APPENDIX A – Organization and Functions Manual

For Socorro General Hospital's Medical & Dental Staff Bylaws

Approved by Socorro General Hospital Board of Trustees

January 28, 2025

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1 Definitions

1.1 Appendix A

Means the Organization and Functions Manual of the bylaws.

1.2 Appendix B

Means the Credentials Procedures Manual of the bylaws.

1.3 Appendix C

Means the Investigations, Corrective Actions, Hearings and Appeals Manual of the bylaws.

1.4 Attendance

With reference to general meeting participation (unless otherwise specified with respect to a particular type of meeting or a particular meeting), means participation in person or via electronic means which includes but is not limited to teleconferencing, video conferencing, web conferencing and live streaming where the individuals participating by electronic means can hear or otherwise communicate during the meeting with individuals participating in person or electronically. If visual materials are used or documents are voted on during the meeting, they must be made available by any reasonable business means prior to any scheduled meeting as well as provided during the meeting to the attending participants.

1.5 Board or The Board (singular)

Means the governing body of Presbyterian Healthcare Services of Socorro General Hospital.

1.6 Boards or The Boards (plural)

Means the governing bodies of Presbyterian Healthcare Services and Presbyterian Healthcare Services of Socorro General Hospital.

1.7 Credentialing Authority

Means the Board and the other groups or individuals defined in Appendix B, the Credentials Manual, and may also include the MEC at those PHS hospitals where the applicable hospital board has delegated credentialing oversight to the MEC in lieu of a separate credentials committee.

1.8 Credentials Procedures Manual

Means Appendix B to these bylaws, which provides additional details associated with credentialing process.

1.9 Hospital

Means the medical facility, Presbyterian Healthcare Services of Socorro General Hospital.

1.10 Medical Executive Committee or MEC

Means a committee of the medical staff organized and authorized to act pursuant to these

bylaws. References to the medical executive committee, sometimes called the MEC, shall include any designee(s) charged with a specific task of the MEC who is acting on the MEC's behalf.

1.11 Meetings

With reference to any meeting (unless otherwise specified with respect to a particular type of meeting or any given meeting), means a gathering of individuals in person or via electronic technology which includes but is not limited to teleconferencing, video conferencing, web conferencing and live streaming where the individuals participating by electronic means can hear or otherwise communicate during the meeting with individuals participating in person or electronically. If visual materials are used or documents are voted on during the meeting, they must be made available during the meeting to the participants attending via electronic means via a secure data room or similar method.

1.12 Organization and Functions Manual

Means Appendix A to the bylaws, which provides additional associated details to the organization and functions of the medical staff.

1.13 Organized Health Care Arrangement or OHCA

Means the mechanism adopted by the hospital, all members of the medical staff and all practitioners to implement and comply with the Standards for Privacy of Individual Identifiable Health Information promulgated by the US Department Of Health and Human Services pursuant to the Administrative Simplification provisions of Healthcare Information Portability and accountability Act (HIPAA). The hospital, and all of its medical staff members and practitioners shall be members of and participate in the OHCA, which functions as a clinically integrated care setting in which patients typically receive health care from more than one healthcare provider.

1.14 PHS

Means Presbyterian Healthcare Services.

1.15 Practitioners

Means physicians (M.D. or D.O), dentists, oral maxillofacial surgeons, podiatrists, psychologists, Advanced Practice Clinicians who have medical staff membership or exercise privileges at the hospital.

1.16 Professional Review Action

Professional Review Action means an investigation and resulting proceeding against a physician on the medical staff that is reportable to the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 and its successor statues, and any applicable state reporting requirements, that is related specifically to clinical incompetence or misconduct that adversely affects clinical privileges for greater than thirty (30) calendar days (e.g., denial of appointment and/or reappointment; reduction in clinical privileges) or a resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation that could result in a decision which adversely affects clinical privileges for greater than thirty (30) days.

Peer review activities are those involving the evaluation of the professional judgment,

skill or behavior of medical staff members and fall under New Mexico's Review Organization Immunity Act ("ROIA"). ROIA, in turn, involves strict confidentiality of opinions, observations and evaluations on a need-to-know basis. PHS medical staff bylaws provide for both "informal" and "formal" mechanisms to address issues, incidents or patterns of action, inaction or behavior of medical staff members. Peer review activities are generally conducted in a peer review committee setting but can also include individual case reviews, interactions, interviews or other activities that contribute to the evaluation of the professional judgment, skill or behavior or medical staff members. Thus, peer review is not limited solely to "peer reviewed cases".

1.17 Vote

Means a ballot cast by one or the following approved mechanisms: verbally in person or through teleconference, written or electronic via personal or courier delivery, mail, fax, email, text, and secure voting through the web or other technology that communicates the voter's choices. No proxy voting will be permissible.

2 Authority and Interpretation

2.1 Authority

This Organization and Functions Manual supplements the Medical Staff Bylaws, and in particular, Article I of the Medical Staff Bylaws.

2.2 Interpretation

To promote continuity and uniformity throughout the hospitals owned or managed by Presbyterian Healthcare Services (PHS), this Organization and Functions Manual reflects the overarching philosophies and practices of PHS, including those included in its corporate bylaws. Subject to the authority and approval of the hospital boards, this manual is designed to be interpreted consistent with such philosophies and practices, including the policies and procedures of PHS as applied to its individual hospitals. Additionally, this manual has been written to provide flexibility, where appropriate, to each PHS hospital, taking into consideration the size of the hospital and its medical staff and the types of services offered. Definitions contained in this manual apply to the bylaws and other manuals designated as appendices to the bylaws.

3 Organization of the Staff

3.1 Organization of the Medical Staff

To the extent the hospital provides general and specialty hospital services, the medical staff shall be organized as a departmentalized staff according to clinical services and divisions. These will be approved by the MEC and the medical staff and recorded in the rules and regulations. A clinical service chair shall head each clinical service and a division chief shall head each division with the assistance of a vice-chief. The clinical service chair shall have overall responsibility for the supervision and satisfactory discharge of assigned functions of the divisions under the MEC. The division chiefs shall be responsible for the day-to-day activities of the specialties in the division including

credentialing and contribution to peer review activities as indicated. Where services and practitioners are limited in scope and number, such functions will be assigned to the MEC.

3.2 Organized Health Care Arrangement

The hospital, all membership of the medical staff, and other practitioners at the hospital are considered members of, and shall participate in, the hospital's OHCA formed for the purpose of implementing and complying with the Standards for Privacy of Individually Identifiable Health Information promulgated by the U.S. Department of Health and Human Services pursuant to the Administrative Simplification provisions of HIPAA.

a. Information Sharing

Under the OHCA, the hospital and its practitioners and their offices may share information for purposes of treatment, payment, and healthcare operations in a clinically integrated care setting.

b. Notice of Privacy Practices

Hospital patients will receive one Notice of Privacy Practices during the hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the hospital, medical staff members and others, including non-employees who are authorized to provide patient care.

c. HIPAA Compliance

All practitioners authorized to provide patient care agree to comply with the hospital policies as adopted from time to time regarding the use and disclosure of individually identifiable health information ("IIHI") and protected health information ("PHI"), as those terms are defined by HIPAA or as any similar terms are defined by more stringent state law (collectively, "IIHI/PHI").

3.3 Delegation of Function

When a function is to be carried out by a member of hospital administration, a medical staff member, or a medical staff committee, the individual, or the committee, through its chair, may delegate performance of the function to one or more designees. Similarly, when a medical staff member is unavailable or unable to perform an assigned function, one or more of the medical staff leaders may perform the function personally or delegate it to another appropriate individual.

4 Responsibilities for Medical Staff Functions

In addition to the medical staff purposes and responsibilities described in the bylaws, the hospital medical staff, through its MEC, is actively involved in the measurement, assessment, and improvement of the functions stated below. The MEC may create committees to perform certain prescribed functions. The medical staff officers, clinical service chairs, division chiefs, hospital and medical staff committee chairs are responsible for working collaboratively to accomplish required medical staff functions. This process

may include periodic reports, as appropriate, to the appropriate clinical service, division or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

4.1 Medical Staff Function – Governance, Direction, Coordination and Action

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

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

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

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

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

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

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

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

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

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

4.2 Medical Staff Function – Practitioner Performance Evaluation

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff. Outside peer review resources may be used for peer review if approved by the MEC.

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

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance.

4.3 Medical Staff Function - Performance Improvement and Patient Safety Programs

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

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

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

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

4.4 **Medical Staff Function - Credentials Review (see Bylaws Article II and Appendix B Credentials Procedures Manual)**

4.5 Medical Staff Function - Information Management

a. Review and evaluate medical records to determine that they properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken;

b. Review and evaluate medical records to determine that they are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services;

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

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

4.6 Medical Staff Function - Emergency Preparedness

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

4.7 Medical Staff Function - Strategic Planning

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

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

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

4.8 Medical Staff Function - Bylaws review

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

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

4.9 Medical Staff Function - Nominating

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

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

4.10 Medical Staff Function - Infection Control Oversight

a. Oversee the development and coordination and assist in implementation of the program for surveillance, prevention, implementation, and control of infection.

4.11 Medical Staff Function - Pharmacy and Therapeutics Functions

a. Oversee the development and coordination and assist in implementation of the formulary of approved drugs, protocols, policies, standards and utilization pertaining to pharmacy and therapeutics.

4.12 Medical Staff Function - Practitioner Health

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

b. Establish programs for educating practitioners and staff to recognize and report impairment;

c. Notify the medical staff officers and/or hospital administrator who will then notify the MEC, a medical staff officer, clinical service chair or division chief

whenever the impaired practitioner's actions could endanger patients. The existence of the MSA Provider Support Committee does not alter the primary responsibility of the clinical service chair for clinical performance within that chair's clinical service;

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

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

5 Responsibilities of Clinical Service Chairs

Where hospital clinical service chairs are assigned, they will have the following responsibilities. In the absence of division chiefs, the MEC will assume these functions, including the delegation of appropriate functions.

a. To oversee all clinically-related activities of the clinical service;

b. To oversee all administratively-related activities of the clinical service, unless otherwise provided by the hospital;

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

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

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

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

g. To integrate the clinical service into the primary functions of the hospital;

h. To coordinate and integrate inter-clinical services and intra-clinical service services and communication;

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

j. To recommend to the hospital executive sufficient numbers of qualified and competent persons to provide patient care and service;

k. To provide input to the hospital executive regarding the qualifications and competence of clinical service or service personnel who are not LIPs but provide patient care, treatment, and services;

l. To continually assess and improve of the quality of care, treatment, and services;

m. To maintain quality control programs as appropriate;

n. To orient and continuously educate all persons in the clinical service or service; and

o. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff clinical service to provide patient care services.

6 Responsibilities of the Officers and At Large Member of the Medical Staff

6.1 President

a. General

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

b. Specific responsibilities

The president of the medical staff shall have the specific authority to:

1) Call, serve as chair, preside, and vote at all general and special meetings of the medical staff;

2) Serve as ex officio member of all other medical staff committees without vote unless voting rights are otherwise granted to the president elsewhere in these bylaws, appendices or rules and regulations, and to participate as invited by the hospital administrator or the Board on hospital or Board committees;

3) Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;

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

5) Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

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

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

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

9) Attend Board meetings and Board committee meetings as invited by the Board;

10) Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

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

6.2 President Elect

In the absence of the president, the president elect shall assume all the duties and have the authority of the president, including any voting rights granted to the president. They shall perform such further duties to assist the president as the president may request from time to time. The president elect shall have such other duties as may be assigned from time to time. When serving as an ex officio member of medical staff committees in the role of president elect, the president elect will not have the right to vote unless specific voting rights are otherwise granted elsewhere in these bylaws, appendices or rules and regulations

6.3 Immediate Past President

This officer will serve as a consultant to the president and president elect and provide feedback to the officers regarding their performance of assigned duties on an annual basis. They shall perform such further duties to assist the president as the president may request from time to time. When acting in the role of immediate past president, the immediate past president will not have the right to vote at medical staff committees unless specific voting rights are otherwise granted elsewhere in these bylaws, appendices or rules and regulations.

6.4 MEC at-large members

These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.

6.5 Responsibilities of Division Chiefs

Where hospital division chiefs are assigned, they will have the following responsibilities. In the absence of division chiefs, the MEC will assume these functions, including the delegation of appropriate functions.

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

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

c. Discuss policies and procedures and recommend same to the appropriate division chief;

d. Discuss equipment needs pertinent to that division;

e. Develop recommendations of a specific issue at the request of a division chief or the MEC; and

f. Encourage participation in the development of criteria for clinical privileges and give input on an application or reapplication, when requested by the appropriate division chief, credentials committee or MEC.

7 Medical Staff Committees

7.1 In General – Standing Committees Established

The following shall be the standing committees of the medical staff: MEC (as described in the bylaws), Credentials Committee (as described in the Bylaws and Appendix B, the Credentials Manual), Medical Staff Practice Committee, Medical Education Committee, MSA Provider Support Committee, Clinical Performance Committee and Leadership and Succession Committee. Where the size of a medical staff precludes the function of separate committees, the MEC will perform one or more of such functions. The MEC may also establish other committees by policy or rules and regulations to perform specific functions.

7.2 Committee Procedures and Protocols

A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC.

7.3 Ad Hoc Committees

The MEC, with the approval of the medical staff, may also establish other committees by policy or rules and regulations to perform specific functions. The president of the medical staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the president of the medical staff when establishing the committee. The president of the medical staff and the hospital executive or their designees, are ex officio members of all standing and ad hoc committees.

7.4 Removal of Committee Members

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

7.5 Standing Committees other than MEC and Credentials Committee

For those hospitals with one or more separate standing committees described below, such committees will be organized and function as follows:

a. Medical Staff Practice Committee

1) Composition

The medical staff practice committee membership is set by its committee charter as approved by the MEC, the medical staff and the Board.

2) Responsibilities

The committee shall be responsible for Medical Care Evaluation/Performance Improvement/Patient Safety Activities and other functions related to individual practitioner performance.

b. Clinical Performance Committee

1) Composition:

The clinical performance committee may have up to sixteen members consisting of medical staff members and hospital staff. Ten must be medical staff members to include the president-elect of the medical staff, and chairs of the clinical services. There may be up to six non-medical staff members to include two representatives from nursing, one representative from pharmacy and one representative from the laboratory. The committee's size may be adjusted by hospital committee charter based on size of the medical staff.

2) Responsibilities

The committee shall be responsible for Performance Improvement and Patient Safety Programs and others pertaining to performance improvement and patient safety, excluding the performance of individual practitioners.

c. Medical Education Committee /CME Advisory Council

1) Composition

The medical education committee shall be multidisciplinary with required members to be consistent with the recommendations of the ACGME and pertinent state law. The director of medical education will be a member of the committee.

2) Responsibilities

The committee provides program leadership with duties as described by the ACGME and pertinent CME accreditation rules..

d. MSA Provider Support Committee

1) **Composition**

The practitioner health committee shall consist of at least five (5) members of the active medical staff and shall include the chair of the credentials committee and a physician with a previous history of impairment whose impairment who has been successfully treated (if feasible), and other members of the medical staff selected by the president of the medical staff to bring the total complement to five (5) physician members. The composition of this Committee may be altered via the committee's charter.

2) Responsibilities

This committee shall be responsible for the practitioner health functions, specifically those contained in the committee's charter.

e. Leadership & Succession Committee

1) Composition

The leadership and succession committee shall consist of at least five (5) members of the medical staff including the president-elect, the immediate past president of the medical staff and an equal number of individuals from the clinical services appointed by the president of the medical staff. The chair shall be the president-elect of the medical staff. Except for the president-elect and immediate past president, terms will be for three (3) years and an approximately equal number of the appointed members will rotate off the committee each year. All members should be active members of the medical staff and be in leadership positions such as a clinical service, division or committee chair, medical staff officer, or MEC member during at least part of their term or the committee.

2) Responsibilities

The committee shall:

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

ii. Provide a biannual slate of nominees for the elected medical staff officers and MEC at-large members;

iii. Provide an annual list of potential leaders;

iv. Define a process for evaluating current leaders e.g. clinical service chairs, division chiefs, committee chairs, medical staff officers, and MEC members and potential leadership candidates;

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

vi. Submit recommendations for medical staff committee chairs based on the potential leaders' needs for development and readiness to serve (the president of the medical staff will consider these recommendations for committee chairs but will not be bound by them);

vii. Develop job descriptions for officer positions; and

viii. Report as needed to the MEC.

8 Quorum of Meetings

8.1 Quorum General Medical Staff Meetings

Those present in person or via electronic means who are eligible to vote on a medical staff issue will constitute a quorum.

8.2 MEC, Credentials Committee, Clinical Performance Committee and Medical Staff Practice Committee

A quorum will exist when 50% of the members are present in person or via electronic means unless otherwise determined in a charter approved by the MEC. When dealing with Track 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least three members present in person or via electronic means.

8.3 Clinical service meetings and other medical staff committees

Those present in person or via electronic means and eligible medical staff members voting on an issue.

9 Attendance Requirements

9.1 Medical Staff Meetings

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

9.2 MEC, Credentials Committee, Clinical Performance Committee and Medical Staff Practice Committee Meeting

Members of these committees are expected to attend in person or via electronic means at least two-thirds of the meetings held unless otherwise determined in a committee charter approved by the MEC.

9.3 Special meeting attendance requirements

Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the president of the medical staff or the applicable division chief/clinical service/committee chair may require the practitioner to confer with them or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

10 Actions, Minutes, Procedure, and other Meeting and Committee Rules

10.1 Action of Committee, Clinical Service or Division

The recommendation of a majority of its members attendance at a meeting at which a quorum is present shall be the action of a committee or clinical service. Such recommendation will then be forwarded to the MEC for action when required pursuant to bylaws or policy.

10.2 Notice of Meetings

Unless provided otherwise pursuant to a specific provision of the bylaws or policy, written, verbal or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the clinical service or committee not less than three (3) business days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

10.3 Participation by the Hospital Executive

The hospital administrator is an ex-officio member of all medical staff committees to encourage participation of management to assist the medical staff. The committee may go into executive session, with medical staff members only, when desired.

10.4 Rights of Ex officio Members

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

10.5 Robert's Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of Robert's Rules of Order shall determine procedure.

10.6 Minutes

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

11 Confidentiality, Releases, and Conflict of Interest

11.1 Confidentiality of Information

To the fullest extent permitted by law, confidential information shall be kept confidential.

11.2 Effect of Application and Reapplication – Releases and Immunities

By applying for appointment or reappointment to the medical staff, or for an advancement in medical staff category or additional or other change in clinical privileges,

the applicant and/or practitioner:

a. Authorizes the PHS representative to solicit and act upon information, including otherwise privileged or confidential information provided by Third Parties bearing on the applicant and/or practitioner's credentials or privileges and agrees that any such information so provided shall not be disclosed to the applicant or practitioner if the third party providing such information provides it on the condition that it be kept confidential;

b. Authorizes Third Parties to release information, including otherwise privileged or confidential information, as well as

c. reports, records, statements, recommendations and other documents in their possession, bearing on the applicant and/or practitioner's credentials to the appropriately designated PHS Representative, and consents to the inspection and procurement by the PHS Representative of such information, records, and other documents;

d. Authorizes the PHS Representative to release information obtained from or about the applicant, medical staff member, or practitioner, when requested by such applicant, medical staff member or practitioner, to other hospitals, healthcare facilities, and their agents, who solicit information for the purpose of evaluating the applicant, medical staff member, or practitioner's professional qualifications pursuant to such individual's request for appointment, reappointment, or clinical privileges at such other hospital or healthcare facility;

e. Authorizes hospital and PHS, as its owner, to maintain information concerning the applicant, medical staff member, and practitioner's age, training, board certification, licensure, and other confidential information in a centralized data base for the purpose of making aggregate information available for PHS and its affiliated hospitals;

f. Authorizes hospital, and PHS, as its owner, to release confidential information, including [peer review information and/or quality assurance information] obtained from or about the applicant, medical staff member, or practitioner, to [peer review] committees of PHS and its affiliates for purposes of reducing morbidity and mortality and for the improvement of patient care;

g. Agrees to appear for a personal interview at any time if requested by any PHS Representative;

h. Consents to the reporting by hospital, and the appropriate PHS Representative, of information to the National Practitioner Data Bank and other federal and state agencies which the hospital and PHS Representative believe, in good faith, is required by law to be reported;

i. Agrees that if any adverse recommendation or decision is proposed or made with respect to such applicant, medical staff member, or practitioner, under Section II of thee bylaws, they will (i) follow and exhaust the administrative remedies afforded in these bylaws and the fair hearing plan and (ii) have the burden of demonstrating that they meet the standards for appointment or

continued appointment to the medical taff or for the clinical privileges under review as set for elsewhere in these bylaws and Appendix I, the Credentialing Manual;

j. Releases from any and all liability (i) the hospital, PHS, and PHS Representatives for their acts performed in documenting, investigating, evaluating, acting upon and/or making recommendations with respect to their credentials and privileges and for the permitted or required disclosures made to Third Parties and (ii) Third Parties who provide information, including otherwise privileged or confidential information, to the hospital or PHS Representatives concerning their credentials and privileges, unless such information is false and the Third Party providing it knew or had reason to believe that it was false; and

k. Agrees that these bylaws provisions are in addition to any agreements, understandings, covenants, waivers, authorizations, or releases provided by law or contained in any application or request form.

11.3 Covered Activities

The confidentiality and immunity provided in the bylaws applies to all acts, communications, reports, recommendations, information obtained, or disclosures performed or made in connection with this the hospital, PHS, and Third-Party healthcare facility or organization's peer-related covered activities concerning, but not limited to:

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

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

c. Evaluation of requests for changes in medical staff category or clinical privileges;

d. Corrective or disciplinary actions;

e. Hearings and appellate reviews;

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

g. Patient or medical care audits;

h. Utilization review and performance improvement activities;

i. Claims reviews;

j. Risk management and liability prevention activities;

k. Other hospital, committee, clinical service, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct;

l. Matters or inquiries concerning credentials or privileging of any applicant, medical staff member or practitioner;

m. Matters relating to the reduction of morbidity or mortality or otherwise directly or indirectly affecting patient care of the efficient operation of the hospital;

n. Reports to the National Practitioner Data Bank and other federal or state agencies; and

o. Any other peer review process or action permitted or required in these Bylaws, Appendices, and Medical Staff, hospital or PHS policy.

11.4 Conflict of Interest

The hospital will use the following definitions and process to assess, eliminate or mitigate potential conflicts of interest.

a. An absolute conflict of interest would exist if the reviewing practitioner is spouse of the practitioner under review or a first-degree relative (parent, sibling, or child). Absolute conflicts of interest are not permitted.

b. Examples of potential conflicts of interest are the involvement in the same patient's care by the reviewing practitioner and the practitioner under review, even if such care unrelated to the professional issues under review or because of a relationship between the reviewing practitioner and the practitioner being reviewed as direct competitors, partners or key referral sources.

c. The involved physicians have the obligation to disclose to the affected committee the potential conflict.

d. The committee has the responsibility to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested as a witness.