges that include the services provided under the contract.

6.20.5 When the hospital contracts for care services with 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 the accrediting body expanded guidelines all independent practitioners 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 these Bylaws

ARTICLE VII

Clinical Privileges

7.1 **Exercise-** Every practitioner or other individual providing clinical services at the Hospital shall, except as expressly provided in these Bylaws, be entitled to exercise only those privileges specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and each practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 **Admitting Privileges -** Only staff members may be granted admitting privileges. The privileges to admit shall be delineated and are not automatic.

7.3 **General Delineation-** Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant.

- 7.3.1 An application for only clinical privileges shall contain the same obligations as are imposed upon an applicant for a staff membership.
- 7.3.2 An applicant for clinical privileges shall be subject to the same obligations as are imposed upon an applicant for a staff appointment as provided in Article VI, Sections 1 and 2.
- 7.3.3 A request by a staff member for a modification of privileges must be supported by documentation of training and experience supportive of the request.
- 7.3.4 Applications and request for clinical privileges shall be evaluate don the basis of the practitioner's education, training, performance, demonstrated ability, judgment, experience, current ability to perform procedures requested, references, professional liability experience and other relevant information, including an evaluation by the clinical departments in which such privileges have been sought.
- 7.3.5 The criteria for granting clinical privileges shall also include the ability of the Hospital to provide supportive services for the applicant and his or her patients and patient care needs for additional persons with applicant's skill and training.
- 7.3.6 The basis for privileges determinations for periodic reappointment for otherwise shall include documentation of observed clinical performance, documented results of patient care evaluation, review of staff records which document the applicant's delivery of medical care, quality improvement records required by the Bylaws and the Rules and Regulations and evaluation of the applicant's physical and mental capabilities.
- 7.3.7 Clinical privileges granted or modified on initial appointment, reappointment or otherwise shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other hospitals and health care facilities where a practitioner exercises clinical privileges.
- 7.3.8 The Hospital may, in its discretion, obtain an evaluation of the applicant by consultant selected by the Hospital
- 7.3.9 All such information shall be maintained in the individual Staff file of the Applicant or appointee.

7.4 **Temporary Privileges-** Temporary privileges may be granted by the CEO (or designee) acting on behalf of the Board of Trustees, 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 4.2 below, such other credentials

as may be required under Section 4.2 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 Board of Trustees.

7.4.1 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 Board of Trustees 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 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 Board of Trustees 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;

d. 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.)

7.4.2 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 Board of Trustees. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the Lovelace Regional Hospital - Roswell: 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 have a complete file that does not raise concerns including but not necessarily limited to the following:

a. The application is deemed to be incomplete. A complete application includes, at a minimum, a signed, dated application form; a 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 prior to application; all applicable fees; and receipt of all references..

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 are 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 any health care institution raises possible concerns with the applicant's quality

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

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

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

r. 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 Regional Hospital - Roswell 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.

s. Termination of temporary privileges: The CEO, acting on behalf of the Board of Trustees 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 affect 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.

t. 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.

7.5 **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 (*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.); 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 Article VII, Part C, Section 4 of these Bylaws addressing contracted services.

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

a. The MEC has recommended that the scope of telemedicine services provided at Lovelace Regional Hospital - Roswell 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.

b. 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 Regional Hospital – Roswell.

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

7.5.3 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:

a. The distant site hospital is consistent with accrediting body expanded guidelines;

b. The practitioner is privileged at the distant site hospital for those services to be provided at the originating site hospital; and

c. 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 accrediting body 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.

7.6 Emergency and Disaster Privileges

7.6.1 For the purpose of this section an "emergency" is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger and delay in administering treatment immediately would add to the at danger and no appropriately credentialed individual can be available in the time required to respond.

7.6.2 A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing available medical staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency or disaster as defined herein any practitioner or LIP, to the degree permitted by his/her license and regardless of staff status or clinical privileges shall, as approved by the CEO or his/her designee or the Chief of Staff, be permitted to do and be assisted by hospital personnel in doing everything reasonable and necessary to save the life of a patient or to prevent imminent harm to the patient.

7.6.3 Disaster privileges may be granted by the CEO or COS when, and for so long as, the Hospital's emergency management plan has been activated and the hospital is unable to hand e the immediate patient needs. The CEO and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis. Prior to granting any disaster privileges the volunteer practitioner or LIP shall be required to present a valid photo ID issued by a state, federal or regulatory agency and at least one of the following:

a. a current license, certification or registration;
b. primary source verification of licensure, certification or registration (if required by law to practice a profession);
c. ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT) or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP);
d. ID indicating the individual has been granted authority to render patient care, treatment and services in a disaster; or
e. ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications.

7.6.4 As soon as possible after disaster privileges are granted but not later than seventy two (72) hours thereafter, the practitioner shall undergo the same verification process outlined above for temporary privileges when required to address an emergency patient care need. 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. In all cases whether or not primary source verification can be obtained within seventy two hours following the granting of disaster privileges, the COS or his/her designee shall review the decision to grant the practitioner disaster privileges and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

7.6.5 In addition 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) the clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review , mentoring, or as otherwise provided in the grant of privileges.

ARTICLE VIII

Corrective Action

8.1 **Initiation.** Whenever the activities of professional conduct of a practitioner or other individual with clinical privileges are considered to conflict with the standards of the Staff, disruptive to Hospital operations or are detrimental to patient safety or quality patient care, corrective action against the practitioner may be initiated by any Staff officer, any department Chairperson, the CEO or the Board. All requests for corrective action shall be in writing to the Chief of Staff and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall notify the CEO and keep him or her fully informed of all proceedings and action taken. The Chief of Staff shall also notify the Board, as well as the Chairperson of the department in which the questioned activities or conduct occurred, requesting an investigation.

8.2 **Investigation.** The Chief of Staff or, at his or her direction, the Chairperson of the department to which the request for investigation is made, shall immediately refer the request to the MEC. The MEC, or its designated Ad Hoc Committee, may request an interview with the practitioner, and he or she shall cooperate promptly with the Committee in its investigation. A written investigation report from the investigating committee will be documented as a matter of record.

8.3 **Action on Report.** As soon as practical following the committee's findings, the MEC shall take action on the request.

8.3.1. The action may include, without limitation, rejecting the request; issuing a warning, a letter of admonition or letter of reprimand;

8.3.2 recommending terms of probation or requirements of consultations; recommending reduction, suspension or revocation of clinical privileges;

8.3.3 recommending a change in Staff category or limitation of Staff prerogatives;

8.3.4 recommending suspension or revocation of Staff appointments; or

8.3.5 referring the matter to the Board for any such actions.

8.3.6 Any adverse action shall entitle the practitioner to the procedural rights afforded by the Fair Hearing Plan, except as provided in the Fair Hearing Plan.

8.4 **Summary Suspension.**

8.4.1 **Action.** Whenever a practitioner willfully disregards these bylaws or Hospital policies, or whenever his or her conduct may require that immediate action be taken to protect the life of a patient or to reduce the substantial likelihood of imminent injury to the health or safety of any patient, employee or other person in the Hospital, the CEO, with the concurrence of the Chief of Staff or designee, may summarily suspend the staff privileges. The Summary Suspension shall become effective immediately upon imposition. The CEO shall immediately notify the MEC and the Board of the suspension.

8.4.2 The practitioner's failure or refusal to comply with the Physician Advisory Committee, investigating committee or MEC to submit to immediate substance abuse testing or failure or refusal to submit to immediate testing from impairment, refusal to participate in an impairment rehabilitation program or the breach of any impairment rehabilitation agreement between the practitioner and any state or hospital medical review committee,

when such actions are likely to result in immediate danger to patients or to other persons, will be grounds for summary suspension.

8.4.3 Medical Executive Committee Decision. Upon summary suspension of a practitioner, the MEC shall direct that an investigation be conducted by persons designated by the MEC to determine the need for the suspension or further action concerning the practitioner. As promptly thereafter as possible, the MEC shall conduct a meeting regarding the allegations and investigation findings. The MEC may, as a result of the meeting, review the allegations, and evidence presented therein, recommend modification, continuation or termination of the summary suspension, and may take such further action concerning the Staff membership and clinical privileges of the practitioner as it considers appropriate. If the investigation is completed within fourteen (14) days from the date of the suspension and the investigation does not result in adverse actions, as defined in the Fair Hearing Plan, the practitioner shall not be entitled to the procedural rights of the Fair Hearing Plan. If the MEC does recommend immediate termination of the suspension, or if further adverse action, as defined in the Fair Hearing Plan, is taken as result of the investigation, the practitioner shall be afforded the right to appellate review as provided in the Fair Hearing Plan, but the terms of the summary suspension remain in effect pending a final decision by the Board. The Chairperson of the MEC or the Chairperson of the department to which the practitioner is assigned shall arrange for alternative medical coverage of the suspended practitioner's patient in the Hospital. The wishes of the patient shall be considered in the selection of an alternative practitioner.

8.5 **Automatic Suspensions.** If a Staff appointee's license or other legal credential authorizing or enabling him or her to practice is revoked or suspended or otherwise limited by a state or federal licensing authority, he or she shall immediately and automatically be suspended from practicing in the Hospital by the CEO and his or her staff membership shall automatically be terminated. A practitioner or other professional with clinical privileges who does not maintain professional liability insurance as required in these Bylaws shall be automatically suspended until he or she furnishes adequate and satisfactory evidence of such coverage. A practitioner whose Drug Enforcement Administration or New Mexico Controlled Substance Certificate is revoked or who is suspended from prescribing scheduled drugs, as recognized by the DEA or New Mexico Board of Pharmacy shall immediately and automatically be divested by the CEO of his or her Staff membership and all clinical privileges. In regard to actions restricting a practitioner's right to prescribe non-scheduled drugs, the MEC may consider and take such action, as it deems necessary.

No staff member whose privileges are automatically suspended under this section shall have the right of hearing or appeal as provided under these bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended practitioner's patients.

8.6 **Medical Records.**

8.6.1 Automatic suspension of practitioner's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules and Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the Chief of Staff or designee that he/she has a justifiable excuse for such omissions.

8.6.2 Medical Records-Expulsion: Notwithstanding the provision of the above, any staff member who accumulates forty-five (45) or more consecutive clays of automatic

suspension under said subsection shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45^{th}) consecutive day of such automatic suspension.

8.7 **Peer File.** All reports relating therein in this section will be retained in the practitioner's peer review file.

8.8 **Confidentiality**. To maintain confidentiality participants in the corrective action process shall limit their decision of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

8.9 **Protection from Liability.** All members of the Board, the Medical Staff and hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity describe in these bylaws.

ARTICLE IX

Clinical Departments

9.1 **Departments.** The Staff will be organized into clinical departments. The MEC may create, eliminate, subdivide or combine departments, subject to the approval of the Board. The Departments of the Staff are the Department of Medicine and the Department of Surgery.

9.2 **Organization.** Each department shall be organized as a separate part of the Staff and shall have a Chairperson approved by the Board with the duties and responsibilities provided in these bylaws.

9.3 **Assignment to Departments.** Each Staff member shall be assigned to at least one department by the MEC and may be granted clinical privileges in one or more departments in the same manner. The exercise of clinical privileges within any department shall be subject to the rules and regulations of the department and the authority of the department Chairperson.

9.4 **Function a/Department.** The primary function of each department is to implement specific review and evaluation of activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall:

9.4.1 Require patient care evaluation to be performed for the purpose of improving and/or maintaining the quality of care performed within the department. Each department shall monitor clinical work performed in the department. Department patient care evaluation shall be conducted no less than quarterly through quality improvement mechanisms and shall include review, recommendations and subsequent findings relative to patient care within the department concerning:

a. department monitors to evaluate important aspects of care, including diagnoses, procedures and patient categories as evidenced by frequency of volume and risk;
b. medical records monitoring;
c. blood usage review;
d. mortality review;
e. drug usage review;
f. utilization management;
g. infection surveillance;
h. surgical case review; and
i. other monitors as established by each department, the organization or regulatory requirements.

9.4.2 Establish guidelines for the granting of clinical privileges within the department and submit to the MEC the recommendations required regarding the specific privileges of each Staff member or applicant may exercise and the specific service that each Licensed Independent Practitioner may provide.

9.4.3 Conduct or participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in medical practice.

9.4.4 Monitor on a continuing basis adherence to:

a. Staff and Hospital policies and procedures, Bylaws, and Rules and Regulations;
b. requirements for alternate coverage and consultations;
c. sound principles of clinical practice and professional standards; and
d. fire and other regulations to promote patient safety.

e. Coordinate the patient care provided by the members of the department with nursing and other non-physician patient care services and with administrative support services.
f. Foster an atmosphere of professional decorum within the department appropriate to the practice of medicine.
g. Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:
   1) findings of the department's review and evaluation activities, actions taken thereon, and the results of such actions;
   2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and
   3) such other matters as may be requested from time to time by the MEC.
h. Meet on as needed basis for the purpose indicated above and for receiving reports on other department and Staff functions.
1. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to the department.
J. Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members on an ongoing basis.

9.5 **Department Officer.**

8.5.1. Election. Prior to the last Departmental meeting the nominating committee shall convene and submit to the respective departments a list of one or more qualified nominees for the position of Chairperson of Medicine and Chairperson of Surgery, to which is attached a statement of the chairperson that each nominee has agreed to stand for election to office. The elected Chairperson will also be reported to the staff before the prior to its next meeting for voting/election.

a. A nominee shall be elected upon receiving a majority of votes cast. If no candidate for an office receives a majority vote, a runoff election by secret written ballot shall be held between the two candidates receiving the highest number of votes.
   1.) If a tie results, the deciding vote shall be cast by the Board.
   2). The election shall become effective upon approval of the Board.
b. Vacancies. Vacancies in offices, other than the Chief of Staff, shall be appointed by the MEC to complete the term in the medical staff year.
c. Resignations and Removals. Any department officer may resign at any time by giving written notice to the MEC, and unless specified therein, the acceptance of such resignation shall not be necessary to make it effective. At least two-thirds of the active staff members of the department may submit a request for removal of a department officer to the CEO, and upon receipt thereof, the CEO shall call a meeting of the MEC to be held within thirty (30) days to consider and act upon the petition. Failure of an officer to fulfill his or her responsibilities of his or her office as outlined in these bylaws may warrant removal of an officer. A department officer shall be removed upon receiving at least a majority of the valid votes cast at the meeting of the MEC in favor of removal. If a tie results, the deciding vote shall be cast by the Board. If a department officer resigns or is removed, his or her successor shall be filled in the same manner as any other vacancy.
d. Terms of Elected Office. Each officer shall serve a two (2) year term, commencing on the first day of the medical staff year following his or her election. Each officer shall serve

until the end of his or her term and until a successor is elected.

e. General Duties of Chairperson. Each department Chairperson shall be responsible for the organization of the department and delegat.ion of duties to department members to promote the best interests of patients. Members of departments shall be responsible to department Chairperson and, through him or her, to the Chief of Staff. Each department Chairperson shall: cooperate with the CEO for the purchasing of supplies, instruments and equipment in order to provide quality care at the optimal cost; assess and recommend to relevant hospital authority off-site sources for needed patient care, treatment and services not provided by the department of the organization; department, providing guidance and help when required;

1) serve as an ex-officio member of all committees in his or her department, providing guidance and help when required;
2) represent the department in a medical advisory capacity to the Hospital and attempt to resolve administrative problems within or affecting the department with the Hospital;
3) be responsible for checking medical records in his other department to determine that they are properly written and acceptable in content and quality;
4) be responsible for the arranging and expediting in the department programs covering the organization of education, supervision and evaluation of clinical work; orientation and continuing education of all persons in the department;
5) be responsible to the Chief of Staff and work with and cooperate with the Hospital in serving the needs of hospital patients;
6) integrate the department or service into the primary functions of the organization;
7) be responsible for insuring the members of the department are kept aware of developments in hospital programs and services;
8) evaluate the effectiveness of department committees and take appropriate action to improve their effectiveness;
9) develop an annual calendar to show dates of department meetings, other meetings and educational programs and hold department meetings;
10) maintain surveillance of the clinical performance of all the individuals exercising clinical privileges or rendering specified services within the department along with recommending clinical privileges for each member of the department, including any recommended proctoring or provisional review;
11) monitor and evaluate the quality and appropriateness of patient care provided within the department;
12) maintain quality control programs as appropriate;
13) recommend space and other courses needed by the department;
14) recommend to the medical staff criteria for clinical privileges that are relevant to the care provided by the department;
15) assist in the development and implementation of policy and procedures that guide and support the provisions of the service;
16) make recommendations for a sufficient number of qualified and competent persons to provide care and services;
17) make determinations of the qualifications and competence of department or service personnel and/or Licensed Independent Practitioners who are not physicians and who provide patient care and services; serve as an officer of the staff and a member of the MEC and the Board as requested; and address important problems in patient care and clinical performance opportunities to improve care as identified; assess and make improvements to the quality of care, treatment and services;

take appropriate action and evaluate the effectiveness of the actions taken; and

18) transmit to the credentials committee, department recommendations concerning

appointment and classification, reappointment and delineation of clinical privileges of practitioners, or specified service 0 f Licensed Independent Practitioners, and corrective action with respect to practitioners in the department.

9.6 **Clinical Privileges.** Subject to Article VII, each department shall establish its own criteria and shall define and delineate privileges for its members, consistent with these bylaws, and the policies of the Staff and the Board, for the granting of clinical privileges. Such definition and delineation shall be approved by the MEC and the Board. The department shall make recommendations to the Credentials Committee regarding the clinical privileges for those requesting only clinical privileges in the department and recommendations concerning appointment, reappointment, c1assification and delineation of clinical privileges or special services and corrective actions.

9.7 **Attendance at Meeting.** Each member of the active and Affiliate staff shall be required to attend each year not less than fifty percent (50%) of the meetings held during each year by the clinical department of which he or she is assigned. If the physician is a member of more than one department, he or she shall be required to attend twenty five percent (25%) of each department's meetings. If an excused absence is desired, the reason for such an absence shall be submitted to the Chairperson of the Department. Failure to meet the foregoing annual attendance requirement, unless excused for cause, may be grounds for disciplinary action as determined by the MEC. A member of any category of the Staff who has attended a case which will be presented for discussion at any department meeting shall be notified prior to the meeting and, if he or she is not: a member of the active or Affiliate staff, he or she shall be invited to the department meeting. If he or she does not attend the meeting at which such case will be discussed, the matter nevertheless shall be discussed unless the member is absent for good cause and requested that the discussion be postponed. In no event shall postponement be permitted beyond the next regular meeting.

ARTICLE X

Officers

10.1 **Officers**. The officers of the Staff shall be:
- 10.1.1 Chief of Staff
- 10.1.2 Vice Chief of Staff (aka Chief of Staff Elect) -Chair of Credentials Committee
- 10.1.3 Immediate Past Chief of Staff
- 10.1.4 Secretary-Treasurer, and
- 10.1.5 Chairperson of the departments (Medicine and Surgery)

10.2 **Qualifications.** Officers must be members of the active staff at the time of nomination and elections and must remain in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

103 **Nominations and Elections.** Elections for the chairmen of the departments are as outlined in Article IX, Section 5:
- 10.3.1 Prior to the final medical Staff meeting of the year, the Nominating Committee shall convene and submit to the secretary-treasurer a list of one or more qualified nominees for the Chief of Staff and secretary-treasurer, to which is attached a statement of the Chairperson that each nominee has agreed to stand for election to office. This list will also be reported to the staff before the annual meeting.
- 10.3.2 If, before the election, all nominees refuse or are disqualified or are otherwise unable to accept nomination, the nominating committee shall submit one or more additional nominees at the annual meeting.
- 10.3.3 Nominations may also be made from the floor at the annual staff meeting for Chief of Staff-elect and secretary-treasurer.
- 10.3.4 Voting at the annual meet.ing shall be by secret ballot. Voting by proxy shall not be permitted.
- 10.3.5 A nominee shall be elected upon receiving a majority of votes cast. If no candidate for an office receives a majority vote, a runoff election by secret written ballot shall be held between the two candidates receiving the highest number of votes.
- 10.3.6 If a tie results, the deciding vote shall be cast by the Board.
- 10.3.7 The election shall become effective upon approval of the Board.

10.4 **Terms.** Officers shall be elected for a term of two (2) years and until their successors are duly elected and have qualified.
- 10.4.1 A vacancy in any office shall be filled by the MEC for the unexpired portion of the term, subject to the automatic succession of the Chief of Staff-elect as provided herein.
- 10.4.2 Individuals may not serve in more than one (1) officer position per medical staff year.

10.5 **Resignations and Removals**. Any officer may resign at any time by giving written notice to the MEC, and unless specified therein, the acceptance of such resignation shall not be necessary to make it effective.
- 10.5.1 At least two-thirds of the active staff members of the Staff, or department in the case of a department Chairperson, may submit a request for removal of an officer to the CEO, and, upon receipt thereof, the CEO shall call a meeting of the MEC to be held within thirty (30) days to consider and act upon the petition.
- 10.5.2 An officer shall be removed upon receiving at least a majority of the valid votes cast at the

meeting of the MEC in favor of removal.

10.5.3 If a tie results, the deciding vote shall be cast by the Board.

10.5.4 Failure of an officer to fulfill his or her responsibilities of his or her office as outlined in these bylaws may warrant removal of an officer.

10.5.5 If an officer resigns or is removed, his or her successor shall be filled in the same manner as in any other vacancy.

10.6 **Chief of Staff.** The Chief of Staff shall serve as Chief Administrative Officer of the medical staff and shall have general overall supervision of the affairs of the medical staff. He or she shall:

10.6.1 assist in coordinating the activities of the Administration, the nursing staff, Licensed Independent Practitioners and other non-physician patient care services with those of the Staff;

10.6.2 call, preside at and be responsible for the agenda of the Staff meetings;

10.6.3 is responsible to the Administration and the Board for the quality and efficiency of clinical services and professional performance in the Hospital and the effectiveness and quality of patient care;

10.6.4 develop and implement, in conjunction with department Chairmen, methods for credentials review, delineation of privileges, educational programs, utilization review and quality improvement;

10.6.5 communicates and represents the opinions, policies, concerns, needs and grievances of the Staff to the CEO and the Board;

10.6.6 is responsible for enforcement of these bylaws and the Rules and Regulations, implementation of sanctions as needed with procedures in all instances when corrective action has been requested or taken against a practitioner;

10.6.7 act as a representative of the Staff to the public, as well as to other health care providers, other organizations, the Administration, the Board, and government and voluntary organizations;

10.6.8 appoints and discharges Chairperson and members of all Staff committees, except the MEC and serve as ex officio member of all Staff committees;

10.6.9 receive and interpret the opinions, policies and directives of the Administration and the Board to the Staff;

10.6.10 serves as Chairperson of the MEC;

10.6.11 perform all duties incident to the function of principal administrative officer of the Staff; and

10.6.12 serves as a member of the Board.

10.7 **Vice Chief of Staff-Credentials Chairperson**. The vice Chief of Staff shall perform the duties of the Chief of Staff in the absence of or inability of the Chief of Staff to perform. He or she shall serve as Chairperson-elect of the MEC and Chairperson of the Credentials Committee until serving as Chief of Staff, and shall perform such additional duties as may be assigned to him or her by the Chief of Staff or the Board.

10.8 **Secretary-Treasurer.** The secretary-treasurer shall, subject to the direction of the Chief of Staff, review and approve the minutes of Staff meetings; assure that all notices of Staff meetings are given as provided in these bylaws; be custodian of Staff records; supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments and maintain proper records of such funds; serve as a member of the MEC; render an annual report for presentation at the last staff meeting of each year; and in general perform all duties incident to the office of secretary-treasurer and such other duties as may be assigned by the Chief of Staff.

10.9 **Immediate Past Chief of Staff.** The immediate past Chief of Staff shall be a member of the MEC and shall perform such other advisory duties as are assigned to him or her by the Chief of Staff, the MEC and/or the Board.

10.10 **Department Chairmen.** The chairmen of the departments shall be members of the MEC. Their duties are as outlined in Article IX, Section 5.

10.11 **Chain of Authority.** In the event of the absence or unavailability of the Chief of Staff, the chain of authority is to be as follows: a) First -Vice Chief of Staff b) Second -Secretary/Treasurer c) Third -Chairperson of the Respective Department (Medicine or Surgery) c1) Fourth, -Immediate Past Chief of Staff

10.12 **Conflict of Interest of Medical Staff Leaders.** The best interest of the community, Medical Staff and the hospital are served by Medical Staff leaders (defined as any member of the MEC, chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospitals' Board of Managers) 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 leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders 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.

10.12.1 Annually, on or before January 31st, each Medical Staff leader 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 leader, 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:

10.12.2 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 member of the governing body, MEC, or service or department Chairpersonship with an entity or facility that competes directly or indirectly with the Hospital;

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

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

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

a. A new medical staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly and a medical staff leader should finally determine the need for all possible disclosures of which h/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization(s) that is related to or competes with the Hospital. This disclosure procedure 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. Membership, other than in a leadership role, on the medical staff of a related or competing facility or admitting privileges at such a facility does not automatically constitute such a conflict.

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

c. 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. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI

Committees

Part A -Standing Committees

11.1 Standing Committees. The standing committees shall be:

11.1.1 Medical Executive Committee (MEC)
11.1.2 Bylaws Committee/Nominating Committee
11.1.3 Critical Care Committee
11.1.4 Physicians Advisory Committee
11.1.5 Credentials Committee

11.1.6 Members of standing committees shall be appointed and removed in the same manner as members of operating committees except as specifically provided in these bylaws or as otherwise recommended by the Medical Executive Committee and approved by the Board.

11.2 **Tenure**. Except as otherwise expressly provided in these bylaws each member of a standing committee shall be appointed for a term of one year and until his or her successor is appointed or elected unless sooner removed. Members of operating committees shall be appointed for similar terms unless the committee is established for a specified lesser period of time. Vacancies on any medical staff committee shall be filled in the same manner which original appointment to such committee is made.

11.3 **Medical Executive Committee.**

11.3.1 **Size and Composition:** The Medical Executive Committee (MEC) shall consist of six (6) members of the medical staff as follows:

a. Chief of Staff
b. Chief of Staff-Elect
c. Secretary-Treasurer
d. Immediate Past Chief of Staff
e. Chairperson of the Medicine Department
f. Chairperson of the Surgery Department

g. The Chief of Staff shall serve as the Chairperson. The CEO, CFO, and COO/CNO shall serve as ex officio members without vote. Other ex-officio members may be appointed by the CEO.
h. No Medical Staff member actively practicing or acting on behalf of the Hospital is ineligible for membership on the Medical Executive Committee solely because of his or her professional discipline or specialty.

11.3.2 **Responsibilities and Authority**. The Medical Executive Committee shall meet at least six (6) times per year and shall maintain a permanent record of its proceedings and actions. Special meetings may be called by the Chief of Staff, when a majority of the Medical Executive Committee can be convened. The Medical Executive Committee shall consider and act on all matters affecting the Staff which are not of a clinical nature, shall act on behalf of the Staff in intervals between staff meetings, subject to the limitations of these bylaws, and shall:

a. coordinate the activities and general policies of Staff committees and clinical departments;

b. receive and act on committee and department reports;
c. implement Staff policies that are not otherwise the responsibilities or the departments; provide liaison between the Staff and the CEO, and between the Staff and the Board;
d. make recommendations to the Board regarding medical staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which medical staff membership may be terminated; recommend action on matters of the medical administrative nature to the Board;
e. make recommendations on matters of Hospital management to the Board;
f. account to the Board for the overall quality and efficiency of medical care provided to patients in the Hospital;
g. assist the Board in and recommend to the Board all matters concerning Staff appointments, reappointments, department assignments, delineation of privileges, specified services, medical staff structure and membership, and corrective action, based on recommendations of the departments;
h. take all reasonable steps to ensure professionally ethical conduct and competent clinical performance by all Staff members, including the initiation of, and participation by all Staff members, corrective action and review of measures when warranted;
i. evaluate the effectiveness of staff committees and take appropriate action to improve or terminate them;
j. report on its activities at Department meetings;
k. review, evaluate and recommend to the Board organized services related to patient care including services furnished by a contractor. All medical and surgical services will be evaluated as related to appropriateness of diagnosis and treatment;
l. review, monitor, evaluate and recommend action to the Board regarding significant departures from established practice patterns regarding incident reports and patient/staff complaints regarding Medical Staff members.
m. review and evaluate reports concerning, and monitor the conduct and clinical performance of Licensed Independent Practitioners;
n. developing and implementing programs to inform the staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;
o. informing the medical staff of CMS and other accreditation programs and the accreditation status of the hospital;
p. developing and monitoring compliance with these bylaws, the rules and regulations, policies and other hospital standards;
q. vote for approval, removal, and implement rules and regulation as needed and in place of the full medical staff; and
r. participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.

11.3.3 **Quality Improvement.** The Medical Executive Committee shall ensure that provisions are made for the effective performance of Staff functions as provided by these bylaws or as the Board may reasonably require, and for the adequacy of the Hospital's quality improvement plan.

11.4 **Bylaws /Nominating Committee.** The Bylaws/Nominating Committee shall be composed of at least three practitioners appointed by the chief of staff. The CEO shall serve as an ex officio member without vote. Other ex-officio members may be appointed by the CEO. It shall meet at least as needed but at least every three (3) years to review these bylaws and the Rules and Regulations and recommend to the Medical Staff or directly to the Board any needed additions, revisions, modifications, amendments or deletions.

The Nominating Committee shall consist of three (3) members of the staff the CEO shall serve as an ex officio member without vote. Other ex-officio members may be appointed by the CEO. The nominating committee shall consult with the nominees concerning their qualifications and willingness to serve, prepare ballots and supervise elections of officers. The nominating committee shall meet at least annually in sufficient time to make or solicit nominations and shall meet at other times as may be necessary.

11.5 **Critical Care Committee.** The critical care committee shall consist of at least two (2) members of the medical staff; the CEO shall serve as an ex officio member without vote. Other ex-officio members may be appointed by the CEO. The purpose of this committee is to meet on an as needed basis, but at least four (4) times a year, to review and discuss critical care matters, emergency department matters, lCU matters, and cardiology matters.

11.6 **Physician Advisory Committee**

11.6.1 **Composition and Duties.** The Physicians' Advisory Committee (PAC) shall consist of at least three (3) members of the Active Staff (who are not department chairpersons or heads of departments) appointed by the Chief of Staff so selected as to ensure representation of the two (2) clinical departments. In order to assure continuity terms of individual members shall be staggered. The Committee shall meet as frequent as necessary to fulfill its responsibilities and on call of the Chairperson to investigate reports related to possible impairment of medical staff appointees.

11.6.2 Physicians serving on the PAC who also serve on other peer review committees shall abstain from any subsequent corrective action in any case that was first heard before the PAC. Physicians serving on the PAC who are alleged to be impaired shall not participate in the review or in the management of their own case.

11.6.3 **Function.** The PAC shall perform the following functions:

a. The PAC shall constitute a medical review committee with immunity as provided by law, and shall receive and evaluate reports related to the possible impairment of medical staff appointees. Impairment includes any condition which impedes or limits a practitioner's ability to practice his or her profession or to interact successfully in a hospital environment, including but not limited to substance abuse, psychiatric disorders or diseases (e.g., schizophrenia, depression, paranoia, dementia, personality disorders), or physical conditions that adversely affect the practitioner's professional judgment or abilities (e.g., stroke, neurological deficits, or vision impairment).

b. After evaluating the report, the PAC may request that the Practitioner provide current medical information, respond to allegations, and/or submit to immediate testing.

Following the review, the PAC shall determine if intervention is needed, recommend means of rehabilitation or treatment for the practitioner, and monitor reentry of the practitioner into the hospital setting in accordance with hospital policies.

c. The PAC shall promptly notify the CEO and Chief of Staff if the practitioner refuses to cooperate or otherwise appears to constitute a danger to any persons, so that summary suspension may be imposed if necessary. The PAC shall also report to the Medical Executive Committee if the PAC determines that corrective action is warranted because it has been unsuccessful in rehabilitating the practitioner, protecting patients, or maintaining an effective hospital environment. In addition, the PAC shall make periodic reports to the Medical Executive Committee regarding cases that are under the continuing supervision of the PAC but that do not require corrective action.

d. The PAC shall meet as necessary at the discretion of the Committee Chairperson, and s hall report to the Medical Executive Committee.

e. The PAC shall provide ongoing education to al staff members regarding their duty to refrain from treating patients while impaired and their duty to report the apparent impairment of any practitioner in order to protect patients and to assist the practitioner to a prompt recovery.

11.7 **Credentials Committee.**

11.7.1 **Composition and Duties.** Credentials Committee shall consist of at least three (3) members of the Active Staff appointed by the Chief of Staff so selected as to ensure representation of the two (2) clinical departments. The CEO shall serve as an ex officio member without vote. Other ex-officio members may be appointed by the CEO.

a The Committee shall meet as frequent as necessary to fulfill its responsibilities and on call of the Chairperson to investigate the character and qualifications of all applicants for membership on the Staff and for the granting of clinical privileges.

b The Committee shall also investigate the character and qualifications of all Licensed Independent Practitioners who apply to render specified services and shall make recommendations concerning their applications.

c The Committee shall submit at the regular and other meetings of the executive committee a report of its findings and recommendation with regard to: appointments; Affiliate staff members and grants or extensions of provisional privileges; reappointments; modifications of appointments; suspensions and revocations of appointments to the Staff; privileges to be granted, modified, suspended or revoked.

d The Committee shall also be responsible for the completion of all requests for verification of Staff membership or privileges and all other requested information that is received from other institutions only with the written consent of the practitioner.

11.7.2 **Credentialing.**

a, **Appointments**. The Committee shall review all application submitted for Staff membership and privileges. The Committee shall verify medical license, federal DEA certificate, state pharmacy registration/controlled substance, malpractice insurance, medical school, internship and residency. The Committee shall review all peer recommendations for current competence, current ability to perform procedures requested, history of disciplinary actions/professional liability actions and professional liability experience pertaining to privileges requested. The Committee shall review the

report provided by the National Practitioner Data Bank. Upon review, the Committee shall submit to the executive committee any findings and its recommendations with regard to the appointment of the applicant and the granting of privileges to the applicant.

b. **Reappointments**. The Committee shall review all requests for reappointments to the Medical Staff and renewal of privileges. The Committee shall review the competence and performance of the Staff member through the monitoring and evaluation activities of the Staff member; attendance at Staff, department and committee meetings; hospital utilization reviewed through the clinical activity profiles of the Staff member; comments regarding the competence, performance and current ability to perform procedures requested of the Staff members received from operating committees, other Staff members, and Hospital personnel; and a review of the evaluation and recommendation from the Chairperson of the clinical department of which the member belongs. The Committee will submit to the Medical Executive Committee any findings and its recommendations with regard to the reappointment of the Staff members and any recommendations for changes in Staff status or clinical privileges.

c. **Licensed Independent Practitioner**. The committee shall review all requests for renewal of privileges of Licensed Independent Practitioners. The committee shall review and evaluate the qualifications, competence, and performance of Licensed Independent Practitioners and make recommendations with respect thereto. The committee shall submit to the executive committee any findings and its recommendations with regard to the renewal of privileges for Licensed Independent Practitioners and recommendations for any changes in clinical privileges.

11.7.3 **Applications and Delineation of Privileges.** The Committee shall be responsible for the design, review and revisions of the Medical Staff application, delineation of privileges, and any other forms that pertain to the appointment and reappointment of Staff members. The Committee shall ensure that these materials reflect the current practices of the Hospital and Medical Staff.

11.7.4 **Other.** The Committee shall investigate, review and report to the Medical Executive Committee on all matters involving clinical or ethical misconduct of any Medical Staff member or Licensed Independent Practitioner.

11.8 Operating Committees

11.8.1 Operating committees may be created and abolished by the chief of staff or be in cooperation with–the Board–or other hospital bodies. The operating committees shall discharge such responsibilities as may be assigned to them. The Chief of Staff shall appoint the members of the operating committees and shall designate a Chairperson. Members of committees need not be staff members or practitioners. The Chief of Staff may from time to time appoint one or more additional persons as ex officio non-voting members of operating committees. Administrative staff appointment shall be made after consultations with, and approval of, the CEO. Any member of an operating committee may be removed by the Chief of Staff whenever in his or her judgment the best interest of the Hospital will be served by such removal.

11.9 Committee Procedures

11.9.1 **Notice.** Notice of a committee meeting may be given in the same manner as notice for Staff meetings, but in addition, notice for committee meetings may be given orally and may be given not less than three (3) days before the meeting.

11.9.2 **Quorum.** Fifty percent (50%) of the voting members of a committee present in person or by telephone at a meeting shall constitute a quorum of the committee.

11.9.3 **Manner of Acting**. The act of a majority of the members of a committee present at a meeting at which a quorum is present shall be the act of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action which may be taken at a meeting may be taken without a meeting if consent in writing setting forth the action is signed by a majority of the members of the committee entitled to vote.

11.9.4 **Minutes.** Each committee shall prepare minutes or reports of each meeting and forward copies thereof to the appropriate departments and to the executive committee.

11.9.5 **Procedures**. Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these bylaws.

11.9.6 **Required Attendance.** Each member of the active staff shall be required to attend during the Staff year at least 50% of the committees on which he or she serves. Attendance requires personal presence throughout the meeting. Unless duly excused, failure to meet attendance may be grounds for disciplinary action as determined by the Medical Executive Committee. Any staff member who is compelled to be absent from any committee meeting shall promptly provide in writing to the Committee Chairperson the reason for such absence.

11.9.7 **Reports.** Each committee shall report its activities, findings and recommendations to the appropriate department (s) and to the executive committee. A copy of all reports, records and evaluations of each committee shall be maintained in the minutes of the committee.

11.10 Committee Functions

11.10.1 The functions of the staff/committees are to:

a. Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;
b. Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate reviews;
c. Conduct or coordinate utilization review activities;
d. Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs, and supervise Hospital's professional library services;

e. Develop and maintain surveillance over drug utilization policies and practices;
f. Investigate and control nosocomial infections and monitor the Hospital's infection control program;
g. Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;
h. Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;
i. Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Starr with the care provided by the nursing service and with the activities or other hospital patient care and administrative services;
j. Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, a mechanism for addressing the health' of all licensed individual practitioners including an Impaired Practitioner Policy The purpose of this mechanism is to provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The Impaired Practitioner Policy affords resources separate from the corrective action process to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals.
k. Provide leadership in activities related to patient safety;
l Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:
m. medical assessment and treatment of patients;
n. use of medications, use of blood and blood components;
o. use of operative and other procedure(s);
p. efficiency of clinical practice patterns; and
q. significant departure from established patterns of clinical practice.

11.10.2 Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:
a. education of patients and families;
b. coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient;
c. accurate, timely and legible completion of patients' medical records including history and physicals;
d. patient satisfaction;
e. sentinel events; and
f. patient safety.

11.10.3 Ensure that when the findings of assessment processes are relevant to an individual's performance the Medical Staff determines their use in Peer Review or the ongoing evaluation of a practitioner's competence.
11.10.4 Recommend to the Board policies and procedures which define the circumstances, trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord

with the Hospital's Peer Review Policy. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or information): internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing or Administrative personnel involved in the care of patients;

11.10.5 Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

11.10.6 Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;

11.10.7 Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

11.10.8 Review, on a periodic basis, applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

11.10.9 Investigate any breach of ethics that is reported to it;

11.10.10 Review LIP appeals of adverse privilege determinations as provided in Section 5.4(b); and

11.10.11 Prepare and recommend a slate of nominees for the officers of the Medical Staff.

11.10.12 These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

ARTICLE XII

Meetings

12.1 **Regular Meeting**. The Staff shall hold regular general staff meetings at least twice each year. The end of the year meeting constitutes the meeting at which the election of officers shall be conducted.

12.2 **Special Meetings.** Special. meetings of the Staff may be called at the direction of the Chief of Staff and shall be called by the chief of staff at the request of the executive committee or by the Board, or any five (5) members of the active staff by written request, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified by the notice or as otherwise expressly provided in these bylaws.

12.3 **Notice.** Notice of the date, time and place of any meeting shall be provided no less than five (5) days nor more than thirty (30) days prior to a regular meet.ing and not less than five (5) days nor more than ten (10) days prior to a special meeting by written notice delivered personally or sent by mail to each member of the staff at his or her address or through other established mechanisms of for written communication within the Hospital. Any member may waive notice of any meeting in writing. The attendance of any member at a meeting shall constitute waiver of notice, except where a member attends a meeting for the express purpose of objecting at the beginning of the meeting to the transaction of any business because the meeting is not lawfully called or convened.

12.4 **Quorum.** The presence of fifty percent (50%) of the voting members of the active staff at any regular or special meeting shall constitute a quorum for the purpose of amendment to these bylaws. The presence of fifty percent (50%) of the voting members of the active staff shall constitute a quorum for transaction of all other business. The Medical Executive Committee may vote for approval, removal, and implement rules and regulation as needed.

12.5 **Manner of Acting.** The act of a majority of active staff members and LIPs meeting medical staff membership requirements that allow membership and vote, present at a meeting at which a quorum is present, shall be the act of the Staff. Members may vote by written proxy or written ballot. No action of members shall be valid unless taken at a meeting in which a quorum is present, except that any action which may be taken at a meeting may be taken without a meeting if a consent in writing or vote, setting forth the action so taken, is signed by a majority of members entitled to vote.

12.6 **Minutes.** The secretary shall review and approve minutes of each meeting, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the secretary, approved by the presiding officer and maintained in a permanent file. Minutes shall be available for inspection by Staff members for any proper purpose, subject to any policies concerning confidentiality of record and information.

12.7 **Procedures**. The chief of staff or in his or her absence, the chief of staff-elect shall preside at Staff meetings. Meetings shall be conducted in an orderly manner.

12.8 **Required Attendance**. Each Staff member with admitting privileges is required to attend at least fifty percent (50%) of the staff meetings. Any staff member who is compelled to be absent from any staff meeting shall promptly provide, in writing, to the chief of staff, the reason for such absence.

ARTICLE XIII

Privileges and Immunities

13.1 **Agreement of Applicants and Practitioners.** Any applicant for staff privileges, and every practitioner and member of the Staff, and everyone having or seeking privileges to practice his or her profession or to render specified services in the Hospital agrees that the provisions of this Article shall specifically control with regard to his or her relationship to the Staff, other members of the Staff, members of the Board, and the Hospital.

13.1.1 By submitting an application for membership, by accepting appointment or reappointment to the Staff or clinical privileges, by exercising staff privileges, including temporary privileges, and by seeking to render and rendering specified services, each practitioner and each Licensed Independent Practitioner specifically agrees to be bound by the provisions of this Article during the processing of his or her application and at any time thereafter, and they shall continue to apply during his or her appointment or reappointment.

13.2 **Privileges.** Any act, communication, report, recommendation or disclosure concerning any applicant for Staff membership, clinical privileges or specified services performed, given or made by any practitioner or member of the Staff in good faith and without actual malice and at the request of any authorized representative of the Staff, the Administration, the Board, the Hospital or any other health care facility or provider for the purpose of providing, achieving or maintaining quality patient care in the Hospital or at any other health care facility shall be privileged to the fullest extent permitted by law. Such privileges shall extend to members of the Staff, the CEO, Administrative officials, board members and their representatives and to third parties who furnish information to any of these to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities or associations from whom information has been requested or to whom information has been given by a member of the Staff, authorized representatives of the Staff, the Administration or the Board.

13.3 **Immunity.** There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report. recommendation or disclosure performed, given or made, even if the information involved would otherwise be privileged. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, reports, recommendations and disclosures performed, given or made in connection with or, for or, on behalf of any activities of any other health care facility or provider including, without limitation, those relating to:

13.3.1 applications for appointment to the medical staff or for clinical privileges or specified services;

13.3.2 periodic appraisals or reviews for reappointments, clinical privileges or specified services;

13.3.3 corrective action or disciplinary action, including suspensions or revocations of clinical privileges or Staff membership or licenses to practice medicine;

13.3.4 hearing and appellate review;

13.3.5 medical care evaluations;

13.3.6 peer review evaluations;

13.3.7 utilization reviews; and

13.3.8 any other hospital, departmental, service or committee activities related to quality of patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competency, character, fitness to practice medicine, physical condition, ethical or moral standards or any other matter that mayor might have an effect or bearing on patient care.

13.4 **Release.** In furtherance of and in the interest of providing, quality patient care, each applicant for clinical privileges or specified services, shall release and discharge from loss, liability, cost damage and expense, including reasonable attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article, and shall, upon request of the Hospital or any officer of the Staff, execute a written release in accordance with the tenor and import of this Article.

13.5 **Non-exclusivity.** The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of the privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

13.6 **Confidentiality and Immunity Stipulations and Releases.** Information with respect to any practitioner, including applicants, staff members or LIPs submitted, collected or prepared by any representative of the hospital including its Board or medical staff, for purposes related to the achievement of quality care, shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

13.7 **Releases from Liability.** No representative of the hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.

13.8 **Action in Good Faith.** The representatives of the hospital, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XIV

General Provisions

14.1 **Rules and Regulations.** Subject to the approval of the Board, the Medical Executive Committee shall adopt such Rules and Regulations as may be necessary to implement these bylaws. The Rules and Regulations shall relate to the proper conduct of Staff organizational activities and shall embody the level of practice required of each Staff appointee.

14.2 **Forms.** Application forms and other prescribed forms required by these bylaws for use in connection with Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be prepared by the credentials committee subject to the approval of the Board.

14.3 **No Implied Rights.** Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy or right of action upon any person, except as expressly provided in Article XIII. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the governance of internal affairs of the Hospital. No person is authorized to rely on any provision of these bylaws or the rules and regulations except as specifically provided herein, and no person may personally enforce any provision hereof, except as specifically provided. These Bylaws and the Rules and Regulations are intended for professional internal use and governance only.

14.4 **Pronouns.** All pronouns and any variations thereof in these bylaws and the Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

14.5 **Notices.** Any notices, demands, requests, reports or other communications required or permitted to be given in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive notice at his or her last known address, except as otherwise provided in these bylaws or in the Rules and Regulations.

14.6 **Distributions.** The officers of the Staff shall ensure that a copy of these bylaws and the Rules and Regulations, and all amendments thereto, are given to each applicant for privileges and are continuously available to each member of the Staff upon request; a reasonable charge may be imposed for copies given to persons who request more than one copy.

14.7 **No Contract Intended.** Notwithstanding anything herein to the contrary, it is understood that these bylaws and the Rules and Regulations do not create, nor shall they be construed as creating in fact by implication or otherwise a contract of any nature between or among the Hospital or the Board or the Staff and any member of the Staff or any person granted clinical privileges or entitled to perform specified services. Any clinical or other privileges are simply privileges that permit conditional use of the Hospital facilities, subject to the terms of these bylaws and the Rules and Regulations. Any provisions of these bylaws may be amended, altered, modified or repealed at any time as provided herein. Notwithstanding the foregoing, the provisions of Article XIII, Article V, Part C, Section 2, and other provisions containing undertaking in the nature of an agreement or an indemnity or a release shall be considered

contractual in nature, and not a mere recital and shall be binding upon practitioners, Staff members and those granted clinical privileges in the Hospital.

14.8 **Confidentiality.** Members of the Staff shall respect and preserve the confidentiality of all communications and information relating to credentialing, peer review and quality improvement activities. Any breach of this provision, except as provided by law, shall subject the Staff member to corrective action.

14.9 **Conflicts of Interest.** Practitioners shall disclose any conflict of interest or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his or her participation on any committee or in his or her activities in medical staff affairs, including in departmental activities and in the review of cases. Where such conflict of interest exists or may arise, the practitioner shall not participate in the activity or, as appropriate, shall abstain from voting, unless the circumstance clearly warrants otherwise. This provision does not prohibit any person from voting for himself or herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action. Further, nothing herein shall prohibit any hearing panel member from participating in appellate review as permitted by the Fair Hearing Plan.

14.10 **Entire Bylaws**. These bylaws are the entire medical staff bylaws of the Hospital and supersede any and all prior medical staff bylaws, which by adoption hereof, shall be automatically repealed.

14.11 **Adoption and Amendment.**

14.11.1 Staff Responsibility and Authority. The staff shall have the initial responsibility and delegated authority to formulate and to submit recommendations to the Board regarding Medical Staff Bylaws and amendments thereto. All amendments or revisions shall be effective when approved by the Board. These Medical Staff Bylaws are not to be unilaterally amended. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. The Bylaws Committee shall review the Medical Staff Bylaws tri-annually.

14.11.2 **Methodology.** Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

a. Staff. The affirmative vote of a majority of the staff members eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least thirty (30) clays written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action; and

b. Board. The affirmative vote of a majority of the Board. Provided, however, that in the event that the staff shall fail to exercise its responsibility and authority as required by Section 13, Part A, and after such notice from the Board to such effect including a thirty (30) day period of time for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, staff recommendations and view shall be carefully considered by the Board during its deliberations and in its actions which shall be pursuant to this section.

c. Upon Board approval of significant changes and/or revisions to the Medical Staff Bylaws, Rules and Regulations, or policies, Medical Staff members and other individuals who have delineated clinical privileges will be provided a revised text of the written materials.

MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:
MEDICAL STAFF;

By: _____ _____
Chief of Staff Date

LOVELACE REGIONAL HOSPITAL - ROSWELL

By: _____ _____
Chief Executive Officer Date

LOVELACE REGIONAL HOSPITAL – ROSWELL BOARD OF TRUSTEES

By: _____ _____
Chair, Board of Trustees Date