



Plains Regional Medical Center

MEDICAL STAFF BYLAWS

Part I: Governance

February 2023

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The medical staff is responsible for the quality of medical care. The additional purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Plains Regional Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the facility and the Plains Regional Medical Center Board of Trustees.

1.2 Authority

Subject to the authority and approval of the boards the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of Presbyterian Healthcare Services (PHS). Henceforth, whenever the term “the hospital” is used, it shall mean Plains Regional Medical Center; whenever the term “the Board” is used, it shall mean facility board; whenever the term “the boards” is used it shall mean the facility board and the PHS board.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

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

2.2 Qualifications for Membership

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

2.3 Nondiscrimination

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

2.4 Conditions and Duration of Appointment

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

2.5 Medical Staff Membership and Clinical Privileges

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

2.6 Medical Staff Members Responsibilities

2.6.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

2.6.2 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.

2.6.3 Whenever a staff member's physical or mental condition is believed to put patients or staff safety at risk, the MEC or Credentials Committee may request the member to undergo a physical or mental fitness for duty examination by a provider acceptable to both parties. A member may refuse to undergo such examination but the MEC or Credentials Committee is entitled to weigh such refusal to provide proof of fitness for duty against the member when considering whether to grant, deny, suspend or reduce a member's privileges.

2.6.4 Each staff member must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.

2.6.5 Each staff member must provide evidence of professional liability coverage of a type and in an amount that shall deem staff member a qualified healthcare provider as that term is defined in the New Mexico Medical Malpractice Act or, in the alternative, shall provide coverage of \$1million/\$3million per occurrence from an A.M. Best rated company or other evidence of self-insurance approved by the Board of Trustees. In addition, staff members shall comply with any financial responsibility requirements that apply under the state law to the practice of their profession. Each staff member shall notify the hospital administrator or designee within 30 days of any and all malpractice claims filed against the medical staff members.

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

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

2.6.8 Each staff member will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with state and federal laws and regulations, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.6.9 Each staff member must participate in any type of competency evaluation when determined necessary by the MEC or designee and/or Board in order to properly delineate that member's clinical privileges.

2.6.10 Each medical staff member must notify a medical staff officer and/or hospital administrator (who will then notify the MEC) whenever an impaired practitioner's actions could endanger patients.;

2.6.11 Report to the MEC all practitioners providing unsafe treatment;

2.6.12 Each medical staff member must report to an officer of the medical staff any arrests or convictions for misuse of alcohol or drugs, or offenses of moral turpitude.

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

- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oro-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
- b. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oro-maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

- c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

2.6.14 Each staff member, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community. Participation in on-call coverage becomes voluntary, no longer mandatory, for medical staff members who have been on the active medical staff for more than 5 consecutive years and are over the age of 55 years.

2.6.15 Each staff member must provide a current electronic mail (email) address to the medical staff office and update such information when it changes. All correspondence related to membership/privileges, meeting notifications and relevant updates will be sent only to the email address provided, and staff members are responsible for timely attention to all medical staff correspondence.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her department chair or other appropriate medical staff leader(s), that practitioner may, upon written notice to the president of the medical staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

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

2.7.3 Each staff member in the active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty percent of the members of the active category, the MEC shall schedule a special general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the active category may challenge any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by ten percent or more of the members of the active staff category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each staff member in the active category may call for a department meeting by presenting a petition signed by 10 percent of the members of the department. Upon presentation of such a petition the department chief will schedule a department meeting.

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

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

2.8 Staff Dues

All physicians credentialed and/or privileged fall under the auspice of the Medical Staff and shall pay medical staff dues if any as recommended by the MEC. Failure of any medical staff member to pay dues by April 30th of each year may be considered a voluntary resignation from the Medical Staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Indemnification

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

2.8.2 Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

2.10 Medical Director

The Office of Medical Staff Affairs, under the advisement of the Medical Director, shall organize and coordinate medical staff affairs and arrange for the review, analysis, and evaluation of medical care in the hospital. The Medical Director shall be charged with implementation of the directives of the Board of Trustees and the Medical Staff. The Office of Medical Staff Affairs shall organize and direct educational programs as approved by the Board of Trustees and the Medical Staff. The Medical Director shall be selected by the hospital administration, with the consent of the Medical Executive Committee. The Medical Director serves ex-officio, without vote, on those Medical Staff Committees and the Medical Staff Departmental committees to which the President of the Medical Staff appoints the Medical Director.

Section 3. Categories of the Medical Staff

3.1 The Medical Staff

The Medical Staff shall be divided into Emeritus, Active, Associate, Consulting, Emergency Room, and Military Staff.

3.2 The Emeritus Medical Staff

A member of the Active Staff may, at age 70, or, after twenty-five (25) years of service, request transfer to emeritus status. Emeritus Staff Members shall not be eligible to admit patients, hold office, vote, serve on standing Medical Staff committees and they shall not be required to carry malpractice insurance nor to attend Medical Staff meetings.

3.3 The Active Medical Staff

The Active Medical Staff shall consist of physicians, dentists, and podiatrists who are located close enough to the hospital to provide adequate care to their patients, and who assume all of the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be eligible to vote, to hold office and to serve on Medical Staff committees, and shall be required to attend Medical Staff meetings and meetings of Medical Staff Committees as stipulated in these Bylaws and the Rules and Regulations of the Medical Staff.

3.3.1 Members of the Active Medical Staff, specifically granted the clinical privileges to do so under the provisions of Part III of these Bylaws, may be engaged by the hospital to work in the Emergency Room as specified by the Rules and Regulations of the Medical Staff and under policies established by the hospital through the Medical Staff and approved by the Board of Trustees.

3.3.2 Active Medical Staff members will hold membership in the Department of Medicine or Department of Surgery, according to their specialty. Radiologists will be assigned to the Department of Medicine. Pathologists will be assigned to the Department of Surgery.

3.4 The Associate Medical Staff

3.4.1 Following initial appointment by the Board of Trustees, every physician, dentist, or podiatrist having made initial application for appointment to the Active Medical Staff shall be assigned to the Associate Medical Staff for a period of not less than six months.

Reappointments to the Associate Staff shall not exceed two full Medical Staff years, at which time the failure to advance an Associate Medical Staff member to Active medical Staff status shall be deemed a termination of his staff appointment. An Associate Staff member whose membership is to be terminated shall have the right accorded in these Bylaws to a member of the Medical Staff who has failed to be reappointed.

3.4.2 The performance of each member of the Associate Staff shall be observed and monitored by his/her Medical Staff Department's standing peer review committee. The departmental peer review committee shall report a summary of its observations, and any conclusions based on those observations, to the Departmental Chairman and to the Credentials Committee. The Credential Committee shall consider this information as it determines its recommendations for or against advancement of the Associate Medical Staff Member to Active Medical Staff status, and as it makes its recommendations for or against granting clinical privileges requested by the Medical Staff member.

3.4.3 Members of the Associate Medical Staff shall be ineligible to vote or hold office in the Medical Staff. They shall be required to attend Medical Staff meetings as stipulated in these Bylaws and the Rules and Regulations of the Medical Staff.

3.4.4 The President of the Medical Staff may assign members of the Associate Staff to serve on committees, ex-officio, without vote, or to other responsibilities permitted by these Bylaws or by the Rules and Regulations of the Medical Staff of Plains Regional Medical Center.

3.4.5 Members of the Associate Medical Staff, specifically granted the clinical privileges to do so under the provisions of Part III of these Bylaws, may be engaged by the hospital to work in the Emergency Room as specified by the Rules and Regulations of the Medical Staff of Plains Regional Medical Center and under policies established by the hospital through the Medical Staff and approved by the Board of Trustees.

3.5 The Consulting Medical Staff

The Consulting Medical Staff shall consist of members qualified for staff membership who act only as consultants. Consulting Medical Staff members shall be members of an Active Medical Staff in some other hospital in the United States. Consulting Staff members shall not have admitting or surgical privileges. Peer Consulting Staff members may not write medical orders.

3.6 The Emergency Room Medical Staff

The Emergency Room Medical Staff shall consist of physicians who are engaged by the hospital to work in the Emergency Room under policies established by the hospital through the Medical Staff and approved by the Board of Trustees. Physicians on the Emergency Room Medical Staff shall have privileges to carry out duties as specified by the Medical Staff and by the hospital Board of Trustees. Privileges shall not extend to privileges of admitting patients or of participating in inpatient care beyond admission to the hospital. It is understood, however, that these physicians are expected to respond to life-endangering emergencies within the hospital if such arise when the emergency room physician is present and able to leave his/her duties in the emergency room; the emergency room physician must, however, immediately turn over these patients to an attending physician of the Active or Associate Staff when the attending physician arrives.

Members of the Emergency Room Medical Staff shall make application for privileges to practice within the Emergency Room in the same form as prescribed elsewhere in these Bylaws for all other appointments and reappointments. Members of the Emergency Room Medical Staff shall be ineligible to vote or hold office in the Medical Staff organization. They shall not be required to attend Medical Staff meetings. Appointment to the Emergency Room Medical Staff is subject to each of the procedures set forth in Part III of these bylaws. In addition, if any contract between a member of the Emergency Room Medical Staff and the hospital so provides the medical staff membership of the member of the Emergency Room Medical Staff will automatically terminate upon termination of such contract. Biennial reappointment shall be the same as for members of the Active and Associate Medical Staff.

Members of the Active and Associate Medical Staff specifically granted the clinical privileges to be engaged by the hospital to work in the Emergency Room as stipulated Part III of these Bylaws are not categorized as members of the Emergency Room Medical Staff.

3.7 Military Staff

The Military Staff shall consist of those physicians who are on active duty with the Medical Group at Cannon Air Force Base and who otherwise are duly qualified and appointed to the Active or Associate Medical Staff pursuant to these Bylaws. Members of the Military Staff shall be voting members after advancement from Associate to Active Staff of the Medical Staff. All the requirements and obligations set forth in these Bylaws concerning medical staff membership shall be applicable to the Military Staff, except:

Military Staff shall not be required to maintain medical malpractice coverage in full compliance with the New Mexico Medical Malpractice Act as set forth in Section 3.4 of these Bylaws, provided that they are subject to the provisions of both the Federal Tort Claims Act and the Medical Malpractice Immunity Act;

Military Staff shall be required to carry medical malpractice insurance coverage as specified in section 3.4, when the Federal Tort Claims Act is not applicable with regard to the patient being treated.

Military Staff shall be governed under medical staff meeting or department/committee meeting attendance requirements.

Military Staff shall not be required to have a New Mexico Medical License or Pharmacy License as long as this is legal under Federal and State law. They can only treat patients who would be fully eligible for treatment in a Federal Military Facility. They must have an active license in a state or territory of the U.S.A.

3.8 Ancillary Medical Staff

The Ancillary Medical Staff shall consist of the Scientific Staff and the Advanced Clinical Practitioner's. The Ancillary Medical Staff will maintain qualifications and Privileges as stated in the Rules and Regulations of the Medical Staff. The Ancillary Staff will be credentialed according to the Credentials Procedure Manual of the Medical Staff Bylaws.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

- 4.1.1 President of the Medical Staff
- 4.1.2 Vice President of the Medical Staff
- 4.1.3 Secretary/Treasurer
- 4.1.4 Chairman, Department of Surgery
- 4.1.5 Chairman, Department of Medicine

4.2 Qualifications of Officers

- 4.2.1 Officers must be members of the Active Medical Staff for at least three years at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

4.3 Election of Officers

The President, Vice-President and the Secretary-Treasurer shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote. The Department Chairmen will be elected by their Departments at the last regularly scheduled department meeting of each calendar year. Officers must be elected by a majority vote of those members of the Active Medical Staff present and voting. If there are three or more candidates for any office, and if no candidate receives a majority, the name of the candidate receiving the fewest votes will be omitted, and successive votes will be conducted until one candidate has received a majority vote.

4.4 Term of Office

All officers serve a term of one (1) year. They shall take office in the month of January.

4.5 Vacancies of Office

Vacancies in office during the Medical staff year, except for the presidency, shall be filled by the Executive Committee of the Medical Staff until the next regular meeting of the Medical Staff, at which time the vacancy shall be filled by election as provided in Section 10.3 for the balance of the Medical Staff year. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

4.6 Duties of Officers

4.6.1 **President:** The president shall serve as the Chief Administrative Officer of the Medical Staff and represent the interests of the medical staff to the MEC and the Board. The president will fulfill the duties specified in Part IV of these bylaws (Organization and Functions Manual).

4.6.2 **Vice President:** In the absence of the president, the vice president shall assume all of the duties and have the authority of the president. S/he shall serve on the Executive Committee of the Medical Staff. S/he shall automatically succeed the President when the latter fails to serve for any reason. In the absence of the president, the vice president shall assume all the duties and have the authority of the president. S/he shall perform such further duties to assist the president as the president may request from time to time.

4.6.3 Secretary Treasurer: The Secretary Treasurer shall oversee the following: accurate and complete minutes of all Medical Staff meetings are kept; Medical Staff meetings are called on order of the President; all correspondence is attended to. S/he will perform such other duties as ordinarily pertain to this office. The secretary/treasurer shall serve on the Executive Committee of the Medical Staff. S/he shall assure a current set of the Medical Staff Bylaws and Rules and Regulations is maintained, and assure that all revised Medical Staff Bylaws, Rules and Regulations are maintained.

4.7 Removal and Resignation from Office

4.7.1 . An officer of the Medical Staff may be removed from office by two-thirds of the members of the Active Medical Staff present at any special meeting of the medical staff called for the expressed purpose of removing an officer of the Medical Staff. The special meeting of the medical staff must be in accordance with Section 7.1.5 of these Bylaws.

4.7.1 a

Chairman of Department of Surgery and or Chairman of Department of Medicine may be removed from office by two thirds the members of the active medical staff in respective department at any special meeting of the department called for expressed purpose of removal of chairman. The special meeting can be called for by 10% of members of the active staff in respective department. The special meeting of the department must be in accordance section 7.1.5.

4.7.2 **Resignation:** Any elected officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein. In the interim, the president will appoint a replacement until the next regularly scheduled meeting of the general medical staff.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

The Medical Staff shall be divided into two clinical departments: The Department of Medicine and The Department of Surgery. Members will be assigned to either The Department of Medicine or The Department of Surgery according to the specialties and qualifications of the members. These departments shall have the responsibility for monitoring and evaluating the quality of care for all patients presenting to the hospital.

5.2 Qualifications, Selection, Term, and Removal of Department Chairs

During the last regularly scheduled department meeting of each calendar year, each department shall elect its own chairman to service for one-year periods. Each chairman will serve as a member of the Medical Executive Committee. The department chairman shall be certified by an appropriate specialty board, or affirmatively establish comparable competence, through the credentialing process. The department chairman will also have the responsibility for developing the agenda for the department meetings, presiding at the meetings, and preparing the departmental reports for the Medical Executive Committee. The Chairman will make department committee assignments.

5.2 Assignment

All members of the Active and Associate Medical Staff with clinical privileges shall be assigned to the appropriate department according to his or her field of practice; if any difficulties arise, the Medical Executive Committee shall make the assignment, bearing in mind the desires of the particular member.

Section 6. Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and ad hoc committees as established by the MEC and enumerated in Part IV of the bylaws (Organization and Functions Manual). Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions. The president of the medical staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 MEC

6.2.1 Committee Membership:

6.2.2 The Medical Executive Committee of the Medical Staff shall consist of the President, Vice-President, Secretary-Treasurer, Chairman of the Department of Surgery, Chairman of the Department of Medicine and may include other non-voting practitioners and other individuals as determined by the Organized Medical Staff. . The hospital administrator shall meet with the Executive Committee as an ex-officio member without vote.

6.2.3 Duties: The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operation of the Medical Staff. With the assistance of the Chief of Staff and without limiting this broad delegation of authority the Medical Executive Committee shall perform in good faith the duties listed below:

- a. Serve as the decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, clinical service/division assignments, clinical privileges, and corrective action;
- d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
- e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;
- f. Make recommendations to the Board on medical administrative and hospital management matters;
- g. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
- h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
- i. Review and act on reports from medical staff committees, clinical services, divisions and other assigned activity groups;
- j. Formulate and recommend to the Board medical staff rules, policies, and procedures;

- k. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
- l. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;
- m. Oversee that portion of the corporate compliance plan that pertains to the medical staff;
- n. Hold medical staff leaders, committees, and clinical services accountable for fulfilling their duties and responsibilities;
- o. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws; and
- p. The MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.
- q. The authority delegated pursuant to this section may be removed by amendment of these Bylaws, or may be temporarily removed by the resolution of the Medical Staff, approved by 2/3 vote of the voting Medical Staff, taken at a general or special meeting noticed to include the specific purpose of removing specifically-described authority of the Medical Executive Committee, which resolution is thereafter approved by the Governing Body.

6.2.4 Meetings: The MEC shall meet at least four (4) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 The Medical Staff shall meet at least four (4) times per year.

7.1.2 The Medical Staff Meeting occurring in the fourth quarter of the calendar year shall be the Annual

Staff Meeting at which any elections of officers for the ensuing period shall be conducted.

7.1.3 The Executive Committee shall, by standing resolution, designate the time and place for all regular Staff Meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Staff in the same manner as provided in Section 7.1.5 for notice of special meeting.

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

7.1.5 Special Meetings of the Medical Staff

The President of the Staff, the Executive Committee, or 10 percent (10%) of the members of the Active Medical Staff may at any time file a written request with the President that within four working days of the filing of such request, a special meeting of the Medical Staff be called. The Executive Committee shall designate the time and place of any such special meeting.

Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, email or text to each member of the Active Staff not less than one, nor more than three days before the date of such meeting by the Medical Staff office. If mailed, emailed or texted to the notice of the meeting shall be deemed delivered. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

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

7.3 Special Meetings of Committees and Departments

A special meeting of any committee may be called by or at the request of the chairman or chief thereof, by the President of the Medical Staff, or by one-third of the group's then members, but not less than two.

7.4 Quorum

- 7.4.1 General Medical Staff Meetings: Those active medical staff members present and eligible to vote.
- 7.4.2 MEC, Credentials Committee: A quorum will exist when 50% of the members are present unless otherwise determined in a charter approved by the MEC.
- 7.4.3 Department meetings or medical staff committees other than those listed in 7.4.2 above: Those present and eligible medical staff members voting on an issue.

7.5 Attendance Requirements

7.5.1 Members of the medical staff are encouraged to attend meetings of the medical staff. Each member of the Active and Associate Medical Staffs shall be required to attend at least one (1) general medical staff meeting, or their department committee meeting, in each year. Failure to meet the requirement may result in grounds for denial of reappointment to the medical staff.

- a. MEC and Credentials Committee meetings: Members of these committees are expected to attend at least two-thirds of the meetings held unless otherwise determined in a committee charter approved by the MEC.
- b. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the president of the medical staff or the applicable division chief/clinical service/committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner 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.
- c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the hospital administrator

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 in to executive session, with medical staff members only, when desired.

7.7 Robert's Rules of Order

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

7.8 Notice of Meetings

Written, 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 one (1) business day before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department. Such recommendation will then be forwarded to the MEC for action. Action may be taken without a meeting by unanimous consent in writing setting forth the action so taken, signed by each member entitled to vote thereat.

7.10 Rights of Ex officio Members

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

7.11 Minutes

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

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC or medical staff, the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 The chair of the Board or the president of the medical staff may call for a joint conference as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.1.3 The Bylaws Committee shall be responsible for recommendations relating to revision and updating the Bylaws, Rules and Regulations. Committee members shall be active members, and may include associate members, of the Medical Staff appointed by the President of the Staff. The Committee shall meet as necessity requires. It shall also consider, review and make recommendations on those matters formally submitted to it by any member of the Medical Staff, the Executive Committee, hospital administration, or the Board of Trustees. It shall submit written reports of its meetings to the Medical Executive Committee.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall lay over until either the next regular meeting of the Medical Staff or, if so directed by majority vote of the staff, may be taken up not earlier than ten (10) days before a special meeting called for the purpose of final adoption. To be adopted, an amendment shall require a two-thirds vote of the active members present at a Medical Staff meeting that has established a quorum. A mail or electronic ballot may be authorized by a majority vote of the active staff at a regular or special meeting of the Medical Staff. Mail or electronic ballots must be returned and the vote tallied within ten (10) working days of distribution. Affirmative vote by 2/3 of returned ballots by active members constitute passage of proposed amendment(s). Amendments so made shall be effective when approved by the Board of Trustees. Neither the organized medical staff nor the board may unilaterally amend the medical staff bylaws (as provided in 15.2.6)

9.2.2 These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the Board of Trustees.

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

9.3.1 The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.

9.3.2 Proposed amendments to the rules, regulations and policy manual may be originated by the MEC.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.3 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.3.5 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital administrator as a representative of the board. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

9.3.6 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party prior to vote.

Plains Regional Medical Center

MEDICAL STAFF BYLAWS

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

February 2020

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

1.1 Criteria for Initiation

These bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

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

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

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted by a medical staff officer, member of the credentials committee or department chair, hospital administrator, CMO or hospital board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC initiates the request, it shall appropriately document its reasons.

2.2 Investigation

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

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

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

2.2.1 An external peer review consultant should be considered when:

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

2.3 MEC Action

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

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

2.4 Subsequent Action

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

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

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

3.1.1 Licensure

- a. **Revocation and suspension:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
- b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- d. **Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs:** Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.2 Controlled substances

- a. **DEA certificate:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or New Mexico Controlled Substance Registration is revoked, limited, or suspended or expires, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

- b. **Probation:** Whenever a practitioner's DEA certificate or New Mexico Controlled Substance Registration is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.3 Professional liability insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by the medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a practitioner's clinical privileges. If within 30 calendar days of the suspension the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.4 Medical Staff dues/special assessments: Dues are assessed on January 1 of each calendar year. Failure of a member to pay dues by March 31 will be escalated to the Medical Executive Committee and may result in the automatic suspension of the member. The suspension shall remain in effect until the dues payment is received by the office of Medical Staff Affairs. The amount of dues shall be determined by the Medical Executive Committee, but may not exceed \$100 per year. The MEC may determine different dues requirements for each medical staff membership category.

3.1.5 Felony/misdemeanor conviction: A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of immoral action in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.6 Failure to satisfy the special appearance requirement: A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

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

3.1.8 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release and/or provide documents when requested by the president of the medical staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.9 **MEC Deliberation:** As soon as practicable after action is taken or warranted as described in Sections 3.1.1 through Section 3.1.10, the MEC shall convene to review and consider the facts, and may recommend such further corrective action or reinstatement as it may deem appropriate following the procedure generally set forth in the Section 2.3 above.

3.2 Precautionary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A precautionary restriction or suspension may be imposed when:

- a. The medical staff feels that immediate action must be taken to protect the life or well-being of a patient(s)
- b. When a staff member's actions present a substantial risk of imminent harm to the life or well being of patients, employees, other staff, or the member themselves; or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person.
- c. When medical staff leaders and/or the hospital administrator determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution.

Under such circumstances the president of the medical staff or their designee, and the hospital administrator, or designee, may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

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

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the president of the medical staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.2 **MEC action:** As soon as feasible and within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 **Procedural rights:** Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for medical staff appointment or physicians, advanced practice nurses or PAs eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

- a. Denial of medical staff appointment or reappointment;
- b. Revocation of medical staff appointment;
- c. Denial or restriction of requested clinical privileges;
- d. Involuntary reduction or revocation of clinical privileges;
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or
- f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

- a. Issuance of a letter of guidance, warning, or reprimand;
- b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or privileges;
- g. Imposition of a precautionary suspension or administrative time out that does not exceed 14 calendar days;
- h. Denial of a request for leave of absence, or for an extension of a leave;
- i. Determination that an application is incomplete or untimely;
- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;
- l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
- m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;

- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;
- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of any contract with or employment by hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;
- r. Any recommendation voluntarily accepted by the practitioner;
- s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- t. Change in assigned staff category;
- u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;
- v. Removal or limitations of emergency department call obligations;
- w. Any requirement to complete an educational assessment;
- x. Retrospective chart review;
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;
- z. Grant of conditional appointment or appointment for a limited duration; or
- aa. Appointment or reappointment for duration of less than 24 months.

To the extent that any of the above listed matters result in an adverse report about a member to the New Mexico Medical Board or to the National Practitioner Data Bank, the member will have access to all hearing rights identified in Paragraph 4.1.

4.3 Notice of Recommendation

When a precautionary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the hospital administrator, delivered either in person or by certified mail, return receipt requested. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;
- c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and
- d. The individual shall receive a copy of Sections 4.4 to 6.6 of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

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

4.5 Notice of Hearing and Statement of Reasons

The hospital administrator or designee shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Board), at the hearing;
- c. The names of the hearing panel members and presiding officer or hearing officer, if known; and
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

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

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

- a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. The panel will be appointed as follows: (1) a panel member shall be appointed by the hospital administrator; (2) a panel member shall be appointed by the President of the Medical Staff; (3) all remaining panel members shall be selected by a joint decision of the above two referenced individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- b. The hearing panel shall not include any member of the Board, any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner unless the practitioner and the MEC agree to the panel member. This restriction on appointment shall include any individual designated as the chair or the presiding officer.
- c. The hospital administrator or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the hospital administrator, who, in conjunction with the President of the Medical Staff, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the hospital administrator and the President of the Medical Staff.

5.2 Hearing Panel Chairperson or Presiding Officer

- 5.2.1 The panel shall appoint one of its members as presiding for the hearing.
- 5.2.2 The presiding officer (or hearing panel chair) shall do the following:
 - a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
 - b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;
 - c. Maintain decorum throughout the hearing;
 - d. Determine the order of procedure throughout the hearing;
 - e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital will advise the presiding officer or panel chair.

5.3 Hearing Officer

As an alternative to the hearing panel described in Section 5.1 of this manual, the hospital administrator, acting for the Board and in conjunction with the president of the medical staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel contingent on acceptance by the individual and the MEC. The hearing officer may be an attorney in non-clinical matters.

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

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

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

- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;
- b. Reports of experts relied upon by the MEC;
- c. Copies of redacted relevant committee minutes;
- d. Copies of any other documents relied upon by the MEC or the Board;
- e. No information regarding other practitioners shall be requested, provided or considered; and
- f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

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

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

6.2 Pre-Hearing Conference

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

6.3 Failure to Appear

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

6.4 Record of Hearing

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

6.5 Rights of the Practitioner and the Hospital

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

- a. To call and examine witnesses to the extent available;
- b. To introduce exhibits;
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- d. To have representation by counsel who may be present at the hearing, the role of counsel determined at the pre-hearing conference. It will be either to:

Advise his or her client;

Participate in resolving procedural matters; or to

Argue the case for his/her client.

Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing; and

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

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

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

6.6 Post-Hearing Memoranda

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

6.7 Official Notice

The presiding officer or hearing panel if there is no presiding officer, shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.8 Postponements and Extensions

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

6.9 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the president of the medical staff.

6.10 Order of Presentation

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

6.11 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.12 Deliberations and Recommendation of the Hearing Panel

Within thirty (30) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations and shall render a recommendation. The recommendation shall contain a concise statement of the reasons for the recommendation.

6.13 Disposition of Hearing Panel Report

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

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days, or after an extension agreed to by the parties, the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the hospital administrator or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

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

7.3 Time, Place and Notice

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

7.4 Nature of Appellate Review

- a. The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, a record of this procedure, similar to that done for the hearing panel, will be made.
- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

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

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision on the recommendation from the appeal panel. The member shall be informed of the Board's decision in writing, including specific reasons for its action, with copies sent to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current member, that individual may not apply within 36 months for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.



Plains Regional Medical Center

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

February 2020

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Section 1. Medical Staff Credentials Committee

1.1 Composition

The Credentials Committee shall consist of at least the following four (4) members:

- Credentials Committee Chairman
- Chairman of the Medical Department Peer Review Committee
- Chairman of the Surgical Department Peer Review Committee
- Chairman of the Emergency Room Committee

The Chairman of the Credentials Committee and the Chairman of the Emergency Room Committee shall be appointed by the President of the Staff, The Chairman of the Medical Department Peer Review Committee and the Chairman of the Surgical Peer Review Committee are appointed by the respective Departmental Chairmen as noted in Article 9.4.

1.2 Meetings

The Credentials Committee shall meet as necessity requires and at those other times when matters are referred to it by the Board of Trustees, The Medical Staff, or the Medical Executive Committee.

1.3 Responsibilities

- 1.2.1 To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category;
- 1.2.2 To review and recommend action on all requests regarding privileges from eligible practitioners;
- 1.2.3 To recommend eligibility criteria for the granting of medical staff membership and privileges;
- 1.2.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;
- 1.2.5 To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders;
- 1.2.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

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

- 1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the hospital administrator or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

- a. Only upon written request approved by the president of the medical staff, hospital administrator, credentials chair or chief medical officer.
- b. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration.
- c. Confidential letters of reference and other documents written by others about the practitioner but not previously provided to the practitioner may not be reviewed by practitioner. These documents will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner.
- d. Nothing may be removed from or copied from the file.
- e. The practitioner may make notes for inclusion in the file.
- f. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

- 2.1** No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.
- 2.2** The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges:
- 2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry or applicable recognized course of training in a clinical profession eligible to hold privileges;
 - 2.2.2 Have a current state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of New Mexico;
 - 2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the Office of the Inspector General (OIG) List of Excluded Individuals/Entities;
 - 2.2.4 Have a record that is free of felony convictions within the last five (5) years;
 - 2.2.5 A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada (RCPSC) or the American Osteopathic Association (AOA).
 - 2.2.5a Or the Royal College of Physicians and Surgeons of Canada (RCPSC), or the Royal College of Physicians, or the Royal College of Surgeons, or (ii) have satisfactorily completed a residency program in his/her specialty that is recognized by the Accreditation council for Graduate Medical Education (ACGME.)
 - 2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;
 - 2.2.7 Oromaxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program;
 - 2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA);
 - 2.2.9 A psychologist must have earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA);
 - 2.2.10 Possess a current, valid, drug enforcement administration (DEA) number and New Mexico Controlled Substance Registration if applicable;
 - 2.2.11 Have appropriate written and verbal communication skills;
 - 2.2.12 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:
 - a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or

remuneration with respect to referral or patient service opportunities; and

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

2.3 The following qualifications must also be met by all applicants requesting clinical privileges:

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

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

2.3.3 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.4 Demonstrate recent clinical performance as defined by the appropriate department with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.5 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan;

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

2.4 Exceptions

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

Section 3. Initial Appointment Procedure

3.1 Completion of Application

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

A completed application includes, at a minimum:

- a. A completed, signed, dated application form;
- b. A completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees, if any;
- e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;
- f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;
- g. Relevant practitioner-specific data as compared to aggregate data, when available; and
- h. When requested by the credentialing body, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's

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

3.1.3 Upon receipt of a completed application the Manager of Medical Staff Affairs, CMO, President of the Medical Staff or Credentials Committee Chair, in collaboration with the medical staff office, will determine if the requirements of the above sections are met. In the event the requirements of the above sections are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of the above sections are met, the application will be accepted for further processing.

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

3.1.5 Upon receipt of a completed application, the medical staff office or designee will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office or designee will collect relevant additional information which may include:

- a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past 5 years;
- b. Documentation of the applicant's past clinical work experience;
- c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office or designee will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
- d. Information, at a minimum, from the AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities, and EPLS.
- e. Information from professional training programs including residency and fellowship programs;
- f. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;
- g. Other information about adverse credentialing and privileging decisions;
- h. Two or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;

- i. Information from a criminal background check ;
- j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;
- k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and
- l. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing 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 forty-five calendar days will be deemed a withdrawal of the application.

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

3.2 Applicant’s Attestation, Authorization and Acknowledgement

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

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

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

3.2.3 Authorizes the hospital and 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.

3.2.4 Consents to hospital and medical staff representatives’ inspection of all records and documents that may be material to an evaluation of:

- a. Professional qualifications and competence to carry out the clinical privileges requested;
- b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
- c. Professional and ethical qualifications;
- d. Professional liability actions including currently pending claims involving the applicant; and
- e. Any other issue relevant to establishing the applicant’s suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning 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.

3.2.6 Authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges against any medical staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff and agrees to abide by their provisions.

3.2.8 Agrees to provide accurate answers to the questions on the New Mexico Uniform Statewide Application and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any of the questions affirmatively and/or provides information identifying a problem with any of the items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

3.3.1 **Expedited Credentialing:** An expedited review and approval process may be used for initial appointment. Applicants in Track 1 may be granted medical staff membership and/or privileges after review and action by the following: [department chair, credentials chair acting on behalf of the credentials committee], the President of the MEC or his/her designee and a Board Chairman or designee.

All initial applications for membership and/or privileges will be designated Track 1 or Track 2 as follows;

Track 1: A completed application that does not raise concerns as identified in the criteria for Track 2.

Track 2: If one or more of the following factors is identified through self-disclosure, criminal background checks and/or if present in an Applicant's work, training, medical or professional history or disclosed through a reference at any time during the application process shall result in a Track 2 designation: Applications in Track 2 must be reviewed and acted on by the department chair, credentials committee, MEC, and the Board. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Track 2 applications include but are not necessarily limited to the following:

Work History

- Gaps in training great than 6 months, multiple training programs (greater than 2 programs)
- Work history gaps greater than 6 months

Health & Behavior

- Behavioral health issues that would negatively impact professional performance
- Medical issues that would negatively impact professional performance
- Current or recent (last 3 months) participation in any substance abuse monitoring program

References & Evaluations

- Negative Reference Response(s)
- Negative Work History/Affiliation Response(s)
- Concerns from current Medical Staff Members or other representatives of the Hospitals which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.
- Applicants that are or have been the subject of an investigation, focused review, performance improvement plan or conditions at any hospital, health care facility or health plan
- Applicants that have been the subject of a revocation, restriction or involuntary reduction of medical staff, membership or privileges at any hospital or health care facility
- Applicants that have resigned from any medical staff or health plan provider panel during or after being advised of an investigation
- Negative or questionable Ongoing Professional Practice Evaluation (OPEE), Focused Professional Practice Evaluation (FPPE)
- There is a discrepancy between the information received from the applicant and references, or verified information

Licensing/Board/Government/Criminal Actions

- Licensing Board Actions – denial, revoked, restricted, suspended (medical boards, DEA, CSR)
- The suspension, exclusion, debarment or sanction of provider under the Medicare Program or Medicaid Program or other federal or state program
- Adverse NPDB report
- Arrests and/or violations (including guilty plea and pleas of no contest) for driving while under the influence, illegal use, possession or distribution of an illegal substance, sexual offenses, crimes against a minor, domestic violence or crimes of moral turpitude

Malpractice History

- Initial Appointments: 3 or more claims or lawsuits in the last 5 years (Open or Settled)
- Reappointment: Greater than 1 in the last 2 years (Open or Settled)
- Settlements over 1 million (claim or litigation)

3.3.2 Applicant Interview

- a. All applicants for appointment to the medical staff and/or the granting of clinical

privileges may be required to participate in an interview at the discretion of the department chair, credentials committee, MEC or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.

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

3.3.3 Department Chair Action

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

A recommendation as to whether the application should be acted on as Track 1 or Track 2;

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

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

Comments supporting the recommendations in 3.3.3 b above.

3.3.4 Medical Staff Credentials Committee Action

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

- a. A recommendation as to whether the application should be acted on as Track 1 or Track 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny

membership and/or privileges; and

- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
Comments supporting the recommendations in 3.3.4 b above.

3.3.5 MEC Action

If the application is designated Track 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. The president of the medical staff has the opportunity to determine whether the application is forwarded as a Track 1 or may change the designation to a Track 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

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

Comments supporting the recommendations in 3.3.5 b above.

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

3.3.6 Board Action:

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

- b. If the application is designated as a Track 2, the Board reviews the application and votes for one of the following actions:

The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

If the board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.7 Notice of final decision: Notice of the Board's final decision shall be given, through the hospital administrator to the MEC and to the chair of each department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the clinical service to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.8 Time periods for processing: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days from receipt from the Presbyterian Health System CVO, designated agency and/or personnel.

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

Section 4. Professional Practice Evaluation

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

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

Section 5. Reappointment

5.1 Criteria for Reappointment

5.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. Failure to successfully complete proctoring prior to the practitioner's first reappointment will be considered a relinquishment of privileges. The practitioner must provide the information enumerated in Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. An officer of the medical staff shall substitute for the department chair in the evaluation of current competency of the department chair, and recommend appropriate action to the credentials committee.

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

5.2 Information Collection and Verification

5.2.1 **From appointee:** On or before six (6) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the medical staff office:

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

5.2.2 **From internal and/or external sources:** The medical staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in Section 3.2.8, items a. to y.

5.2.3 The following information is also collected and verified:

- a. A summary of clinical activity at this hospital for each appointee due for reappointment;
 - b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided any clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
 - c. Service on medical staff, clinical service, and hospital committees;
 - d. Timely and accurate completion of medical records;
 - e. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;
 - f. Any significant gaps in employment or practice since the previous appointment or reappointment;
 - g. Verification of current licensure;
 - h. National Practitioner Data Bank query;
 - i. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges; and
 - j. Malpractice history for the past two (2) years, which is primary source verified by the medical staff office with the practitioner's malpractice carrier(s).
- 5.2.4 Failure, without good cause, to provide any requested information, at least ninety (90) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

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

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

5.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment".

Section 6. Clinical Privileges

6.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), physicians serving short locum tenens positions, telemedicine physicians, or house staff such as residents moonlighting in the hospital, or others deemed appropriate by the MEC and Board.

6.2 Requests

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

6.3 Basis for Privileges Determination

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

6.3.2 Privileges for which no criteria have been established:

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

- a. Review the community, patient and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
- b. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
- c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information and staffing plans; and
- d. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee and appropriate clinical service/specialty or subject matter

experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

For the development of criteria, the medical staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate;

Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the credentials committee who has no vested interest in the issue.

6.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

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

6.4 Special Conditions for Dental Privileges

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

6.5 Special conditions for licensed independent practitioners eligible for privileges without membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Allied health practitioners (AHPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care, unless otherwise provided by the hospital and their licensure or certification. The privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the medical staff organization is terminated for any reason.

6.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests.

6.7 Telemedicine Privileges

6.7.1 Practitioners providing only telemedicine services to the hospital from a distant site will not be appointed to the medical staff but 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:

- a. Be granted clinical privileges that include these services at the hospital and the distant site, where the hospital is the site where the patient is receiving care and the distant site is the site from which the services are provided; or
- b. Contract with the hospital 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 Section 10 of these procedures addressing contracted services.

6.7.2 Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through one of the following mechanisms:

- a. The hospital fully privileges and credentials the practitioner; or
- b. The hospital privileges practitioners using credentialing information from the distant site if the distant site is a verified CVO or a Joint Commission certified hospital, providing that the hospital makes its own decisions about privileges.

6.8 Temporary Privileges

The licensed hospital administrator, or designee, acting on behalf of the Board and based on the recommendation of the president of the medical staff or designee, may grant temporary privileges

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

6.8.1 Important Patient Care, Treatment or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days, while the full credentials information is verified and approved. When granting such privileges, the organized medical staff verifies current licensure and current competence.

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

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

6.8.4 Termination of temporary privileges: The hospital administrator acting on behalf of the Board and after consultation with the president of the medical staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary 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 hospital administrator or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

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

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

6.8.7 Disaster Privileges:

- a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the hospital administrator and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - A current picture hospital ID card that clearly identifies professional designation;
 - A current license to practice;
 - Primary source verification of the license;
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
- b. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
- c. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- d. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.
- e. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

6.9 Completion of History and Physical Examinations

6.9.1 A medical history and physical examination be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oro-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

6.9.2 An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to

surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oro-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

6.9.3 The content of complete and focused history and physical examinations is delineated in the rules and regulations.

Section 7. Preceptorship

- 7.1 A practitioner who has not provided acute inpatient care within the past twelve months or more, depending on specific recommendations of the departments and Credentials Committee, who requests clinical privileges at the hospital must arrange for a preceptorship either with a current member in good standing of the medical staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of sections 7.1 and 7.2.
- 7.2 A description of the preceptorship program, including details of monitoring and consultation must be written and submitted for approval to the department chair and credentials committee and MEC. At a minimum, the preceptorship program description must include the following:
 - 7.2.1 The scope and intensity of required preceptorship activities; and
 - 7.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

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

8.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of 36 months from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

8.2 Request for modification of appointment status or privileges

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

8.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate department chair or president of the medical staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

8.4 Exhaustion of administrative remedies

Every practitioner agrees that s/he will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

8.5 Reporting requirements

The hospital administrator or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any State reporting requirements, if applicable. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 9. Leave of Absence

9.1 Leave Request

A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities longer than 90 days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the president of the medical staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

9.2 Termination of Leave

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

9.3 Failure to Request Reinstatement

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

Section 10. Practitioners Providing Contracted Services

10.1 When the hospital contracts for care services with licensed independent practitioners including but not limited to those who provide readings of images, tracings or specimens through a telemedicine mechanism all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual. This also applies to individuals providing contracted services onsite.

10.2 Qualifications

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

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

10.4 Effect of contract or employment expiration or termination

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

10.5 Exclusivity policy

Practitioners who have previously been granted privileges under an exclusive contract, which then become covered by a subsequent exclusive contract, will not be able to exercise those privileges unless they become a party to the new contract.

Section 11. Medical Administrative Officers

- 11.1** A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.
- 11.2** Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities.
- 11.3** Effect of removal from office or adverse change in appointment status or clinical privileges:
- 11.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.
- 11.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.
- 11.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.



Plains Regional Medical Center

MEDICAL STAFF BYLAWS

Part IV: Organization and Functions Manual

February 2020

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Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The Medical Staff shall be divided into two clinical departments: The Department of Medicine and The Department of Surgery. Members will be assigned to either the Department of Medicine or the Department of Surgery according to the specialties and qualifications of the members. These departments shall have the responsibility for monitoring and evaluating the quality of care for all patients presenting to the hospital. All members of the Active and Associate Medical Staff with clinical privileges shall be assigned to the appropriate department according to his or her field of practice; if any difficulties arise, the Executive Committee shall make the assignment, bearing in mind the desires of the particular member.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, , hospital 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 department committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, is responsible for the following activities:

1.3.1 Governance, direction, coordination, and action

- a. Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, 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 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.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

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

1.3.3 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.

1.3.4 Credentials review (see Part III: Credentials Procedures Manual)

1.3.5 Information Management

- a. Review and evaluate medical records to determine that they:
 - Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and
 - Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services.

- b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein; and
- c. Provide liaison with administration, nursing service, and medical records professionals in utilization on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness

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

1.3.7 Strategic Planning

- a. Participate in evaluating existing programs, services, and facilities 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.

1.3.8 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.

1.3.9 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.

1.3.10 Infection Control Oversight

- a. The medical staff oversees the development and coordination and assists in implementation of the program for surveillance, prevention, implementation, and control of infection.

1.3.11 Pharmacy and Therapeutics Functions

- a. The medical staff oversees the development and coordination and assists in implementation of the formulary of approved drugs, protocols, policies, standards and utilization pertaining to pharmacy and therapeutics.

1.3.12 Practitioner Health

- a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental and/or physical impairment. 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 a medical staff officer and/or hospital administrator who will then notify the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Physician Aid Committee does not alter the primary responsibility of the department chair for clinical performance within that chair's department;
- 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 his/her rehabilitation is complete, and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.4 Responsibilities of Department Chairs

- 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 interdepartmental and intradepartmental 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 administrator sufficient numbers of qualified and competent persons to provide patient care and service;
- k. To provide input to the hospital administrator 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.

1.5 Responsibilities of the President of the Medical Staff

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

- a. Call, preside at, and be responsible for the agenda of all general and special meetings of the medical staff;
- b. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the hospital administrator or the Board on hospital or Board committees;
- c. Enforce medical staff bylaws, rules, regulations and medical staff/hospital policies;
- d. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
- e. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;
- f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of 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;
- g. 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;
- h. 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;
- i. Attend Board meetings and Board committee meetings as invited by the Board;
- j. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

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

Section 2. Medical Staff Committees

2.1 General language governing committees

The following shall be the standing committees of the medical staff: MEC, Credentials, Departmental Peer Review Committees, Medical Education Committee, and Practitioner Aid Committee. 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. 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 administrator, or their designees, are ex officio members of all standing and ad hoc committees.

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.

2.2 MEC

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

2.3 Credentials Committee

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

2.4 Departmental Peer Review Committees

Each department shall establish a departmental peer review committee that shall review the clinical performance of all members of the department. The departmental peer review committee shall report summaries of those observations, and any conclusions based on those observations, to the Department Chairman and to the Credentials Committee. The Credentials Committee shall consider this information as it determines its recommendations regarding reappointment and the granting of specific clinical privileges. The departmental peer review committee shall also monitor the performance of the Associate Medical Staff members in its department as noted in Article 4.4.b.

The Department Chairman will appoint the chairman and members of the departmental peer review committee. Peer review will be done only by physicians. No physician shall review his own record or the record of any physician with whom he is associated in group practice.

2.5 Medical Education Committee

2.5.1 Composition: The medical education committee shall consist of the members of the Medical Executive Committee and will be consistent with the recommendations of the ACGME and pertinent state law.

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

2.6 Practitioner Aid Committee

2.6.1 Composition: The practitioner health committee shall consist of at least five (5) members of the active medical staff of the PHS Central Delivery System and shall include the chair of the credentials committee of the PHS Central Delivery System and a physician with a previous history of impairment whose impairment has been successfully treated (if feasible), and other members of the medical staff of the PHS Central Delivery System selected by the PHS Central Delivery System president of the medical staff to bring the total complement to five (5) physician members.

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

2.7 Emergency Room Committee

2.7.1 The Emergency Room Committee shall be responsible for peer review and for evaluating qualifications for credentialing for the Emergency Room Clinic physicians. Committee members shall be members of the Medical Staff appointed by the President of the Medical Staff. It shall submit written reports of its meetings to the Executive Committee.

2.7.2 The Emergency Room Committee shall review the clinical performance of all certified nurse practitioners, physician assistants, and medical staff of the Emergency Room Medical Staff. The Emergency Room Committee shall report summaries of those observations, and any conclusions based on these observations, to the Credentials Committee. The Credentials Committee shall consider this information as it determines its recommendations regarding reappointment and the granting of specific clinical privileges.

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

2.8 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research;
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

2.9 Immunity from Liability

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

2.10 Covered Activities

2.10.1 In accordance with state and federal law the confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's 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. Corrective or disciplinary actions;
- d. Hearings and appellate reviews;
- e. Quality assessment and performance improvement/peer review activities;
- f. Utilization review and improvement activities;
- g. Claims reviews;
- h. Risk management and liability prevention activities; and

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

2.11 Conflict of Interest

A member of the medical staff requested to perform a Board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a 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.

ADOPTION

The foregoing amended Bylaws of the Medical Staff of Plains Regional Medical Center were duly adopted by the Medical Staff of Plains Regional Medical Center at a meeting held on the 14th day of February 2023, to be effective on the date of approval of the Board of Trustees of Plains Regional Medical Center.

President of the Medical Staff

Date

Secretary/Treasurer

Date

Approved by the Board of Trustees, Plains Regional Medical Center, on the ____ day of _____, 2023.

Chairman of the Board of Trustees

ADOPTION

The foregoing amended Bylaws of the Medical Staff of Plains Regional Medical Center were duly adopted by the Medical Staff of Plains Regional Medical Center at a meeting held on the 14th day of February 2023, to be effective on the date of approval of the Board of Trustees of Plains Regional Medical Center.



President of the Medical Staff

2/15/2023

Date



Secretary/Treasurer

2/17/2023

Date

Approved by the Board of Trustees, Plains Regional Medical Center, on the 1 day of March, 2023.



Chairman of the Board of Trustees