Medical Staff Bylaws

AVITA HEALTH SYSTEM MEDICAL STAFF

A Medical Staff Document

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PREAMBLE

Avita Health System is comprised of the following hospitals: Bucyrus Community Hospital LLC d/b/a Avita Bucyrus Hospital, located in Bucyrus, Ohio (Bucyrus); Galion Community Hospital, d/b/a Avita Galion Hospital, located in Galion, Ohio (Galion); and Avita Ontario Hospital, LLC, located in Ontario, Ohio (Ontario) (Bucyrus, Galion, and Ontario hereinafter collectively referred to as “Hospital”). Bucyrus, Galion, and Ontario have elected to create a unified Medical Staff and adopt a single set of Medical Staff governing documents.

The Medical Staff of the Hospital recognizes that it is responsible for the quality of patient care provided in the Hospital and accepts and discharges this responsibility subject to the ultimate authority of the Hospital's Board. The Medical Staff recognizes that it must work in cooperation with the Hospital's administration and the Board to fulfill the Hospital's goal of providing quality care to Hospital patients.

DEFINITIONS

The following terms shall have the meanings defined herein when used in these Bylaws unless otherwise specified:

ACCREDITED HOSPITAL means a hospital that is accredited by the Centers for Medicare and Medicaid Services ("CMS") or an entity that has deeming authority from CMS.

ADVANCED PRACTICE PROVIDER or APP means those physician assistants, advanced practice registered nurses, and other qualified and eligible APPs, as designated in the APP Policy, who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently, or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

ADVERSE means a recommendation or action of the Medical Executive Committee or Board that denies, limits (*i.e.* suspension, restriction, *etc.*), or terminates a Practitioner's Medical Staff appointment and/or Privileges on the basis of professional conduct or clinical competence.

APPLICANT means a Practitioner who seeks appointment to the Medical Staff and/or Clinical Privileges in the Hospital or a change in the category of appointment and/or Privileges.

APPOINTEE means a Practitioner who has been appointed to the Medical Staff. An Appointee must also have applied for and been granted Clinical Privileges unless the appointment is to a Medical Staff category without Privileges or unless otherwise provided in these Bylaws.

BOARD means the Board of Avita Health System which is the governing body of the Hospital that has overall responsibility for the conduct of the Hospital including the Medical Staff. References to the Board shall include the Board's designee(s) including any individual or Board committee authorized by the Board to act on its behalf in designated matters.

BYLAWS or MEDICAL STAFF BYLAWS means the articles herein and amendments thereto that constitute the base governing document of the Medical Staff.

CHIEF EXECUTIVE OFFICER or CEO means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

CHIEF OF STAFF means the active Appointee who serves as chief administrative officer of the Medical Staff.

CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Practitioner or APP to provide patient care, treatment, and/or services, pursuant to an applicable Delineation of Privileges, at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, character, and judgment.

DENTIST means an individual with a Doctor of Dental Surgery (D.D.S.) degree or a Doctor of Dental Medicine (D.M.D.) degree who is licensed to practice dentistry in Ohio.

DEPARTMENT means a grouping or division of Medical Staff clinical services as provided for in these Bylaws. A Medical Staff Department may be further divided into "Sections" headed by a "Section Chair."

DEPARTMENT CHAIR means the active Appointee who serves as the leader of a Medical Staff Department with responsibility for Department administration as set forth herein.

EX OFFICIO means service as a member of a body by virtue of an office or position held. Unless otherwise expressly provided, individuals serving in an *Ex Officio* capacity shall serve without voting rights and shall not be counted for purposes of determining a quorum.

FEDERAL HEALTHCARE PROGRAM means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

GOOD STANDING means that a Practitioner, at the time the issue is raised, has not received a restriction or suspension of his/her appointment and/or Privileges in the previous twelve (12) months; provided, however, that if a Practitioner has been automatically suspended in the previous twelve (12) months for delinquent medical records and has subsequently taken appropriate action, such automatic suspension shall not adversely affect the Practitioner's Good Standing status.

HEALTH SYSTEM means Avita Health System.

HOSPITAL means Bucyrus Community Hospital LLC d/b/a Avita Bucyrus Hospital, located in Bucyrus, Ohio (Bucyrus); Galion Community Hospital, d/b/a Avita Galion Hospital, located in Galion, Ohio (Galion); and Avita Ontario Hospital, LLC, located in Ontario, Ohio (Ontario) including all Bucyrus, Galion, and Ontario provider-based locations, if any, all of which comprise Avita Health System.

JOINT CONFERENCE COMMITTEE means an *ad hoc* Board advisory committee consisting of an equal number of Board members (to include the Board chair) and Medical Staff Appointees (to include the Medical Staff officers). In the event the Joint Conference Committee is addressed in the Hospital's governing documents, then the Hospital's governing documents shall govern and this definition shall automatically be likewise amended.

MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the Medical Staff.

MEDICAL STAFF means the formal organization of all Physicians, Dentists, Podiatrists, Psychologists, and Optometrists who have been granted appointment to the Hospital Medical Staff with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed. Bucyrus, Galion, and Ontario have each elected to create a unified Medical Staff. References to "Medical Staff" in the Medical Staff governing documents shall mean the unified Medical Staff.

MEDICAL STAFF POLICY/POLICIES means those Medical Staff policies, approved by the Medical Executive Committee and the Board, that serve to implement the Medical Staff Bylaws. Policies shall include, but not be limited to, the Fair Hearing Policy, Advanced Practice Provider Policy, Practitioner/APP Conduct Policy, Practitioner/APP Impairment Policy, and the Practitioner/APP Peer Review Policy.

MEDICAL STAFF YEAR means the period from January 1 through December 31 of each year.

ORAL SURGEON or ORAL MAXILLOFACIAL SURGEON means a Dentist who has successfully completed an accredited postgraduate/residency program in oral/maxillofacial surgery.

PATIENT ENCOUNTER means a professional contact between a Practitioner and a patient (including an admission, consultation, provider-based visit, or diagnostic, operative, or invasive procedure) at the Hospital or a provider-based location thereof.

PHYSICIAN means an individual with a Doctor of Allopathic Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree who is licensed to practice medicine in Ohio.

PODIATRIST means an individual with a Doctor of Podiatric Medicine (D.P.M.) degree who is licensed to practice podiatry in Ohio.

PRACTITIONER means an appropriately licensed Physician, Dentist, Podiatrist, Psychologist, or Optometrist.

PREROGATIVE means the right to participate, by virtue of Medical Staff category, granted to an Appointee and subject to the ultimate authority of the Board, the conditions and limitations imposed in the Bylaws, Policies, Rules & Regulations, and applicable Health System/Hospital policies.

PROFESSIONAL LIABILITY INSURANCE means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

PSYCHOLOGIST means an individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio Board of Psychology who is licensed to practice psychology in Ohio.

QUALIFIED MEDICAL PERSON or QMP means those qualified individuals who are authorized to perform a medical screening examination as set forth in the Medical Staff Rules & Regulations

RULES & REGULATIONS means the Medical Staff rules and regulations, approved by the Medical Staff and the Board, that govern the provision of care, treatment, and services to Hospital patients.

SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgment of receipt.

OTHER

Designee. Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position (*e.g.,* CEO, Chief of Staff, Department Chair, *etc.*), then reference to such individual shall also include the individual's authorized designee.

Not a Contract. The Medical Staff Bylaws, Policies, and Rules & Regulations are not intended to and shall not create any contractual rights between the Hospital and a Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and a Practitioner.

ARTICLE I

NAME

The name of the Medical Staff shall be the Avita Health System Medical Staff.

ARTICLE II

PURPOSE AND RESPONSIBILITIES

2.1 The purpose and responsibilities of the Medical Staff are to:

2.1-1 Be the formal organizational structure through which the benefits of appointment to the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff appointment, including the requirement that Practitioners work cooperatively with each other and with Hospital staff, may be fulfilled.

2.1-2 Serve as the primary means of accountability to the Board for the appropriateness of the professional performance and conduct of Practitioners and APPs, to monitor the quality of patient care delivered in the Hospital, and to make recommendations thereon, through the MEC, to the Board.

2.1-3 Establish procedures whereby issues concerning the Medical Staff and the Hospital may be discussed both within the Medical Staff and with the Board and to provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning process.

2.1-4 Recommend to the Board, through the MEC, action with respect to appointments, Medical Staff categories, Clinical Privileges, and corrective action.

2.1-5 Initiate and pursue corrective action with respect to Practitioners and APPs when warranted.

2.1-6 Establish Medical Staff Bylaws, Policies, and Rules & Regulations to govern Practitioners and APPs.

2.1-7 Ensure that all patients admitted to the Hospital or treated in the Hospital’s ambulatory facilities receive appropriate patient care.

2.1-8 Provide an appropriate educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill through educational activities that relate, at least in part, to the type and nature of care offered by the Hospital as demonstrated through the Hospital's quality assessment and improvement activities.

2.1-9 Provide input to the Hospital regarding the Hospital’s annual budget, long-term and short-term planning, and the development and implementation of plans for efficient patient flow throughout the Hospital.

2.1-10 Participate in creating and implementing policies and procedures for procuring and donating organs and other tissues.

2.1-11 Assist the Hospital in planning and supporting patient educational activities and identifying resources necessary for achieving such educational objectives.

2.1-12 Work with the CEO, as the Board's representative, outside of Board meetings.

ARTICLE III

MEDICAL STAFF OFFICERS

3.1 IDENTIFICATION

3.1-1 The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and Secretary-Treasurer.

3.2 QUALIFICATIONS

3.2-1 Officers must have been Appointees of the active Medical Staff category with Clinical Privileges at Bucyrus, Galion, and/or Ontario for at least one (1) year at the time of their nomination and election and must remain active Appointees with Clinical Privileges, in Good Standing, during their term of office.

3.2-2 Officers shall meet the attendance requirements set forth in Section 6.5.

3.2-3 A Practitioner may not simultaneously serve as a Medical Staff officer and as a Department Chair or Section Chair.

3.3 NOMINATION

3.3-1 Prior to the end of the third quarter of the Medical Staff Year, the MEC, acting as the Nominating Committee, shall meet and present a slate of officers to the Medical Staff Appointees eligible to vote for review and comment. The proposed slate shall remain open for a period of thirty (30) days during which time additional nominations may be proposed to the MEC.

3.3-2 Additional nominations for the ballot shall not be accepted after the thirty (30) day review and comment period provided all of the positions have candidates willing to serve.

3.3-3 Following conclusion of the thirty (30) day review and comment period, the MEC shall issue to the Medical Staff Appointees eligible to vote a final ballot that will include all qualified nominees that have confirmed their willingness to serve.

(a) If there are two or more qualified candidates seeking election for the same Medical Staff office, then a vote will be taken in accordance with the procedure set forth in Section 3.1-4.

(b) If there is only one qualified candidate seeking election for a Medical Staff office, then such candidate shall be appointed to the office without further Medical Staff action.

3.4 ELECTION

3.4-1 If there are two or more qualified candidates seeking election for the same Medical Staff office, then a vote shall occur in one of the following ways:

(a) At a regular or special Medical Staff meeting. The candidate who receives a majority vote of those Medical Staff Appointees eligible to vote who are present and voting, by written ballot, at a Medical Staff meeting at which a quorum is present shall be elected to the Medical Staff office.

OR

(b) By written or electronic ballot without a Medical Staff meeting. In such event, ballots shall be distributed to each Medical Staff Appointee eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority vote of the total votes returned by the stipulated date shall be elected to the Medical Staff office.

3.5 TERM

3.5-1 Each Medical Staff officer shall serve a two (2) year term commencing on the first day of the Medical Staff Year following the election. Each Medical Staff officer shall serve in office until the end of his or her term, or until a successor is elected or appointed, unless the officer sooner resigns or is removed from office.

3.6 REMOVAL AND RESIGNATION

3.6-1 Process for Removal

(a) Removal of the Chief of Staff, Vice Chief of Staff, or Secretary-Treasurer may be initiated by the Board, the MEC, or by a petition signed by at least one-third of the Medical Staff Appointees, in Good Standing, eligible to vote.

(b) Removal shall be considered at a special meeting of the Medical Staff called for that purpose. Provided that a quorum is present, removal shall require a two-thirds (2/3) vote of the Medical Staff Appointees, in Good Standing, eligible to vote who cast votes at the special Medical Staff meeting in person.

3.6-2 Grounds

(a) Permissible Removal. Permissible grounds for removal of a Medical Staff officer shall include, without limitation:

(1) Failure to continuously maintain the qualifications set forth in Section 3.1-2.

(2) Failure to perform the duties of the office held in a timely and appropriate manner.

(3) Conduct or statements inimical or damaging to the best interest of the Medical Staff or the Hospital or to their goals, programs, or public image.

(4) Inability to perform the duties of the office held.

(5) Imposition of an automatic suspension or summary suspension of Medical Staff appointment and/or Privileges or corrective action against the Practitioner which results in a final Adverse decision.

(b) Automatic Removal. A Medical Staff officer shall automatically be removed from office upon imposition of an automatic termination of Medical Staff appointment and/or Privileges.

3.6-3 Resignation

(a) Any officer of the Medical Staff may resign at any time by giving written notice to the MEC. Such resignation shall take effect on the date specified in the notice or as otherwise agreed upon by the MEC and the resigning officer.

3.7 VACANCIES

3.7-1 Vacancies in Medical Staff office occur upon the resignation, removal, or death of an officer.

3.7-2 If there is a vacancy in the office of Chief of Staff, the then Vice Chief of Staff shall serve out the remaining Chief of Staff term.

3.7-3 Vacancies, other than that of the Chief of Staff, shall be filled by interim appointment of the MEC until the next regular election.

3.8 DUTIES

3.8-1 CHIEF OF STAFF

(a) The Chief of Staff shall:

(1) Enforce the Medical Staff Bylaws, Policies, and Rules & Regulations.

(2) Implement sanctions where indicated and promote compliance with procedural safeguards where corrective action has been requested or initiated.

(3) Call, preside at, and be responsible for the agenda of all Medical Staff meetings.

(4) Serve as a voting member/chair of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as specified by each applicable committee composition.

(5) Serve as a voting member of the Joint Conference Committee.

(6) Interact with the CEO and Board in all matters of mutual concern within the Hospital. The Chief of Staff shall attend Board meetings in a non-voting capacity.

(7) Appoint and remove Medical Staff committee members and chairs in accordance with/subject to Section 5.2.

(8) Represent the views of the Medical Staff to the Board and the CEO.

(9) Encourage Practitioners to proactively deal with operational concerns by following the chain of command and using the Problem Resolution Policy (*i.e.*, for constructive problem solving) when possible.

(10) Be a spokesperson for the Medical Staff in external professional and public relations.

(11) Serve as a Medical Staff liaison to the Board and Health System/Hospital administration as well as with outside licensing and/or accreditation agencies.

(12) Make recommendations for temporary Privileges, on behalf of the MEC, to the CEO between meetings of the MEC.

(13) Perform such other duties as assigned by the MEC or as set forth in the Medical Staff governing documents.

3.8-2 VICE CHIEF OF STAFF

(a) The Vice Chief of Staff shall:

(1) Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff.

(2) Serve as a voting member of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as specified by each applicable committee composition.

(3) Serve as a voting member of the Joint Conference Committee.

(4) Attend meetings of the Hospital Quality Steering Committee.

(5) Perform such other duties as assigned by the Chief of Staff or MEC or as set forth in the Medical Staff governing documents.

3.8-3 SECRETARY-TREASURER

(a) The Secretary-Treasurer shall:

(1) Serve as a voting member of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical

Staff committees as specified by each applicable committee composition.

(2) Serve as a voting member of the Joint Conference Committee

(3) Maintain a roster of Medical Staff Appointees.

(4) Keep accurate and complete minutes of all MEC and Medical Staff meetings.

(5) Call meetings of the Medical Staff and MEC on the order of the Chief of Staff or MEC.

(6) Attend to all appropriate correspondence and notices on behalf of the Medical Staff.

(7) Receive and safeguard all funds of the Medical Staff.

(8) Excuse absences from meetings on behalf of the MEC.

(9) Perform such other duties as ordinarily pertain to the office, as assigned by the Chief of Staff or MEC, or as set forth in the Medical Staff governing documents.

ARTICLE IV

MEDICAL STAFF DEPARTMENTS/SECTIONS

4.1 OVERVIEW

4.1-1 The Medical Staff shall be divided into two (2) clinical Departments with designated Sections, as deemed necessary, upon recommendation of the MEC and Board approval. Each Department and Section shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 4.4-6. When appropriate, the MEC may recommend to the Medical Staff, subject to Board approval, the creation, elimination, modification, or combination of Departments and/or Sections.

4.2 DESIGNATION

4.2-1 There shall be a Department of Medicine and a Department of Surgery with the Sections set forth in Section 4.2-2 (b) and Section 4.2-3 (b). Each Department and Section shall have a chair.

4.2-2 DEPARTMENT OF MEDICINE

(a) The areas of responsibility for the Department of Medicine shall include:

(1) Internal medicine

(2) Family medicine

(3) Other related subspecialties.

(b) Within the Department of Medicine, there shall be a:

(1) Section of Emergency Medicine

(2) Section of Hospital-based Clinics (with respect to non-surgical care)

(3) Section of Pediatrics (applicable to Galion and Ontario only; Bucyrus does not provide pediatric services)

(c) Emergency Department activities will be reported to the Department of Medicine on an every other month basis.

(d) Infection control activities will be reported to the Department of Medicine on a quarterly basis and to the Department of Surgery as needed.

4.2-3 DEPARTMENT OF SURGERY

(a) The areas of responsibility for the Department of Surgery shall include:

(1) Anesthesia

(2) Hospital-based clinics (with respect to surgical care)

(3) General surgery

(4) Gynecology

(5) Neurosurgery

(6) Ophthalmology/Optometry

(7) Oral and Maxillofacial Surgery

(8) Orthopedics/Sports Medicine

(9) Otorhinolaryngology

(10) Pathology

(11) Plastic surgery

(12) Radiology

(13) Thoracic Surgery

(14) Urology

(b) Within the Department of Surgery there shall be a Section of Obstetrics (applicable to Galion and Ontario only) responsible for antepartum, intrapartum, and postpartum care of women. Bucyrus does not provide obstetric services.

(c) The chair of the Department of Surgery or the Medical Director of Anesthesia will be the Director of Anesthesia Services and must be a doctor of medicine or osteopathy. The Director of Anesthesia Services will meet the criteria specified in Section 4.4-1 for Department Chairs.

4.3 ASSIGNMENT TO DEPARTMENTS AND SECTIONS

4.3-1 Each Practitioner and APP shall be assigned to a Department and, as applicable, to a Section, if any, within such Department consistent with the Clinical Privileges granted to each such Practitioner and APP.

4.3-2 Practitioners granted Medical Staff appointment without Privileges shall be assigned to a Department and, as applicable, to a Section, if any, within such Department consistent with the Practitioner's specialty.

4.4 DEPARTMENT/SECTION CHAIRS

4.4-1 QUALIFICATIONS

(a) Each Department Chair and Section Chair must have been appointed to the active Medical Staff category with Clinical Privileges at Bucyrus,

Galion, and/or Ontario for at least one (1) year at the time of his/her nomination and election and must remain an active Appointee with Privileges in Good Standing during his/her term.

(b) Department Chairs and Section Chairs shall be board certified in a specialty appropriate to the Department or Section or shall be determined to have affirmatively established comparable competence through training, experience, and demonstrated ability in at least one (1) of the clinical areas covered by the Department or Section.

(c) Department and Section Chairs shall meet the attendance requirements set forth in Section 6.5.

(d) A Practitioner may not simultaneously serve as a Medical Staff officer and as a Department Chair or Section Chair.

4.4-2 NOMINATION

(a) Nominations for the Department Chair and Section Chair positions shall be sought from the voting members of the applicable Department or Section in such manner as determined appropriate by the MEC. Practitioners nominated for the position of Department Chair or Section Chair must satisfy the qualifications for the position and confirm their willingness to serve if elected.

4.4-3 ELECTION OF DEPARTMENT CHAIRS

(a) If there is only one qualified candidate seeking election for a Medical Staff Department Chair position, then such candidate shall be appointed to the position without further Medical Staff action.

(b) If there are two or more qualified candidates seeking election for the same Medical Staff Department Chair position, then a vote shall occur in one of the following ways:

(1) At a regular or special Medical Staff Department meeting. The candidate who receives a majority vote of those Department members eligible to vote who are present and voting, by written ballot, at a Department meeting at which a quorum is present shall be elected as the Department Chair.

OR

(2) By written or electronic ballot without a Department meeting. In such event, ballots shall be distributed to each Department member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority vote of the total votes returned by the stipulated date shall be elected as the Department Chair.

4.4-4 APPOINTMENT OF SECTION CHAIRS

(a) Section Chairs shall be appointed by the Chief of Staff in consultation with the MEC.

4.4-5 TERM

(a) Each Department Chair and Section Chair shall serve a two (2) year term commencing on the first day of the Medical Staff Year following his/her election or appointment, as applicable.

(b) Each Department Chair and Section Chair shall serve until the end of his/her term, or until a successor is selected, unless the Department Chair or Section Chair sooner resigns or is removed from the position.

4.4-6 REMOVAL

(a) Mechanism

(1) Removal of a Department Chair or Section Chair may be initiated by the Board, the MEC, or by a petition signed by at least one-third of the members of the Department or Section eligible to vote for the Department Chair or Section Chair.

(2) Removal shall be considered at a special meeting of the Department or Section called for that purpose. Provided that a quorum is present, removal shall require a two-thirds (2/3) vote of the members of the Department or Section eligible to vote for the Department Chair or Section Chair who actually cast votes at the special meeting in person.

(b) Permissible Grounds for Removal. Permissible grounds for removal of a Department Chair or Section Chair shall include, without limitation:

(1) Failure to continuously maintain the qualifications set forth in Section 4.4-1.

(2) Failure to perform the duties of the position held in a timely and appropriate manner.

(3) Conduct or statements inimical or damaging to the best interest of the Medical Staff or the Hospital or to their goals, programs, or public image.

(4) Inability to perform the duties of the position held.

(5) Imposition of an automatic suspension or summary suspension of Medical Staff appointment and/or Privileges or corrective action against the Practitioner which results in a final Adverse decision.

(c) Automatic Removal. A Department Chair or Section Chair shall automatically be removed from his/her position upon imposition of an automatic termination of Medical Staff appointment and/or Privileges.

4.4-7 VACANCIES

(a) Department Chair and Section Chair vacancies shall be filled in the same manner in which the original selection is made.

4.4-8 DUTIES

(a) Each Department Chair and Section Chair shall:

(1) Act as presiding officer at Department/Section meetings.

(2) Provide oversight for all professional, clinical, and administrative activities within the Department/Section and report to the MEC and to the Chief of Staff regarding such activities.

(3) Develop and implement Department/Section programs to continually assess and improve the quality of care, treatment, and services provided, credentials review, Privilege delineations, medical education, utilization review, and quality assurance.

(4) Serve as a voting member of the MEC (applicable to Department Chairs only).

(5) Provide guidance with respect to Medical Staff and/or Health System/Hospital policies and make specific recommendations and suggestions regarding his or her Department/Section.

(6) Transmit to the MEC Department/Section recommendations concerning, as applicable, appointment and reappointment, Medical Staff category, Clinical Privileges, professional practice evaluation, and corrective action with respect to all persons requesting or granted Clinical Privileges in his or her Department/Section.

(7) Enforce the Medical Staff Bylaws, Policies, and Rules & Regulations within his or her Department/Section.

(8) Implement within his or her Department/Section recommendations/actions of the MEC, the MPRC, or other appropriate Medical Staff committees.

(9) Assess and recommend to the CEO off-site sources for needed patient care, treatment, and/or services not provided by the Department/Section or Hospital.

(10) Integrate the Department/Section into the primary functions of the Hospital.

(11) Coordinate and integrate interdepartmental and intradepartmental services.

(12) Develop and implement policies and procedures that guide and support the provision of care, treatment, and/or services of the Department/Section.

(13) Make recommendations to the MEC regarding a sufficient number of qualified and competent Practitioners and APPs to provide care, treatment, and/or services for the Department/Section.

(14) Assist with determining the qualifications and competence of Practitioners and APPs who provide care, treatment, and/or services in the Department/Section.

(15) Assist with the orientation and continuing education of all Practitioners and APPs in the Department/Section.

(16) Make recommendations to Hospital administration and/or the MEC regarding space and resources needed by the Department/Section.

(17) Educate Department/Section members to proactively deal with concerns by following the chain of command and using the Problem Resolution Policy (*i.e.,* for constructive problem solving) and applicable Medical Staff governing processes as appropriate.

(18) Discuss operational issues affecting the Department/Section with Hospital management.

(19) Attend Board meetings in a non-voting capacity.

(20) Perform such other duties, commensurate with the position, as requested by the Chief of Staff or MEC or as set forth in the Medical Staff governing documents.

4.4-9 RESIGNATION

(a) Department Chairs and Section Chairs may resign at any time by giving written notice to the Chief of Staff.

(b) Such resignation shall take effect on the date specified in the notice or as otherwise agreed upon by the MEC and the resigning Department Chair or Section Chair.

ARTICLE V

MEDICAL STAFF COMMITTEES

5.1 DESIGNATION

5.1-1 The committees described in this Article shall be the standing committees of the Medical Staff unless otherwise specified in the Medical Staff Bylaws or Policies.

(a) Special or *ad hoc* Medical Staff committees may be created by the MEC (or the MEC's designee) to perform specified tasks.

(b) Medical Staff committees shall be responsible to the MEC unless otherwise provided in the Medical Staff Bylaws or Policies.

5.2 GENERAL PROVISIONS

5.2-1 SELECTION OF COMMITTEE MEMBERS AND CHAIRS

(a) Unless otherwise specified in the Medical Staff Bylaws or Policies, the chair and Practitioner members of all Medical Staff committees shall be appointed, and may be removed, by the Chief of Staff in consultation with the MEC.

(b) Unless otherwise specified in the Medical Staff Bylaws or Policies, non-Practitioner Hospital employee members of all Medical Staff committees shall be appointed by the Hospital CEO in consultation with the Chief of Staff.

(c) The Hospital CEO and Chief of Staff (unless otherwise designated as a voting member of a committee) shall be *Ex Officio* (non-voting) members of all committees of the Medical Staff and may attend such meetings at their discretion.

5.2-2 QUALIFICATIONS OF COMMITTEE MEMBERS/CHAIRS

(a) Medical Staff Appointees may serve on a Medical Staff committee if permitted to do so pursuant to the Prerogatives set forth in the Medical Staff category to which each such Practitioner is appointed and subject to satisfaction of the applicable qualifications set forth in the committee composition or elsewhere in the Medical Staff governing documents.

(b) Unless otherwise specified in the Medical Staff Bylaws or Policies, Practitioners appointed to the Hospital's active Medical Staff category with Privileges, in Good Standing, with at least one (1) year of service at the Hospital may serve as Medical Staff committee chairs. Medical Staff committee chairs shall meet the attendance requirements set forth in Section 6.5.

(c) APPs may be invited by the applicable Medical Staff committee chair to attend a portion, or all, of a Medical Staff committee meeting, as guests, but have no right to participate in the discussion or vote on agenda items.

5.2-3 TERM OF COMMITTEE MEMBERS/CHAIRS

(a) Unless otherwise specified in the Medical Staff Bylaws or Policies, Medical Staff committee members and chairs shall be appointed for a term of two (2) years and shall serve until the end of his/her term, or until a successor is selected, unless the member/chair sooner resigns or is removed from the position.

5.2-4 REMOVAL/RESIGNATION

(a) If a Practitioner member/chair of a Medical Staff committee fails to continuously satisfy the qualifications set forth in Section 5.2.2 above, or if any other good cause exists, that member/chair may be removed from service on the committee by the Chief of Staff in consultation with the MEC.

(b) A Medical Staff committee member or chair may resign at any time by giving written notice to the Chief of Staff. Such resignation shall take effect on the date specified in the notice or as otherwise agreed upon by the Chief of Staff and the resigning committee member/chair.

5.2-5 VACANCIES

(a) Unless otherwise provided in the Medical Staff Bylaws or Policies, vacancies on any Medical Staff committee shall be filled in the same manner in which the original selection was made.

5.2-6 MEETINGS

(a) A Medical Staff committee chair shall have the authority to call a meeting of his/her committee at any time.

5.2-7 *EX OFFICIO* (NON-VOTING) COMMITTEE MEMBERS & GUESTS

(a) *Ex Officio*

(1) *Ex Officio* committee members may not vote and are not counted for purposes of determining a quorum unless otherwise specified in the Medical Staff governing documents.

(2) *Ex Officio* committee members are entitled to stay for the entire meeting.

(b) Guests

(1) Guests may be invited to attend a Medical Staff meeting (or portion thereof) by the Chief of Staff, a Medical Staff Department/Section meeting (or portion thereof) by the Department Chair/Section Chair,

or a Medical Staff committee meeting (or portion thereof) by the committee chair in order to make a requested presentation or provide requested information after which such guests are excused.

(2) Guests have no right to participate in the discussion or vote on agenda items.

(3) Guests are not counted for purposes of determining a quorum.

5.3 MEDICAL EXECUTIVE COMMITTEE

5.3-1 COMPOSITION

(a) The MEC shall consist of the following persons:

(1) Officers of the Medical Staff (Chief of Staff; Vice Chief of Staff; and Secretary/Treasurer) with vote.

(2) Chair of the Department of Medicine with vote.

(3) Chair of the Department of Surgery with vote.

(4) Practitioner chair of the Medical Record Committee with vote.

(5) Practitioner chair of the Quality Steering Committee with vote.

(6) Practitioner chair of the Pharmacy and Therapeutics Committee with vote.

(7) Three (3) MEC at-large Practitioners with vote. The MEC at-large Practitioners:

- must be appointed to the active Medical Staff category and granted Privileges at Bucyrus, Galion, and/or Ontario.
- will be appointed and removed in the manner set forth in Section 5.2-1 (a) and Section 5.2-4 with vacancies filled in the manner Section for in Section 5.2-5.
- will serve the term set forth in Section 5.2-3.

(8) The CEO, Vice President of Physician Services, Vice President of Ancillary Services, Chief Nursing Officer, Chief Medical Officers for Bucyrus, Galion, and Ontario, and Director of Medical Staff Services who shall serve as *Ex Officio* members without vote.

(b) The majority of voting members on the MEC shall be Physicians appointed to the active Medical Staff category with Privileges at the Hospital. In the event the membership of the MEC does not result in such a majority, the Chief of Staff may appoint Physicians who satisfy the aforementioned

qualifications as at-large members of the MEC in order to achieve such a majority.

(c) Guests may be invited to attend MEC meetings (or a portion of such meetings) as deemed necessary and appropriate by the MEC members.

5.3-2 DUTIES

(a) The duties of the MEC shall include, but not be limited to:

(1) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

(2) Coordinating and implementing the professional, clinical, and organizational activities and Policies of the Medical Staff.

(3) Receiving and acting upon reports and recommendations from Medical Staff Departments/Sections, committees, and assigned activity groups.

(4) Recommending action to the Board on Medical Staff matters including, but not limited to: the Medical Staff's structure; the process used to review credentials and delineate Privileges; the Delineation of Privileges (*i.e.,* Privilege set) for each Practitioner/APP privileged through the Medical Staff; Medical Staff appointment/reappointment; information received from Medical Staff committees and Departments/Sections; the organization of Medical Staff quality assurance activities; the mechanism (*i.e.,* corrective action process) for limitation/restriction, suspension, or termination of Medical Staff appointment/Privileges; and, fair hearing procedures.

(5) Making recommendations to the Board concerning the effect of current and proposed exclusive contracts on the quality of care, as requested.

(6) Participating in the development of Health System/Hospital policies and the Hospital's planning process, as requested.

(7) Taking reasonable steps to promote professional conduct and competent clinical performance on the part of all Practitioners and APPs.

(8) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff.

(9) Designating such committees as necessary and appropriate to assist in carrying out the duties and responsibilities of the Medical Staff.

(10) Reporting to the Medical Staff at each regular Medical Staff meeting.

(11) Assisting in obtaining and maintaining Hospital accreditation.

(12) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster.

(13) Performing the following duties related to the Medical Staff governing documents:

- Conduct a triennial review of the Medical Staff Bylaws, Policies, and Rules & Regulations.
- Receive and evaluate suggestions for amendment of the Medical Staff Bylaws, Policies, and/or Rules & Regulations.
- Submit recommendations to the Medical Staff for changes to the Medical Staff Bylaws and/or Rules & Regulations, as necessary to reflect current Medical Staff practices, and comply with the applicable procedures set forth in Article XV for adopting and amending the Medical Staff Bylaws and Rules & Regulations.
- Adopt and amend Medical Staff Policies subject to Section 15.2.

(14) Performing the following credentialing duties:

- Obtain and consider reports from the Department Chairs/Section Chairs regarding Practitioners/APPs.
- Review the credentials (*i.e.,* qualifications) of Practitioners/APPs and make recommendations to the Board regarding, as applicable, Medical Staff appointments/reappointments and/or grants/regrants of Clinical Privileges.

(15) Performing the following quality related duties in conjunction with the Multidisciplinary Peer Review Committee (MPRC):

- Approve plans for maintaining quality patient care within the Hospital including, but not limited to, mechanisms to identify potential problems in patient care and address identified problems.
- Refer priority problems for assessment and action to appropriate Medical Staff or Hospital committees.
- Review the results of quality assurance activities throughout the Hospital.

- Coordinate Medical Staff quality assurance activities.

(16) Requesting evaluation of Practitioners and APPs in instances where there is doubt about the Practitioner's or APP's ability to competently perform the Privileges requested or granted.

5.3-3 MEETINGS

(a) The MEC shall meet as needed at the call of its chair, but at least ten (10) times per year, and shall maintain a record of its proceedings and actions.

5.4 MULTIDISCIPLINARY PEER REVIEW COMMITTEE

5.4-1 COMPOSITION, DUTIES, AND MEETING REQUIREMENTS

(a) The composition, duties, and meeting requirements with respect to the Medical Staff Multidisciplinary Peer Review Committee (MPRC) are set forth in the Medical Staff Peer Review Policy and MPRC Charter as such Medical Staff documents may be amended from time to time.

5.5 MEDICAL RECORDS/UTILIZATION REVIEW COMMITTEE

5.5-1 COMPOSITION

(a) The Medical Records/Utilization Review Committee shall consist of the following members:

(1) Voting: At least three (3) qualified eligible Practitioners appointed to the active Medical Staff category (one granted Privileges at Bucyrus; one granted Privileges at Galion; and one granted Privileges at Ontario) representing the Departments of Medicine and Surgery. At least two (2) of the voting committee members must be Physicians. One of the committee members shall act as chair.

(2) *Ex Officio* (non-voting): Hospital representatives from utilization review, case management, nursing services, medical records, and administration in addition to the individuals set forth in Section 5.2-1 (c).

(3) The committee composition shall align with the requirements set forth in the applicable Medicare utilization review condition of participation.

5.5-2 DUTIES

(a) The duties of the Medical Records/Utilization Review Committee shall include:

(1) Reviewing and evaluating a representative sample of medical records to determine whether they: properly describe the condition, diagnosis, and progress of the patient during hospitalization and at

the time of discharge; the care, treatment, and services provided; tests provided and the results thereof; identification of individuals responsible for orders given and care, treatment, and services rendered; and are sufficiently complete at all times to facilitate continuity of care and communication between individuals providing patient care services in the Hospital.

(2) Reviewing and making recommendations for policies related to medical records including completion, forms and formats, filing, indexing, storage, retention, destruction, availability, and methods of enforcement.

(3) Conducting utilization review studies designed to evaluate the appropriateness of admission to the Hospital, length of stay, discharge practices, use of medical and Hospital resources, and related factors which contribute to the effective utilization of services.

(4) Establishing a utilization review plan that shall be approved by the MEC.

(5) Performing such other duties as required by the applicable Medicare utilization review condition of participation.

(b) The Medical Records/Utilization Review Committee may delegate some or all of the aforementioned duties to designated/authorized agents who shall report back to the committee.

5.5-3 MEETINGS

(a) The Medical Records/Utilization Review Committee shall meet as needed at the call of its chair.

(b) It shall maintain a record of its proceedings and shall report its activities and recommendations to the MEC.

5.6 PHARMACY & THERAPEUTICS COMMITTEE

5.6-1 COMPOSITION

(a) The Pharmacy & Therapeutics Committee shall consist of the following members:

(1) Voting: At least three (3) qualified eligible Practitioners appointed to the active Medical Staff category (one granted Privileges at Bucyrus; one granted Privileges at Galion; and one granted Privileges at Ontario).

(2) *Ex Officio* (non-voting): Hospital representatives from pharmaceutical services, nursing services, quality management,

and administration including the individuals set forth in Section 5.2-1 (c).

5.6-2 DUTIES

(a) The duties of the Pharmacy & Therapeutics Committee shall include:

(1) Assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters related to drugs in the Hospital, including antibiotic usage.

(2) Advising the Medical Staff and Pharmacy on matters pertaining to the choice of available drugs.

(3) Making recommendations concerning drugs to be stocked on the nursing unit floors and by other Hospital services.

(4) Periodically developing and reviewing a formulary or drug list for use in the Hospital.

(5) Evaluating clinical data concerning new drugs or preparations requested for use in the Hospital.

(6) Establishing standards concerning the use and control of investigational drugs and/or research in the use of recognized drugs.

(7) Maintaining a record of all activities related to pharmacy and therapeutic functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.

(8) Reviewing untoward drug reactions and significant medication errors.

5.6-3 MEETINGS

(a) The Pharmacy & Therapeutics Committee shall meet as needed at the call of its chair.

(b) It shall maintain a record of its proceedings and shall report its activities and recommendations to the MEC.

5.7 **PRACTITIONER EFFECTIVENESS COMMITTEE**

5.7-1 COMPOSITION

(a) The Practitioner Effectiveness Committee (PEC) will be composed of the following members:

(1) Voting: The chair of the Department in which the Practitioner at issue has Privileges, the Chief of Staff, and the CEO. The Chief of Staff shall serve as the PEC chair.

(b) *Guests* (non-voting): Others may be invited by the Chief of Staff to attend a PEC meeting (or portion of such meeting) as necessary for the PEC to accomplish its assigned task.

5.7-2 DUTIES

(a) The PEC shall have such responsibilities as set forth in the Medical Staff Practitioner/APP Impairment Policy and Practitioner/APP Conduct Policy as such policies may be amended from time to time.

5.7-3 MEETINGS

(a) The PEC shall meet as needed at the call of its chair.

(b) It shall maintain a record of its proceedings and shall report its activities and recommendations to the MEC.

5.8 PEER REVIEW PRIVILEGE

5.8-1 Each Medical Staff committee provided for by the Medical Staff governing documents is hereby designated as a peer review committee as that term is defined in Ohio Revised Code Section 2305.25 *et seq*.

5.8-2 In carrying out his/her duties under the Medical Staff governing documents, whether as a committee member or chair, Medical Staff officer, Department Chair /Section Chair, or otherwise, each Practitioner shall be acting in his/her capacity as a peer review committee member and/or designated agent on behalf of a peer review committee.

5.8-3 Such peer review committees, their members, and designated agents may, from time to time and/or as provided in the Medical Staff governing documents, designate Hospital administrative personnel as their agent in carrying out such peer review duties.

ARTICLE VI

MEETINGS OF THE MEDICAL STAFF, DEPARTMENTS/SECTIONS, AND MEDICAL STAFF COMMITTEES

6.1 MEDICAL STAFF MEETINGS

6.1-1 ANNUAL MEETING

(a) The annual meeting of the Medical Staff shall be the last meeting before the end of the Medical Staff Year.

(b) Advance notice of the annual Medical Staff meeting shall be communicated, in writing, to all individuals entitled to attend such meetings in a manner determined appropriate by the MEC.

(c) Dispersal of funds may be made at this or any other meeting.

6.1-2 REGULAR MEETINGS

(a) Medical Staff meetings will be held no less than four (4) times per year.

(b) Advance notice of regular Medical Staff meetings shall be communicated, in writing, to all individuals entitled to attend such meetings in a manner determined appropriate by the MEC.

(c) The agenda for such meetings must include reports from the MEC, other Medical Staff committees, and from Departments/Sections as applicable.

(d) Attendance is required as provided under Section 6.5 of this Article.

6.1-3 SPECIAL MEETINGS

(a) Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Board, the CEO, the MEC, or upon the written request of one-fifth (1/5) of the Practitioners, in Good Standing, eligible to vote. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting.

(b) Written notice of a special Medical Staff meeting shall be posted on the bulletin board in both the Practitioners' lounge and mailroom, and e-mail notice shall be given to all individuals entitled to attend the meeting not less than twenty-four (24) hours before the special meeting or in accordance with such longer notice period as may be specified elsewhere in the Medical Staff governing documents.

6.1-4 AGENDA

(a) The agenda at any regular Medical Staff meeting shall be:

(1) Call to order

(2) Acceptance of the minutes of the last regular and any special Medical Staff meetings

(3) Unfinished business

(4) Administration report

(5) New business

(6) Medical Staff reports (*e.g.,* utilization review and quality assurance/performance improvement reports; Department/Section reports; reports of standing and special Medical Staff committees, *etc.*).

(7) Adjournment

(b) The agenda at special Medical Staff meetings shall be:

(1) Reading of the notice calling the meeting

(2) Transaction of the business for which the meeting was called

(3) Adjournment

6.2 DEPARTMENT & SECTION MEETINGS

6.2-1 REGULAR MEETINGS

(a) Each Medical Staff Department and Section shall establish a regular meeting schedule as determined by the applicable Department Chair or Section Chair.

(b) Advance notice of Medical Staff Department and Section meetings shall be communicated, in writing, to all individuals entitled to attend such meetings in a manner determined appropriate by the Department Chair or Section Chair.

(c) A Department Chair may attend meetings of any Section within his/her Department, in an *Ex Officio* capacity (without vote), unless the Department Chair otherwise holds Privileges in the Section and is entitled to vote.

(d) The Hospital CEO and Chief of Staff shall be notified of all Medical Staff Department and Section meetings and may attend such meetings at their discretion in an *Ex Officio* capacity (without vote) unless the Chief of Staff otherwise holds Privileges in the Department or Section and is entitled to vote.

(e) APPs with Privileges at the Hospital (*e.g.,* Physician Assistants and Advanced Practice Registered Nurses) are allowed to attend and participate in meetings of the Department/Section to which they are assigned without vote.

6.2-2 SPECIAL MEETINGS

(a) The applicable Department Chair or Section Chair, the Chief of Staff, or the MEC shall have the authority to call a special meeting of a Department or Section at any time.

(b) Written notice of a special Department or Section meeting shall be posted on the bulletin board in both the Practitioners' lounge and mailroom, and e-mail notice shall be given to all individuals entitled to attend the meeting not less than twenty-four (24) hours before the special meeting or in accordance with such longer notice period as may be specified elsewhere in the Medical Staff governing documents.

6.3 MEDICAL STAFF COMMITTEE MEETINGS

6.3-1 REGULAR MEETINGS

(a) Each Medical Staff committee shall establish a regular meeting schedule as determined by the applicable committee chair.

(b) Advance notice of Medical Staff committee meetings shall be communicated, in writing, to all individuals entitled to attend such meetings in a manner determined appropriate by the committee chair.

(c) The Hospital CEO and Chief of Staff shall be notified of all Medical Staff meetings and may attend such meetings at their discretion in an *Ex Officio* capacity (without vote) unless otherwise designated as a voting member of the committee.

6.3-2 SPECIAL MEETINGS

(a) The applicable committee chair, the Chief of Staff, or the MEC shall have the authority to call a special meeting of a Medical Staff committee at any time.

(b) Written notice of a special Medical Staff committee meeting shall be posted on the bulletin board in both the Practitioners' lounge and mailroom, and e-mail notice shall be given to all individuals entitled to attend the meeting not less than twenty-four (24) hours before the special meeting or in accordance with such longer notice period as may be specified elsewhere in the Medical Staff governing documents.

6.4 QUORUM

6.4-1 MEDICAL STAFF MEETINGS

(a) At least three (3) Practitioners, in Good Standing, eligible to vote and present at a regular or special Medical Staff meeting shall constitute a quorum.

6.4-2 DEPARTMENT & SECTION MEETINGS

(a) At least three (3) voting members of the applicable Medical Staff Department, in Good Standing, present at the applicable Department meeting shall constitute a quorum.

(b) At least three (3) voting members of the applicable Medical Staff Section, in Good Standing, present at the applicable Section meeting shall constitute a quorum.

6.4-3 MEDICAL STAFF COMMITTEE MEETINGS

(a) With the exceptions noted below, at least three (3) voting Practitioner members of the applicable Medical Staff committee, in Good Standing, present at the applicable meeting shall constitute a quorum.

(1) At least five (5) voting Practitioner members of the Medical Executive Committee, in Good Standing, present at the MEC meeting shall constitute a quorum.

(2) A quorum for purposes of the MPRC is set forth in the MPRC Charter as such Charter may be amended from time to time.

6.5 ATTENDANCE REQUIREMENTS

6.5-1 Unless otherwise provided in the Medical Staff Bylaws or Policies:

(a) Attendance at Medical Staff and Department/Section meetings is voluntary. Medical Staff Appointees are encouraged to attend and participate in meetings and will receive a 50% reduction in their dues by attending at least fifty percent (50%) of the Medical Staff meetings and those Department and Section meetings of which he/she is a member during a calendar year.

(1) Medical Staff officers must attend at least fifty percent (50%) of the Medical Staff meetings each calendar year.

(2) Department Chairs and Section Chairs must attend at least fifty percent (50%) of their Department/Section meetings each calendar year.

(b) Medical Staff committee members and chairs (other than the MEC and the MPRC) must attend at least fifty percent (50%) of the Medical Staff committee meetings of which he/she is a member each calendar year.

(1) Voting members of the MEC must attend at least seventy-five (75%) of the MEC meetings each calendar year unless otherwise excused by the Chief of Staff as chair of the MEC.

(2) Attendance requirements with respect to the MPRC are set forth in the MPRC Charter as such Charter may be amended from time to time.

6.6 MINUTES

6.6-1 Minutes of all Medical Staff, Department, Section, and Medical Staff committee meetings shall be prepared and shall include a record of attendance, documentation of agenda items, and the actions taken. The minutes shall be approved by the voting members of the Medical Staff, Department, Section, or Medical Staff committee, as applicable.

6.6-2 The minutes of each Medical Staff, Department, Section, and Medical Staff committee meeting shall be kept in Medical Staff Services subject to the Hospital's record retention policy.

6.6-3 Documentation of peer review activities shall be kept separately in a peer review committee's meeting minutes and materials. Such peer review committee minutes and materials are designated and maintained as protected peer review documents.

6.7 MANNER OF ACTION AT A MEETING

6.7-1 Unless otherwise provided in the Medical Staff Bylaws or Policies:

(a) The action of a majority of the Medical Staff Appointees present and eligible to vote at a Medical Staff meeting at which a quorum is present is the action of the Medical Staff.

(b) The action of a majority of the members present and eligible to vote at a Department, Section, or Medical Staff committee meeting at which a quorum is present is the action of that Department, Section, or Medical Staff committee.

(c) Individuals may participate in and act at any meeting in person, by conference call, video conference, or other telecommunication equipment through which all persons participating in the meeting can communicate with each other in real-time. Participation by such means shall constitute attendance at the meeting.

6.7-2 Common sense, as determined by the Chief of Staff, Department Chair/Section Chair, or chair of a Medical Staff committee, as applicable, shall be applied in the conduct of meetings. To the extent there is a disagreement as to procedure, the latest edition of Robert's Rules of Order may be consulted for guidance.

6.8 MANNER OF ACTION WITHOUT A MEETING

6.8-1 Unless otherwise provided in the Medical Staff Bylaws or Policies:

(a) Action may be taken without a meeting by the Medical Staff, a Department, Section, or Medical Staff committee upon presentation of the issue, by written or electronic ballot, to each member eligible to vote thereon.

(b) Ballots shall be distributed to each individual eligible to vote on the matter at issue in such manner as determined appropriate by the Chief of Staff

(with respect to the Medical Staff), by the applicable Department Chair or Section Chair (with respect to a Medical Staff Department or Section) or by the applicable chair (with respect to a Medical Staff committee).

(c) Ballots must be returned by the specified deadline according to the instructions that accompany the ballot. Ballots received after the stipulated deadline shall not be counted.

(d) A majority of the total ballots returned by the specified deadline shall be the action of the Medical Staff, Department, Section, or Medical Staff committee, as applicable.

6.8-2 Notwithstanding the above, the MEC may not make recommendations on applications for Medical Staff appointment or reappointment and/or grant or regrant Privileges without holding a MEC meeting. Further, a recommendation by the MEC with respect to a summary suspension or formal corrective action investigation cannot be made by the MEC without a meeting.

6.9 VOTING OPTIONS

6.9-1 Unless otherwise specified in the Medical Staff Bylaws or Policies, voting may occur in any of the following ways as determined by the chair of the respective Medical Staff Department, Section, or committee; or, for voting by the Medical Staff, as determined by the Chief of Staff:

(a) By hand, voice, or written ballot at a meeting at which a quorum is present.

(b) Without a meeting by written or electronic (e-mail) ballot provided such votes are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

ARTICLE VII

MEDICAL STAFF CATEGORIES

7.1 DESIGNATION

7.1-1 The Medical Staff shall be divided into the following appointment categories: active with Privileges, active without Privileges, courtesy, and honorary.

7.1-2 Appointees with Privileges are responsible for their individual patients and must provide coverage for their patients when not available to provide patient care services.

7.2 ACTIVE MEDICAL STAFF CATEGORY WITH PRIVILEGES

7.2-1 QUALIFICATIONS. To qualify for appointment to the active Medical Staff category with Privileges, a Practitioner must:

(a) Meet the basic qualifications set forth in Section 9.2 for Medical Staff appointment and Privileges.

(b) Have regular Patient Encounters at the Hospital and participate in the transaction of Medical Staff affairs. If a Practitioner fails to have regular Patient Encounters at the Hospital during an appointment/Privilege period, the Practitioner will be transferred to another Medical Staff category for which he is eligible in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur in the next appointment/Privilege period.

7.2-2 PREROGATIVES. Practitioners appointed to the active Medical Staff category with Privileges may:

(a) Exercise the Privileges granted pursuant to the applicable Delineation of Privileges.

(b) Attend meetings of the Medical Staff; vote on Medical Staff matters.

(c) Attend Medical Staff educational activities.

(d) Attend meetings of the Department/Section of which he/she is a member; vote on Department/Section matters.

(e) Attend meetings of the Medical Staff committees of which he/she is a member; vote on committee matters.

(f) Hold Medical Staff office subject to satisfaction of the applicable qualifications.

(g) Serve as a Department Chair or Section Chair subject to satisfaction of the applicable qualifications.

(h) Chair a Medical Staff committee subject to satisfaction of the applicable qualifications.

7.2-3 OBLIGATIONS. Practitioners appointed to the active Medical Staff category with Privileges shall:

(a) Continuously meet the obligations set forth in Section 9.3.

(b) Provide quality patient care services that meet the professional standards established by the Medical Staff and Board.

(c) Provide continuous health care to their patients including making arrangements with other Appointees with comparable Privileges for coverage when the Practitioner will not be available.

(d) Fulfill the responsibilities of appointment to the active Medical Staff category including participation in Emergency Department on-call coverage and consultation assignments as are appropriate to the individual Practitioner's specialty and in accordance with applicable policy.

(e) Agree to accept Medical Staff committee appointments.

(f) Attend Medical Staff meetings and those Medical Staff Department, Section, and committee meetings of which he/she is a member.

(g) Timely pay annual Medical Staff dues.

7.3 ACTIVE MEDICAL STAFF WITHOUT PRIVILEGES

7.3-1 QUALIFICATIONS. To qualify for appointment to the active Medical Staff category without Privileges, a Practitioner must:

(a) Satisfy the qualifications set forth in Section 9.2, to the extent applicable, as recommended by the MEC and approved by the Board.

(b) Not have Privileges at the Hospital but provide primary care services to patients in the community the Hospital serves (*i.e.,* 75% of the patients served are from the Hospital's service area).

(c) Participate in the transaction of Medical Staff affairs as demonstrated by attendance at a minimum of fifty percent (50%) of the Medical Staff meetings and Medical Staff Department, Section, and committee meetings of which the Practitioner is a member; or, otherwise prove to the satisfaction of the MEC and Board that they are or will be significantly involved in Medical Staff organizational and administrative functions during the course of their appointment period.

7.3-2 PREROGATIVES. Practitioners appointed to the active Medical Staff category without Privileges may:

(a) Not be granted Privileges.

(b) Attend meetings of the Medical Staff; vote on Medical Staff matters.

(c) Attend Medical Staff educational activities.

(d) Attend meetings of the Department/Section to which he/she is assigned; vote on Department/Section matters.

(e) Attend meetings of the Medical Staff committees of which he/she is a member; vote on committee matters.

(f) Not hold Medical Staff office.

(g) Not serve as a Department Chair or Section Chair.

(h) Chair a Medical Staff committee subject to satisfaction of the applicable qualifications.

(i) Visit their hospitalized patients and review their patients' Hospital medical records (subject to patient consent and applicable Hospital patient privacy/confidentiality policies) but may not admit patients, attend patients, write orders, progress notes, make other notations in the medical record, or participate in the provision or management of care, treatment, and/or services to patients at the Hospital.

7.3-3 OBLIGATIONS. Practitioners appointed to the active Medical Staff category without Privileges shall:

(a) Fulfill the obligations set forth in Section 9.3, to the extent applicable, as recommended by the MEC and approved by the Board.

(b) Agree to accept Medical Staff committee appointments.

(c) Attend Medical Staff meetings and those Medical Staff Department, Section, and committee meetings of which he/she is a member.

(d) Timely pay annual Medical Staff dues.

7.4 COURTESY MEDICAL STAFF

7.4-1 QUALIFICATIONS. To qualify for appointment to the courtesy Medical Staff category, a Practitioner must:

(a) Meet the basic qualifications set forth in Section 9.2 for Medical Staff appointment and Privileges.

(b) Primarily practice at another Ohio Accredited Hospital although exceptions to this requirement may be made by the MEC and Board for good cause shown. This qualification is not applicable to (c)(4) below.

(c) Satisfy one (1) of the following criteria:

(1) Have periodic Patient Encounters in the Hospital; **OR,**

- If a Practitioner appointed to the courtesy Medical Staff category fails to have periodic Patient Encounters during an appointment/Privilege period and does not otherwise satisfy one of the other criteria for appointment to the courtesy Medical Staff category, the Practitioner will be transferred to another Medical Staff category for which he/she is eligible, if any, or terminated from the Medical Staff without any procedural due process rights under the Fair Hearing Policy in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur in the next appointment/Privilege period.

- If a Practitioner appointed to the courtesy Medical Staff category has regular Patient Encounters in the Hospital during an appointment/Privilege period and does not otherwise satisfy one of the other criteria for appointment to the courtesy Medical Staff, the Practitioner will be transferred to the active Medical Staff category with Privileges in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur in the next appointment/Privilege period.

(2) Are requesting appointment and Privileges for the sole purpose of providing back-up coverage for another Practitioner on the Medical Staff; **OR,**

(3) Are requesting appointment and Privileges for the sole purpose of providing specialty/consulting services in a specialty area in which there is a need at the Hospital; **OR,**

(4) Are employed by or contracted with a group under contract with the Hospital to provide anesthesia, emergency medicine, radiology, pathology, or hospitalist services at the Hospital on a full- or part-time basis. Each such contracted group will be permitted to designate one (1) Practitioner for appointment to the active Medical Staff category with Privileges.

7.4-2 PREROGATIVES. Practitioners appointed to the courtesy Medical Staff category may:

(a) Exercise the Privileges granted pursuant to the applicable Delineation of Privileges.

(b) Attend Medical Staff meetings but shall not be eligible to vote on Medical Staff matters or hold elected Medical Staff office.

(c) Attend meetings of the Department/Section to which he/she is assigned but shall not be entitled to vote on Department/Section matters or to serve as a Department Chair or Section Chair.

(d) May not serve as a committee member or chair.

7.4-3 OBLIGATIONS. Practitioners appointed to the courtesy Medical Staff category shall:

(a) Continuously meet the obligations set forth in Section 9.3.

(b) Not be assigned to the Emergency Department on-call rotation with the exception of:

(1) Practitioners appointed to the courtesy Medical Staff category who are employed by or contracted with a group under contract with the Hospital to provide professional medical services at the Hospital on a full or part-time basis which includes Emergency Department on-call coverage (*e.g.,* radiology, *etc.*).

(2) Practitioners appointed to the courtesy Medical Staff category who are covering for Practitioners appointed to the active Medical Staff category with Privileges who are out of town or otherwise unavailable to treat patients. The courtesy Appointee shall fulfill any ED on-call responsibilities of the active Appointee with Privileges for whom the courtesy Appointee is covering.

(c) Timely pay annual Medical Staff dues.

7.5 HONORARY MEDICAL STAFF

7.5-1 QUALIFICATIONS. To qualify for appointment to the honorary Medical Staff category without Privileges, a Practitioner must have retired from active Hospital practice. Practitioners appointed to the honorary Medical Staff category do not need to reside in the community the Hospital serves.

7.5-2 PREROGATIVES. Practitioners appointed to the honorary Medical Staff category without Privileges may:

(a) Not be granted Privileges at the Hospital.

(b) Not vote on Medical Staff or Department/Section matters.

(c) Not hold elected Medical Staff office or serve as a Department Chair or Section Chair.

(d) May not serve as a member or chair of a Medical Staff committee.

7.5-3 OBLIGATIONS. Practitioners appointed to the honorary Medical Staff category without Privileges shall:

(a) Have no Medical Staff obligations.

(b) Not be required to pay Medical Staff dues.

ARTICLE VIII

ADVANCED PRACTICE PROVIDERS

8.1 ADVANCED PRACTICE PROVIDERS

8.1-1 APPs requesting/granted Privileges at the Hospital shall be subject to the APP Policy and to those provisions of other Medical Staff Policies, the Medical Staff Rules & Regulations, and Health System/Hospital policies and procedures as are applicable to APP practice.

ARTICLE IX

APPOINTMENT, REAPPOINTMENT, AND PRIVILEGING

9.1 NATURE OF APPOINTMENT/PRIVILEGES

9.1-1 Appointment to the Medical Staff is separate and distinct from a grant of Privileges.

(a) A Practitioner can be a Medical Staff Appointee with Privileges, a Medical Staff Appointee without Privileges, or be granted Privileges without a Medical Staff appointment.

(b) A Practitioner who is granted appointment to the Medical Staff is entitled to such Prerogatives and is responsible for fulfilling such obligations as set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed.

(c) Appointment to the Medical Staff shall confer on the Appointee only such Clinical Privileges, if any, as have been granted by the Board.

9.1-2 A Practitioner who is granted Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Delineation of Privileges (*i.e.,* Privilege set).

(a) No Practitioner, including those employed by or contracted with the Hospital may admit or provide care, treatment, or services to patients in the Hospital unless he/she has been granted Privileges to do so in accordance with the procedures set forth in the Bylaws.

9.2 QUALIFICATIONS

9.2-1 Appointment to the Medical Staff and/or the granting of Clinical Privileges shall be extended only to Practitioners who demonstrate that they meet the qualifications for Medical Staff appointment and/or Privileges.

9.2-2 Unless otherwise specified in the Medical Staff Bylaws, every Applicant who applies for Medical Staff appointment and/or Privileges must, at the time of application and initial appointment/privileging and continuously thereafter, at all times during which the Practitioner holds Medical Staff appointment and/or Privileges at the Hospital, demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets the following qualifications, as applicable:

(a) <u>Baseline Qualifications</u>

(1) Hold a current, valid certificate/license issued by the State of Ohio to practice medicine, dentistry, podiatry, psychology, or optometry and meet the continuing education requirements for licensure as determined by the applicable state licensure board.

(2) Hold, if required for the Privileges requested, a current, valid Drug Enforcement Administration ("DEA") registration.

(3) Satisfy the education and training criteria required by the applicable state entity for Ohio licensure and such additional education and training, if any, as set forth in the applicable Delineation of Privileges.

(4) A Physician applicant must either provide documentation of:

- Satisfactory completion of a medical residency, accredited by the Accreditation Council for Graduate Medical Education, in the specialty in which the Physician seeks Privileges at the Hospital.

OR

- Have attained board certification by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association if required for the Clinical Privileges requested; provided, however, that maintenance of such board certification shall not be required.

(5) Be able to read and understand the English language, to communicate (both verbally and in writing) effectively and intelligibly in English, and to prepare medical record entries and other required documentation in a legible and professional manner.

(6) Have and maintain current, valid Professional Liability Insurance.

(7) Be able to participate in Federal Healthcare Programs.

(b) Additional Qualifications

(1) Obtain and maintain a provider number for Medicare issued by the United States Department of Health & Human Services and a provider number for Medicaid issued by the Ohio Department of Medicaid and be a Medicare and Medicaid participating provider.

(2) Document and demonstrate an ongoing ability to provide patient care, treatment, and services at an acceptable level of quality and efficiency consistent with applicable standards of practice and available resources including current experience, clinical judgement/results, and utilization practice patterns.

(3) Document and demonstrate the ability to work/interact with others in a cooperative, professional manner.

(4) Document and demonstrate adherence to the ethics of his or her respective profession.

(5) As a precondition to the exercise of Privileges, a Practitioner must designate another Practitioner with comparable Privileges at the

Hospital who has agreed to provide back-up coverage for the Practitioner's patients in the event the Practitioner is not available. Exceptions may be considered on a case-by-case basis, for good cause, by the Medical Executive Committee and Board.

(6) Agree to fulfill, and fulfill, the obligations of Medical Staff appointment and/or Privileges as set forth in these Bylaws.

(7) Document and demonstrate an ability to exercise the Privileges requested safely and competently with or without a reasonable accommodation.

(8) Comply with Medical Staff requirements (if any) regarding criminal background checks.

(9) Satisfy such other qualifications set forth in the Medical Staff category and/or Delineation of Privileges, as applicable.

9.3 OBLIGATIONS OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

9.3-1 Unless otherwise specified in these Bylaws, each Practitioner granted Medical Staff appointment and/or Privileges at the Hospital must, as applicable to the appointment and/or Privileges granted to each such Practitioner:

(a) Provide (or otherwise arrange for) continuous care and supervision of his or her patients.

(b) Provide his/her patients with professional services consistent with recognized standards of practice in the same or similar communities and the resources locally available.

(c) Abide by the ethical principles of his or her profession.

(d) Discharge such Medical Staff, Department/Section, committee, and Hospital functions for which he or she is responsible.

(e) Accept consultation requests and ED assignments if required by the Medical Staff category to which the Practitioner is appointed.

(f) Work cooperatively with others and not engage in unprofessional conduct, as defined in the Practitioner/APP Conduct Policy.

(g) Cooperate with and serve on Medical Staff/Hospital committees as requested.

(h) Immediately notify Medical Staff Services, during the application process and at all times during which the Practitioner has Medical Staff appointment and/or Privileges at the Hospital, of any changes with respect to the information provided in his/her application including, but not limited to, terminations, suspensions, or any type of restriction or limitation on

appointment/clinical privileges held at other hospitals and healthcare facilities.

(i) Complete medical records in the manner and time period required by the Hospital for all patients he/she admits or otherwise provides care, treatment, and/or services for at the Hospital.

(j) Abide by the terms of the Hospital's Corporate Responsibility Program and Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

(k) Exercise the Prerogatives and satisfy the obligations of the Medical Staff category to which he/she is appointed.

(l) Cooperate and participate, as requested by the Medical Staff, in quality assurance, utilization review, performance improvement, and peer review activities whether related to oneself or others.

(m) Cooperate in review of a Practitioner's (including his/her own) credentials/ qualifications, conduct, clinical competence, or compliance with the Medical Staff Bylaws, Policies, or Rules & Regulations; and refrain from directly or indirectly interfering, obstructing, or hindering any such review whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities, or otherwise.

(n) Comply with the requirements set forth in applicable conflict of interest policies, if any.

(o) Comply with the Medical Staff Bylaws, Policies, Rules & Regulations, the Health System's/Hospital's governing documents, applicable Health System/Hospital policies and procedures, and applicable accreditation standards, laws, rules, and regulations.

9.3-2 Failure to satisfy any of the aforementioned obligations may be grounds, as warranted by the circumstances, for denial of Medical Staff reappointment and/or regrant of Privileges or corrective action pursuant to these Bylaws.

9.4 NON-DISCRIMINATION

Medical Staff appointment and/or Clinical Privileges shall not be denied on the basis of race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the applicant can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; ability to pay, or any other characteristic(s) or class protected by applicable law.

9.5 EFFECT OF OTHER AFFILIATIONS

9.5-1 No Physician, Dentist, Podiatrist, Psychologist, or Optometrist shall be entitled to appointment to the Medical Staff and/or Clinical Privileges at the Hospital merely

by virtue of the fact that he or she holds a certain degree; is duly licensed to practice in this or any other State; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, an appointment and/or privileges at this or another hospital; or is employed by or contracts with the Hospital.

9.6 DURATION OF APPOINTMENT/PRIVILEGES

9.6-1 Unless otherwise provided in the Bylaws:

(a) Granting of appointment, reappointment, and Privileges/regrant of Privileges shall be for a period of not more than two (2) years.

(b) An appointment, reappointment, or grant/regrant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of these Bylaws or the Fair Hearing Policy.

9.7 APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

9.7-1 APPLICATION FORMS

(a) Each Applicant will be apprised of the appointment/privileging process upon request for an application for Medical Staff appointment and/or Privileges.

(b) All applications for appointment to the Medical Staff and/or Clinical Privileges shall be in writing, shall be signed by the Applicant, and shall be submitted on a form prescribed by the Hospital.

9.7-2 CONTENT OF APPLICATION

(a) Unless otherwise provided in these Bylaws, the application shall include, but is not limited to, the following:

(1) Qualifications. Detailed information concerning the Applicant's education, background, training, experience, professional competence, reputation, ability to work cooperatively with others, adherence to the ethics of the Applicant's respective profession; and any additional qualifications set forth in Section 9.2.2 and as otherwise specified in these Bylaws for the particular Medical Staff category to which the Applicant requests appointment. In assessing an Applicant's experience, ability, and current competence, consideration will be given to the following six (6) areas of general competencies:

- Patient care
- Medical/clinical knowledge

- Practice-based learning and improvement (use of scientific evidence and methods to investigate, evaluate, and improve patient care)
- Interpersonal and communication skills
- Professionalism
- Systems-based practice (understanding of the contexts and systems in which health care is provided)

(b) References

(1) The names of at least three (3) individuals (two (2) of the three (3) must be peers of the Applicant) who have worked with the Applicant (*i.e.,* observed the Applicant's performance) within the last five (5) years and who can provide adequate references pertaining to the Applicant's current professional conduct, clinical competence, ability to work cooperatively with others, and ethical character.

(2) Such references shall preferably not come from the Applicant's partners nor may these references come from the Applicant's family members or house staff at any institution.

(3) The Hospital will contact the Applicant's peers to inquire about the following information regarding the Applicant: medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. Peer recommendations may be in the form of written documentation reflecting informed opinions on the Applicant's scope and level of performance or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.

(c) Request. A request stating the Medical Staff category and/or the Clinical Privileges for which the Applicant wishes to be considered.

(d) Licensure. Evidence of current, valid licensure in Ohio and, if applicable, in other states, confirmed with the respective state licensing boards, and the Applicant's attestation of satisfaction of the continuing medical or other professional education requirements for licensure as determined by the applicable state licensure board. In addition, the Applicant shall hold, if required for the Privileges requested, a current, valid Drug Enforcement Administration ("DEA") registration.

(e) Education. Documentation in satisfaction of the educational and training requirements set forth in Section 9.2.2 (a)(3).

(f) Completion of Residency **OR** Board Certification (Physician Applicants)

(1) Documentation of successful completion of a residency program in accordance with the requirements set forth in Section 9.2.2 (a)(4);

OR

(2) Documentation of satisfaction of the board certification requirements set forth in Section 9.2.2 (a)(4).

(g) Professional Sanctions. Information as to whether any of the following have ever been or are in the process of being denied, revoked, terminated, suspended, reduced, limited, modified, not renewed, placed on probation, monitored, or voluntarily relinquished while under investigation or to avoid investigation for conduct or clinical competency concerns:

(1) Medical Staff appointment or clinical privileges at another hospital or other health care institution.

(2) Membership in local, state, or national professional societies.

(3) Specialty board certification/prior board certification.

(4) License to practice any profession in any jurisdiction.

(5) DEA registration.

(6) Faculty appointment at any professional school.

(7) Professional Liability Insurance.

(8) Participation in any Federal Healthcare Program.

If any such actions ever occurred or are pending, the particulars thereof shall be included.

(h) Regulatory Actions. Information as to whether the Applicant has been sanctioned by, precluded, excluded from participation in, or the subject of investigation by a Federal Healthcare Program.

(i) Professional Liability

(1) Evidence of current Professional Liability Insurance coverage, with coverage and limits of liability to be in accordance with that stipulated by the Board from time to time, as well as information on the Applicant's malpractice claims history and experience during the past five (5) years including a consent to the release of information by the Applicant's present and any past malpractice insurance carrier(s). Applicants will be notified of the Professional Liability Insurance coverage requirements.

(2) The Professional Liability Insurance coverage obtained by Practitioners must be coverage acceptable to the Board, as the Board may determine from time to time, from an insurance

company licensed in the United States or a company who has an underwriting agreement with a licensed United States insurance company to assure adequate reserves for payment of claims for all periods of time that the Practitioner has Privileges at the Hospital. In addition, in the event a Practitioner changes insurance companies at any time during which the Practitioner holds Medical Staff appointment and/or Privileges at the Hospital, the Practitioner is obligated to obtain and provide proof to Medical Staff Services of acceptable Professional Liability Insurance coverage for all periods of time when Privileges were held/exercised by the Practitioner at the Hospital.

(j) Ability to Exercise Privileges. Statement and evidence that the Applicant is capable of safely and competently performing the Clinical Privileges requested with or without a reasonable accommodation.

(k) Legal Actions. An explanation of all past and current civil and criminal actions/lawsuits in which the Applicant is/has been a party including the status or resolution of each such action/lawsuit and an explanation of any criminal charges (other than minor traffic violations) of which the Applicant was found guilty or to which the Applicant pled guilty or no contest.

(l) Experience/Current and Previous Affiliations. The names and addresses of any other health care organizations or practice settings where the Applicant currently provides or previously provided clinical services.

(m) Photo Identification. Photo identification to permit the Hospital to ensure that the Practitioner requesting appointment and/or Privileges is the same Practitioner identified in the credentialing documents (such as a current hospital identification card or a driver's license or passport). The Applicant's photo will be retained in Medical Staff Services and will not be circulated to relevant parties until after the application for appointment and/or Privileges is processed.

(n) Morbidity/Mortality Data. Morbidity and mortality data related to the Applicant's care of patients, if such information is available.

(o) Conflict of Interest. Documentation of compliance with applicable conflict of interest policies, if any.

(p) Acknowledgments and Agreements. Acknowledgment of, and agreement with, the information set forth in Section 9.8.3

(q) Other. Such other information as the Board may require from time to time.

(r) Signature. The Applicant's dated signature.

9.7-3 NECESSARY RESOURCES

(a) Applications for Medical Staff appointment and/or Privileges must be compatible with the policies, plans, and objectives formulated by the Board

concerning: the Hospital's patient care needs; the Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved; and, the Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner or group of Practitioners other than the Applicant. To the extent an Applicant believes he/she may require resources, equipment, and/or personnel beyond that normally offered by the Hospital to Practitioners with similar appointment and/or Privileges, the Applicant is responsible for indicating such requests on his/her application.

9.7-4 APPOINTMENT WITHOUT PRIVILEGES

(a) Practitioners appointed to Medical Staff categories without Privileges shall meet such qualifications and fulfill such obligations as set forth in the applicable Medical Staff category and as otherwise recommended by the MEC and approved by the Board.

(b) Practitioners requesting appointment or reappointment to the active Medical Staff category without Privileges shall satisfy the qualifications set forth in Section 9.2-2 (a)(1) and (a)(7) and in Section 9.2-2 (b)(3), (b)(4), (b)(6),as applicable, (b)(8), and (b)(9), with respect to the Medical Staff category.

9.8 EFFECT OF APPLICATION

9.8-1 The Applicant will be given an opportunity to go through the qualifications and other requirements for appointment/Privileges with a Hospital representative either in person, by telephone, or in writing.

9.8-2 A separate credentials file shall be maintained by the Hospital for each Practitioner who requests appointment and/or Clinical Privileges.

9.8-3 By applying for appointment to the Medical Staff and/or Privileges, each Applicant:

(a) Acknowledges and attests that the application is correct and complete and that any material misstatement or omission is grounds for denial/termination of appointment and/or Privileges.

(b) Signifies his or her willingness to appear for interviews in regard to the application.

(c) Understands and agrees that if Medical Staff appointment and/or Privileges are denied based upon the Applicant's conduct or competence, the Applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(d) Acknowledges and accepts the scope and extent of the provisions in Article 13 which relate to authorization to obtain and release information, confidentiality of information, immunity for reviews and actions taken, and release of liability.

(e) Acknowledges and agrees that when an Adverse ruling is made with respect to his or her Medical Staff appointment and/or Clinical Privileges, the Applicant will exhaust the administrative remedies afforded by these Bylaws and the Fair Hearing Policy before resorting to formal legal action.

(f) Agrees to fulfill the obligations of Medical Staff appointment/Privileges as set forth in Section 9.3.1 and such other responsibilities as set forth in the applicable Medical Staff category and/or Privilege set.

(g) Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as he/she is an Appointee to the Medical Staff and/or has Privileges at the Hospital.

(h) Confirms that he/she has received or has access to the Medical Staff Bylaws, Policies, and Rules & Regulations; has had an opportunity to read the Bylaws, Policies, and Rules & Regulations; and agrees to be bound by, and to comply with, the terms thereof if the Applicant is granted Medical Staff appointment and/or Privileges and in all matters related to consideration of the Applicant's application without regard to whether or not the Applicant is granted appointment and/or Privileges.

9.9 CREDENTIALING, MEDICAL STAFF APPOINTMENT, AND PRIVILEGING PROCESS

The following procedure shall be followed for processing applications for Medical Staff appointment and/or Privileges unless otherwise provided in the Medical Staff Bylaws.

9.9-1 COLLECTION AND VERIFICATION

(a) The application shall be submitted to Medical Staff Services for credentialing. Medical Staff Services shall be responsible for collecting and verifying all required information regarding the Applicant and for promptly notifying the Applicant of any problems in obtaining required information. The Applicant must obtain and furnish the information upon such notification. If the Applicant fails to furnish the information within ninety (90) days of written request therefore, the application may be deemed to have been voluntarily withdrawn, without right to a hearing or appellate review, and the Applicant shall be so informed.

(b) Medical Staff Services shall perform primary source verification of the Applicant's credentials and query the National Practitioner Data Bank. Medical Staff Services shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been convicted of a health care related offense, or debarred, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

(c) The Applicant shall have the burden of producing adequate information and documentation for a proper evaluation of his or her qualifications and

for resolving any doubts about such qualifications or any other concerns that the Hospital may have.

(d) Action on the application shall be withheld until all requested information has been received and verified as applicable.

(e) At such time as all requested information has been received and verified, as needed and from primary sources whenever possible, the application shall be deemed complete. Medical Staff Services shall notify the chair of the Department in which the Applicant has requested Privileges that the application and accompanying materials are available for review.

9.9-2 DEPARTMENT CHAIR REVIEW

(a) The chair of the Department in which the Applicant has requested Privileges shall review the application and accompanying materials and may conduct a personal interview with the Applicant at his/her discretion. Review by the appropriate Section Chair may also be solicited.

(b) The Department Chair shall thereafter transmit to the Medical Executive Committee the Department Chair's recommendation as to approval or denial of Medical Staff appointment and/or Privileges and any special conditions thereon.

9.9-3 ACTION BY MEC

(a) At the next regular meeting after receipt of the Department Chair's recommendation, the MEC shall review the application and accompanying materials and make a written recommendation (which may be reflected in the MEC's meeting minutes) to the Board as to whether the Applicant meets all the necessary qualifications for appointment to the Medical Staff category and/or Clinical Privileges requested by the Applicant.

(b) All recommendations to appoint must specify the Clinical Privileges to be granted, if any, which may be qualified by conditions relating to such Clinical Privileges.

(c) The MEC's recommendation shall indicate whether the Applicant should be (1) appointed to the Medical Staff and/or granted Clinical Privileges, (2) denied appointment to the Medical Staff and/or Clinical Privileges, or (3) deferred for further consideration.

(1) <u>Favorable Recommendation</u>

When the recommendation of the MEC is favorable to the Applicant, the Chief of Staff shall promptly forward the recommendation and all related documentation to the Board.

(2) <u>Adverse Recommendation</u>

When the recommendation of the MEC is Adverse to the Applicant, the Chief of Staff shall promptly notify the Applicant by Special Notice. No such Adverse recommendation need be forwarded to the Board until after the Applicant has exercised or been deemed to have waived his or her rights, if any, to a hearing/appellate review as provided in the Fair Hearing Policy.

(3) Defer Recommendation

When the recommendation of the MEC is to defer the application for further consideration, that recommendation must be followed within thirty (30) days by a subsequent recommendation.

9.9-4 BOARD ACTION

(a) Favorable MEC Recommendation

(1) At its next regular meeting after receipt of a favorable recommendation from the MEC, the Board shall act on the matter. The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an Applicant or refer the recommendation back to the MEC for additional consideration. In such event, the Board shall state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation by the MEC must be made.

(2) If the Board's decision is favorable, such action shall be effective as its final decision.

(3) If the Board's decision is Adverse to the Applicant, the CEO shall promptly notify the Applicant of such Adverse decision, by Special Notice, and such Adverse decision shall be held in abeyance until the Applicant has exercised or been deemed to have waived his or her rights, if any, under the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to confer appointment and/or Privileges where none existed before.

(b) Adverse MEC Recommendation

(1) At its next regular meeting after the Applicant's rights, if any, under the Fair Hearing Policy have been exhausted or waived, the Board shall act in the matter.

(2) The Board's decision shall be conclusive.

(c) Without Benefit of MEC Recommendation

(1) If the Board does not receive an MEC recommendation within the time period specified, the Board may, after notifying the MEC of the Board’s intent and allowing a reasonable period for response by the

MEC, take action on the Board's own initiative using the same type of criteria considered by the MEC.

(2) If the Board action is favorable, it shall become effective as the final decision of the Board.

(3) If the Board action is Adverse, the CEO shall promptly notify the Applicant of the Adverse decision, by Special Notice, and the Adverse decision shall be held in abeyance until the Applicant has exercised or been deemed to have waived his or her rights, if any, under the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to confer appointment and/or Privileges where none existed before.

9.9-5 JOINT CONFERENCE COMMITTEE

(a) Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be review of the matter by the Joint Conference Committee. This committee shall, after due consideration, make its recommendation to the Board.

(b) The Board may then render a final decision. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

9.9-6 FINAL DECISION

(a) When the Board's decision is final, the CEO shall send notice of such decision to the Applicant by Special Notice.

9.10 APPLICATION AND PROCESS FOR GRANTING APPOINTMENT WITHOUT PRIVILEGES

9.10-1 Due to the limited nature of a Medical Staff appointment without Privileges:

(a) Applicants requesting appointment to the active Medical Staff category without Privileges must (i) complete such application as is recommended by the MEC and approved by the Board, and (ii) provide such information as is necessary to satisfy the applicable qualifications set forth in Section 7.3-1 of these Bylaws and as otherwise recommended by the MEC and approved by the Board. An application for appointment/reappointment to the active Medical Staff category without Privileges shall be reviewed and acted upon by the Medical Executive Committee and the Board.

(b) Nominees to the honorary Medical Staff category are not required to complete an application. Nominations for appointment to the honorary Medical Staff category may be made by the Medical Executive Committee and acted upon the Board.

9.10-2 Denial of an application for appointment without Privileges and/or suspension or termination of such Medical Staff appointment for reasons other than conduct or

clinical competence shall not trigger procedural due process rights nor shall it create a reportable event for purposes of federal or state law.

9.11 PROCESS FOR MEDICAL STAFF REAPPOINTMENT/REGRANT OF PRIVILEGES

9.11-1 Forms for Medical Staff reappointment/regrant of Privileges shall be available from Medical Staff Services and are scheduled for completion and return in sufficient time for the applicable Department Chair/Section Chair to be able to review each Practitioner's request for reappointment/regrant of Privileges and prepare an appraisal for review by the MEC at the MEC's September meeting.

9.11-2 Prior to Medical Staff reappointment/regrant of Privileges, it is the responsibility of each Practitioner to submit:

(a) All information required by Sections 9.2.2 and 9.7.2 necessary to bring his/her file current.

(b) An attestation of satisfaction of continuing professional education requirements completed during the current appointment/Privilege period.

(c) Any request for a change in Privileges with the basis for the requested change.

(d) Any request for a change in Medical Staff category with the basis for the requested change.

9.11-3 It is the responsibility of Medical Staff Services to verify the information provided in/with each Practitioner's application for Medical Staff reappointment/regrant of Privileges, validate the content of each Practitioner's peer review file, and query the same data banks and programs (*e.g.,* the National Practitioner Data Bank, OIG, *etc.*) as with an initial application for Medical Staff appointment and/or Privileges. Medical Staff Services shall notify the Practitioner of any deficiencies or verification problems regarding his/her application for Medical Staff reappointment/regrant of Privileges. The Practitioner has the burden of producing adequate information and resolving any doubts about his/her qualifications for continued Medical Staff appointment and/or Privileges.

9.11-4 Medical Staff reappointment and/or regrant of Clinical Privileges shall be based, as applicable, on:

(a) The same information requested upon initial application for Medical Staff appointment and/or Privileges with updates and changes to such information.

(b) Participation in Medical Staff and Hospital affairs.

(c) Compliance with the Health System's/Hospital's governing documents; Medical Staff Bylaws, Policies, and Rules & Regulations; and other Health System/Hospital policies and procedures.

(d) Timely completion of medical records.

(e) Evidence of appropriate Professional Liability Insurance and any new or previously unreported claims history since the last appointment/reappointment and/or grant/regrant of Privileges.

(f) General attitude toward/interactions with patients/their families, the Hospital/Hospital staff, other Practitioners, APPs, and the public and whether the Practitioner has engaged in unprofessional conduct.

(g) Professional practice evaluation data regarding the Practitioner at the Hospital.

(h) Peer/case review data regarding the Practitioner's clinical competence/judgement and the quality of care, treatment, and/or services provided by the Practitioner to patients at the Hospital.

(i) Such other information as the MEC and Board deem applicable.

9.11-5 To be eligible to apply for a regrant of Privileges, a Practitioner must have had sufficient Patient Encounters in the previous appointment/Privilege period to enable assessment of the Practitioner's current clinical competence for the Privileges requested. A Practitioner seeking regrant of Privileges who has had minimal activity at the Hospital must submit such professional practice evaluation data (*e.g.,* FPPE/OPPE)/quality assessment information from the Practitioner's primary hospital, if applicable, and/or such other supplemental information (*e.g.,* additional peer references, *etc.*) as may be requested, before the Practitioner's application for regrant of Privileges shall be considered complete and processed.

9.11-6 Upon receipt of the required information and completion of verifications, Medical Staff Services shall notify the chair of the Department in which the Practitioner has Privileges that the application for Medical Staff reappointment/regrant of Privileges and accompanying materials is available for review.

9.11-7 The review and action by the Department Chair, MEC, and Board for an application for Medical Staff reappointment/regrant of Privileges shall proceed in a similar fashion to the process in Section 9.9.2 through Section 9.9.5. For purposes of Medical Staff reappointment/regrant of Privileges, the terms "Applicant" and "appointment/Privileges" as used in Article IX shall be read as "Practitioner" and "reappointment/regrant of Privileges," respectively.

9.11-8 Failure to complete the Medical Staff reappointment/regrant of Privileges process by the end of the Practitioner's current appointment/Privilege period will result in termination of the Practitioner's Medical Staff appointment/Privileges as of the last day of the Practitioner's current appointment/Privilege period without giving rise to the procedural due process rights set forth in the Fair Hearing Policy. The

Practitioner may, thereafter, be eligible for temporary Privileges to meet an important patient care need.

9.12 MODIFICATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

9.12-1 The Practitioner may, either in connection with Medical Staff reappointment/regrant of Privileges or at any other time, request modification of his/her Medical Staff category and/or Privileges by submitting a written request to Medical Staff Services.

9.12-2 A request for transfer from one Medical Staff category to another by a Practitioner with current Medical Staff appointment at the Hospital shall be acted upon by the MEC and the Board.

9.12-3 Practitioners requesting new/additional Privileges during a current appointment/Privilege period shall complete the applicable Delineation of Privileges, provide documentation supportive of the request (*e.g.,* appropriate education, training, experience, *etc.*). Following collection and verification of required information, such request will be acted upon by the Department Chair/Section Chair, the MEC, and the Board.

9.13 TIME PERIOD FOR PROCESSING

9.13-1 The time periods set forth in this Article with respect to Medical Staff Services, the Medical Staff Department Chair, the MEC, and the Board are guidelines, not directives, and do not create any rights for a Practitioner to have an application processed within these precise periods. If the provisions of the Fair Hearing Policy are activated, the time requirements provided therein shall govern the continued processing of the application.

9.13-2 Nothing in this section shall be construed as providing a Practitioner additional time in which to act as required by these Bylaws in the absence of good cause shown.

9.14 RESIGNATION

9.14-1 Resignation of Medical Staff appointment and/or Privileges shall be submitted, in writing, to Medical Staff Services. For information purposes, notice of the resignation shall be provided to the Board, the applicable Department Chair/Section Chair, the MEC, and the Medical Staff.

9.15 LEAVE OF ABSENCE

9.15-1 REQUEST FOR LEAVE

(a) An Appointee may, for good cause (which may include, but is not limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to Medical Staff Services who shall communicate receipt of such notification to the MEC and others as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed one (1) year

except for military service. An Appointee may not take a leave of absence to avoid fulfilling any Medical Staff obligation, such as taking call.

(b) The MEC may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Section 9.15-1 (b). The decision of the MEC is final without right to appeal.

(c) In the event that a leave of absence extends beyond the final date of the Practitioner's current appointment and Privilege period the Practitioner may apply, during the leave, for Medical Staff reappointment and regrant of Privileges.

(i) If the Practitioner applies and is granted Medical Staff reappointment and regrant of Privileges during the leave, the Practitioner's Medical Staff appointment and Privileges (and leave) will continue.

(1) If the Practitioner does not apply for Medical Staff reappointment and regrant of Privileges during the leave, the Practitioner's Medical Staff appointment and Privileges (and leave) will terminate at the end of the Practitioner's current appointment and Privilege period. The Practitioner may thereafter apply for initial Medical Staff appointment and Privileges if/when the Practitioner is able to return to practice.

(d) A Practitioner granted Medical Staff appointment without Privileges or Privileges without a Medical Staff appointment is not eligible for a leave of absence.

9.15-2 APPOINTMENT & PRIVILEGE STATUS DURING LEAVE

(a) During a leave of absence, the Appointee is not entitled to exercise Privileges at the Hospital and has no appointment Prerogatives and responsibilities but must continue to pay Medical Staff dues, unless otherwise waived by the MEC.

(b) Prior to a leave of absence being granted, the Appointee shall have made arrangements for the care of his or her patients during the leave of absence.

9.15-3 RETURN TO PRACTICE

(a) Practitioners who maintain Medical Staff appointment and Privileges at the Hospital during a leave, may request reinstatement of Medical Staff appointment and Privileges at the end of the leave period.

(b) In order to qualify for reinstatement of Medical Staff appointment and Privileges following a leave of absence, the Appointee must also show that he or she has Professional Liability Insurance coverage for prior acts either by maintaining current insurance during the leave or purchasing tail coverage.

(c) An Appointee may request reinstatement of his/her Medical Staff appointment and Privileges by sending a written notice to Medical Staff Services.

(d) The Appointee must submit a written summary of relevant activities during the leave as well as such additional information as is reasonably necessary to reflect that he/she is qualified for reinstatement of Medical Staff appointment and Privileges.

(1) If an Appointee is returning from a medical leave of absence, he/she may also be asked to obtain a physical examination and/or mental evaluation addressing the Appointee's capability to resume clinical practice.

(2) The MEC may, as applicable, recommend reinstatement of Privileges subject to a focused professional practice evaluation period to assess current clinical competency upon return from a leave of absence.

(e) Once the Appointee's request for reinstatement of Medical Staff appointment and Privileges is deemed complete, the applicable procedure set forth in Section 9.7 or Section 9.11 shall be followed.

(f) If an Appointee fails to request reinstatement of Medical Staff appointment and Privileges upon the termination of a leave of absence, the MEC shall make a recommendation to the Board as to how such failure should be construed. If such failure is determined by the Board to be a voluntary resignation, it shall not give rise to any procedural due process rights pursuant to the Fair Hearing Policy.

ARTICLE X

TEMPORARY, EMERGENCY, DISASTER, TELEMEDICINE & MOONLIGHTING PRIVILEGES

10.1 MEDICAL HISTORY AND PHYSICAL EXAMINATION

10.1-1 Each patient shall, as applicable, have a medical history and physical examination completed and documented no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.1-2 For a medical history and physical examination that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.1-3 The medical history and physical examination shall be completed and documented by a Physician, an Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with state law and Health System/Hospital policy and/or the Medical Staff governing documents.

10.1-4 The medical history and physical examination, and any updates thereto, shall be recorded/placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

10.1-5 Additional requirements regarding completion and documentation of the medical history and physical examination are set forth in the Medical Staff Rules & Regulations.

10.2 SPECIAL CONDITIONS FOR DENTISTS, PODIATRISTS, PSYCHOLOGISTS, AND OPTOMETRISTS

10.2-1 DENTISTS, ORAL SURGEONS, AND PODIATRISTS

(a) Dentists, Oral Surgeons, and Podiatrists may admit patients to the Hospital if granted Privileges to do so.

(b) A qualified Oral Surgeon may perform the medical history and physical examination for his/her patients if granted Privileges by the Hospital to do so.

(c) A qualified Podiatrist may perform the medical history and physical examination for his or her patients if granted Privileges by the Hospital to do so.

10.2-2 PHYSICIAN RESPONSIBILITIES

(a) The medical condition of each patient is the responsibility of a Physician Appointee with appropriate Privileges.

(b) Dentists/Oral Surgeons and Podiatrists may not assume responsibility for care of a patient's medical problems present at the time of admission/registration or that may arise during hospitalization that are outside of the scope of practice of the Dentist/Oral Surgeon or Podiatrist.

(c) A Podiatrist shall arrange for a Physician Appointee with appropriate Privileges to complete the medical history and physical examination for the Podiatrist's patient if the Podiatrist does not otherwise have the Privileges to do so.

(d) A Podiatrist shall obtain medical consultation from a Physician Appointee with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Podiatrist's patient or that may arise during hospitalization that is outside the scope of practice of the Podiatrist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Podiatrist's patient and the completion of medical records such as relates to the Physician's care of the patient.

(e) A Dentist shall arrange for a Physician Appointee with appropriate Privileges to complete the medical history and physical examination for the Dentist's patients if the Dentist does not otherwise have the Privileges to do so.

(f) A Dentist shall obtain medical consultation from a Physician Appointee with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Dentist's patient or that may arise during hospitalization that is outside the scope of practice of the Dentist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Dentist's patient and the completion of medical records such as relates to the Physician's care of the patient.

(g) Dentists and Podiatrists are solely responsible for the dental or podiatric portion of the history, examination, diagnosis, operative report, and discharge summary.

10.2-3 PSYCHOLOGISTS AND OPTOMETRISTS

(a) Psychologists and Optometrists may not admit or co-admit patients to the Hospital.

(b) Psychologists and Optometrists may treat only those patients who have been admitted by a Physician Appointee with admitting Privileges and must maintain a consultative relationship with the attending Physician during the course of treatment of the patient.

10.3 **TEMPORARY PRIVILEGES**

10.3-1 CONDITIONS

(a) Temporary Privileges may be granted only in the circumstances and under the conditions set forth in this Section.

(b) Special requirements of consultation and reporting may be imposed by the applicable Department Chair or Chief of Staff.

(c) Under all circumstances, the Practitioner requesting temporary Privileges must agree, in writing, to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and applicable policies of the Health System/Hospital.

10.3-2 CIRCUMSTANCES

(a) When dictated by (i) urgent patient care need; or (ii) when an application is complete, without any negative or adverse information, and before action by the Medical Executive Committee or Board, the CEO may, on a case-by-case basis, grant temporary Privileges upon recommendation of the Chief of Staff or, in the Chief of Staff's absence, another member of the MEC.

(b) Criteria for granting temporary Privileges:

(1) Primary verification of education (AMA/AOA Profile is acceptable).

(2) Demonstration of current competence.

(3) Primary verification of state professional licenses.

(4) Receipt of professional references (including current competence).

(5) Receipt of database profiles from AMA, AOA, NPDB, and OIG Medicare/Medicaid Exclusions.

(6) Confirmation of Professional Liability Insurance.

(c) Temporary Privileges may be granted for a period of time not to exceed 120 days.

(d) In exercising temporary Privileges, the Practitioner shall act under the supervision of the chair of the Department or Section to which the Practitioner is assigned.

10.4 **EMERGENCY PRIVILEGES**

10.4-1 In an emergency any Practitioner, to the degree permitted by his or her license, within his/her scope of practice, and notwithstanding his/her Medical Staff appointment and/or Clinical Privileges, shall be permitted to do and shall be

assisted by Hospital personnel in doing everything possible to save the life of a patient or to save a patient from serious harm. A Practitioner exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. When the emergency necessitating action is no longer present, the Practitioner acting pursuant to this section must relinquish care of the patient to the Practitioner of record.

10.4-2 For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger.

10.4-3 Emergency Privileges automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy.

10.5 DISASTER PRIVILEGES

10.5-1 Disaster Privileges may be granted by the CEO, the Chief of Staff, or, in the event that the CEO or the Chief of Staff is not available, any other Medical Staff officer. Disaster Privileges may be granted to licensed, volunteer Practitioners during a disaster when the Hospital activates its emergency management plan and cannot handle immediate patient needs. The responsible Hospital or Medical Staff leader is not required to grant disaster Privileges to any volunteer Practitioner and is expected to make such decisions on a case-by-case basis at the Hospital or Medical Staff leader's sole discretion.

10.5-2 Volunteer Practitioners requesting disaster Privileges at the Hospital shall certify their education, training, knowledge, and experience to practice in their specialty and shall only exercise those clinical privileges which they hold at another accredited hospital and for which disaster Privileges are granted. Volunteer Practitioners granted disaster Privileges shall agree to practice as directed and under the supervision of the Chief of Staff and/or appropriate Department Chair. Volunteer Practitioners granted disaster Privileges shall wear, at all times while at the Hospital, a Hospital-authorized photo ID and a "volunteer Practitioner" badge.

10.5-3 It is anticipated that disaster Privileges may be granted to both Ohio and out-of-state volunteer Practitioners subject to applicable Ohio licensure laws, rules, and regulations.

10.5-4 The CEO, Chief of Staff, or other Medical Staff officer, as applicable, may grant disaster Privileges upon receipt of a current, valid, government issued photo identification (*e.g.*, driver's license or passport) in addition to at least one (1) of the following identification documents:

(a) A current photo identification (ID) card from a health care organization that clearly identifies professional designation.

(b) A current license to practice.

(c) Primary source verification of licensure.

(d) Identification indicating that the volunteer Practitioner is a member of a state or federal Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group.

(e) Identification indicating that a government entity has granted the volunteer Practitioner the authority to provide patient care, treatment, or services in disaster circumstances.

(f) Presentation by a current Hospital staff member or Medical Staff Appointee or APP with personal knowledge of the volunteer Practitioner's identity and clinical ability.

10.5-5 The CEO, Chief of Staff (or other Medical Staff officer, as applicable) and the appropriate Department Chair shall be informed of any problems regarding a volunteer Practitioner granted disaster Privileges.

10.5-6 Disaster Privileges shall cease upon alleviation of the disaster circumstances as determined by the Hospital CEO.

10.6 TELEMEDICINE PRIVILEGES

10.6-1 CONDITIONS

(a) Section 10.6 applies to distant-site telemedicine Practitioners who do not practice on-site at the Hospital.

(b) Distant-site Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link shall be credentialed (which may be by proxy) and privileged to do so by the Hospital in accordance with the Bylaws, accreditation requirements, and applicable laws, rules, and regulations.

(c) If the Hospital has a pressing clinical need and the distant-site Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in Section 10.3.

10.6-2 CREDENTIALING

Practitioners providing distant-site telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

(a) The distant-site Practitioner shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws; OR,

(b) The credentialing information and/or privileging decision from the distant-site may be relied upon by the Hospital Medical Staff and Board in making its telemedicine privileging recommendations/decision regarding each

distant-site Practitioner provided that the Hospital has entered into a written agreement with the distant-site and all of the following requirements are met:

(1) The distant-site is a Medicare-participating hospital or a facility that qualifies as a "distant-site telemedicine entity." A "distant-site telemedicine entity" is defined as an entity that (i) provides telemedicine services, (ii) is not a Medicare-participating hospital, and (iii) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

- When the distant-site is a Medicare participating hospital, the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7) [42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals], as that provision may be amended from time to time, with regard to the distant-site hospital Practitioners providing telemedicine services.

- When the distant-site is a "distant-site telemedicine entity" the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) [42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals] with regard to the distant-site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2) [42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals] as those provisions may be amended from time to time.

(2) Each distant-site Practitioner is privileged at the distant-site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant-site.

(3) Each distant-site Practitioner holds an appropriate license issued by the applicable licensing entity in the state in which the Hospital whose patients are receiving the telemedicine services is located. The Practitioner must also meet the licensing standards, as

applicable, in the state in which he/she is located (if other than Ohio).

(4) The Hospital maintains documentation of its internal review of the performance of each distant-site Practitioner and sends the distant-site such performance information for use in the distant-site's periodic appraisal of the distant-site Practitioner. At a minimum, this information must include:

- All adverse events that result from the telemedicine services provided by the distant-site Practitioner to Hospital patients; and,

- All complaints the Hospital receives about the distant-site Practitioner.

(c) With respect to Bucyrus and Galion as critical access hospitals:

(1) When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis and treatment furnished by distant-site Practitioners in the critical access hospital.

(2) When telemedicine services are provided by a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment furnished by distant-site Practitioners in the critical access hospital are evaluated by a hospital that is a member of the network, a Quality Improvement Organization or equivalent entity, or an appropriate and qualified entity identified in the State rural health care plan.

10.7 **MOONLIGHTING PRIVILEGES**

10.7-1 QUALIFICATIONS

(a) Moonlighting Privileges in the Hospital's Emergency Department may be granted to residents who:

(1) Satisfy applicable education requirements.

(2) Have and maintain a current, valid, license to practice medicine (<u>not</u> a training certificate).

(3) Have and maintain, if required for the Privileges requested, a current, valid Drug Enforcement Administration ("DEA") registration.

(4) Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital <u>outside</u> of the time periods that the resident is participating in their Graduate Medical Education residency program.

(5) Have completed at least two (2) years of post-graduate training in an ACGME or AOA approved residency program.

(6) Obtain prior written approval from the director of the applicable residency program.

(7) Are in good standing in his/her residency program as confirmed by the program director.

(8) Satisfy such other qualifications, to the extent applicable, set forth in Section 9.2 as recommended by the MEC and approved by the Board.

10.7-2 CONDITIONS

(a) A moonlighting resident must request and be granted Privileges prior to providing any clinical care, treatment, or services to patients at the Hospital.

(b) Special requirements of consultation and reporting may be imposed by the Department Chair responsible for supervision of the moonlighting resident as applicable. A moonlighting resident shall work under the direction of an assigned Practitioner(s) with Medical Staff appointment and Privileges at the Hospital who is responsible for assuring that the moonlighting resident's practice does not exceed the Privileges granted and for overseeing the quality of care provided.

(c) A moonlighting resident must agree, in writing, to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and the policies of the Health System/Hospital in all matters relating to his/her activities at the Hospital.

(d) Residents prohibited by applicable laws, rules, and/or regulations from moonlighting (*e.g.,* on a J-1 visa, *etc.*) are not permitted to moonlight.

(e) Moonlighting is not required and must not interfere with the resident's clinical training/education.

(f) All moonlighting hours must be reported and counted towards work duty hour requirements.

(g) Permission to moonlight may be withdrawn if the residency program director determines that the resident's education/training is adversely impacted by such moonlighting activities.

10.7-3 PROCESSING A REQUEST FOR MOONLIGHTING PRIVILEGES

(a) A resident seeking moonlighting Privileges shall submit an application, the content of which shall be determined by the Board, upon recommendation of the MEC, and shall have such application processed in accordance with the routine credentialing and privileging process, to the extent applicable, set forth in Section 9.9 or Section 9.11.

(b) Moonlighting Privileges may be granted/regranted for a period of up to two (2) years as recommended by the MEC and approved by the Board.

10.8 TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, OR MOONLIGHTING PRIVILEGES

10.8-1 TERMINATION

(a) The CEO or Chief of Staff may, at any time, revoke any or all of a Practitioner's temporary, emergency, disaster, or telemedicine Privileges (or a resident's moonlighting Privileges).

(b) Where the life or well-being of a patient is determined to be endangered, a Practitioner's temporary, emergency, disaster, or telemedicine Privileges (or a resident's moonlighting Privileges) may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

(c) In the event a Practitioner's temporary, emergency, disaster, or telemedicine Privileges (or a resident's moonlighting Privileges) are revoked, the Practitioner's (or moonlighting resident's) patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

10.8-2 EFFECT OF TERMINATION, *ETC.*

(a) A Practitioner who has been granted temporary, emergency, disaster, or telemedicine Privileges (or a resident who has been granted moonlighting Privileges) is not, by virtue of such Privileges, an Appointee of the Medical Staff and is not entitled to any of the procedural due process rights afforded to Medical Staff Appointees.

(b) A Practitioner (or moonlighting resident) shall not be entitled to the procedural due process rights afforded by these Bylaws or the Fair Hearing Policy because the Practitioner's request for temporary, emergency, disaster, or telemedicine Privileges (or a resident's request for moonlighting Privileges) is refused, in whole or in part, or because all or any portion of a Practitioner's temporary, emergency, disaster, or telemedicine Privileges (or a resident's moonlighting Privileges) are terminated, not renewed, restricted, suspended, or limited in any way nor shall any such action be considered an Adverse action for purposes of federal or state law.

10.9 RECOGNITION OF NEW SERVICE OR PROCEDURE

10.9-1 The Board shall determine the scope of patient care services at the Hospital based upon recommendations from the MEC. Overall considerations for approving new services and procedures include, but are not limited to:

(a) The Hospital's available resources and staff.

(b) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).

(c) The availability of other qualified Practitioners with Privileges at the Hospital to provide coverage for the new service or procedure when needed.

(d) The quality and availability of training programs.

(e) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

(f) Whether there is a community need for the service or procedure.

10.9-2 Requests for Privileges to provide a new service or perform a new procedure at the Hospital that has not yet been recognized by the Board shall be processed as follows:

(a) The Practitioner must submit a written request for Privileges for a new service or procedure to Medical Staff Services who shall notify the applicable Department Chair. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance to the Medical Staff and Board in evaluating the request.

(b) If the Department Chair (who may consult with the applicable Section Chief as necessary) determines that the new service or procedure should not be recognized at the Hospital, the Department Chair will provide his/her recommendation to the MEC for consideration.

(c) If the Department Chair (who may consult with the applicable Section Chair, as necessary) determines that the new service or procedure should be recognized at the Hospital and included in an existing Privilege set, the Department Chair will provide the basis for his/her recommendation to the MEC for consideration.

(d) If the Department Chair (who may consult with the applicable Section Chief, as necessary) determines that the new service or procedure should be recognized at the Hospital and that a new Privilege set is required, the Department Chair (who may consult with the applicable Section Chief, as necessary) shall develop and submit to the MEC a new Privilege set for consideration based upon:

(1) A determination as to what specialties are likely to request the Privileges.

(2) The positions of specialty societies, certifying boards, *etc.*

(3) The available training programs.

(4) Recommended standards to be met with respect to the following: education; training; board certification; experience; focused professional practice evaluation requirements to establish current competency.

(5) Criteria required by other hospitals with similar resources and staffing,

(e) Upon receipt of a recommendation from the Department Chair, the Medical Executive Committee shall review the matter and forward its recommendation to the Board:

(1) If the Board approves a new service or procedure, the requesting Practitioner(s) may apply for such Privileges consistent with the applicable procedure set forth in these Bylaws.

(2) If the Board does not approve a new service or procedure, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of the Fair Hearing Policy.

10.10 **ADOPTION & AMENDMENT OF PRIVILEGE SETS**

Privilege sets may be adopted and amended upon review by the applicable Department/Section, review and recommendation by the MEC, and approval of the Board.

ARTICLE XI

COLLEGIAL INTERVENTION, CORRECTIVE ACTION, SUMMARY SUSPENSION, AUTOMATIC SUSPENSION AND TERMINATION

11.1 COLLEGIAL INTERVENTION

11.1-1 Prior to initiating corrective action against an Appointee for professional conduct or competency concerns, the Medical Staff leadership or Board (through the Chief Executive Officer as its administrative agent) may elect to attempt to collegially resolve the concern(s) in a manner determined appropriate. In such event, the following process should be considered but is not mandated:

(a) The Chief Executive Officer, Chief of Staff, and/or applicable Department Chair (acting as designated agents of the applicable peer review committee) will meet with the Appointee in an attempt to resolve the issue(s) with a report back to the applicable peer review committee.

(b) If the CEO, Chief of Staff, and/or applicable Department Chair is unable to resolve the issue(s), the matter should be forwarded for review and collegial intervention to the applicable Medical Staff peer review committee (other than the MEC) for informal resolution.

(c) If the applicable Medical Staff peer review committee is unable to collegially resolve the issue(s), the matter may be referred to the MEC for formal corrective action.

11.1-2 An appropriately designated Medical Staff peer review committee may enter into a voluntary remedial agreement with a Medical Staff Appointee, consistent with the applicable Medical Staff policy, to resolve potential clinical competency or conduct issues. If the affected Medical Staff Appointee fails to abide by the terms of an agreed-to remedial agreement, the Appointee may be subject to the formal corrective action procedure set forth in Section 11.2.

11.1-3 A written record of efforts to collegially resolve a matter (regardless of whether the matter is or is not resolved) shall be prepared and retained in the Appointee's confidential peer review file.

11.1-4 Resolution of an issue pursuant to §11.1 shall not constitute a formal corrective action process.

11.1-5 Nothing in this section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention/informal remediation prior to implementing formal corrective action on the basis of a single incident.

11.2 FORMAL CORRECTIVE ACTION

11.2-1 CRITERIA FOR INITIATION

(a) Any person may provide information to the MEC about the professional conduct or clinical competence of an Appointee.

(b) A request for corrective action against such Practitioner may be initiated by any person/group listed in Section 11.2-2 when reliable information indicates that an Appointee may have acted in a manner reasonably likely to be:

(1) Detrimental to patient safety or to the delivery of efficient, quality patient care within the Hospital.

(2) Unethical.

(3) Contrary to the Medical Staff Bylaws, Policies, or Rules & Regulations; the Health System's/Hospital's governing documents, Corporate Compliance Plan, or other applicable Health System/Hospital policies or procedures.

(4) Below applicable professional standards.

(5) Disruptive to Hospital operations.

(6) Damaging to the Medical Staff's or Hospital's reputation.

(7) In violation of applicable laws or regulations including, but not limited to, those relating to a Federal Healthcare Program.

11.2-2 AUTHORITY TO INITIATE

(a) Any of the following may request that corrective action be initiated:

(1) Any member of the MEC

(2) The chair of the Department in which the Appointee holds Privileges

(3) The CEO

(4) The Board or its executive committee or the Board chair

11.2-3 REQUEST AND NOTICES

(a) All requests for corrective action shall be in writing (which writing may be reflected in meeting minutes) submitted to the MEC and supported by reference to the specific action that constitutes the grounds for the request.

(b) The chair of the MEC shall promptly notify the CEO, in writing, of all requests for corrective action received by the MEC and shall continue to keep him or her fully informed of all action taken in conjunction therewith.

(c) In the event the request for corrective action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes.

11.2-4 INVESTIGATION

(a) Upon receipt of the request for corrective action, the MEC shall act on the request. The MEC may:

(1) Determine that no corrective action is warranted and close the matter. Such action by the MEC shall not be considered Adverse and shall not give rise to any fair hearing rights pursuant to these Medical Staff Bylaws and the Fair Hearing Policy nor constitute a reportable event to the applicable licensing board or National Practitioner Data Bank.

(2) Determine that no corrective action is warranted and remand the matter for collegial intervention or remediation/resolution consistent with the applicable Medical Staff Policy. Unless otherwise specified in the applicable Medical Staff Policy, such action by the MEC shall not be considered Adverse and shall not give rise to any fair hearing rights pursuant to these Medical Staff Bylaws and the Fair Hearing Policy nor constitute a reportable event to the applicable licensing board or National Practitioner Data Bank.

(3) Initiate a formal corrective action investigation in accordance with the requirements set forth in this Section 11.2.

(b) A matter shall be deemed to be under formal investigation as of the start of an MEC meeting at which a request for corrective action is being presented.

(c) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under a formal corrective action investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.

(d) The affected Practitioner shall be provided with written notice of a determination by the MEC to go forward with a corrective action investigation.

(e) The MEC may conduct such investigation itself; assign the task to a Medical Staff officer, a Department Chair, or a standing or *ad hoc* committee; or, may refer the matter to the Board for investigation and resolution.

(f) This investigative process is not a "hearing" as that term is used in these Bylaws or the Fair Hearing Policy and shall not entitle the Appointee to the procedural due process rights provided in the Fair Hearing Policy. The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the Appointee involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating

individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

(g) If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).

(h) The MEC may, at any time in its discretion, and shall, at the request of the Board, terminate the investigative process and proceed with action as provided below.

11.2-5 MEC ACTION

(a) As soon as practical following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

(1) A determination that no corrective action be taken.

(2) Issuing a written warning or letter of reprimand.

(3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practice or behavior but without requirement of prior or concurrent consultation or direct supervision.

(4) Recommendation of a limitation, reduction, or suspension of all, or any portion, of the Appointee’s Clinical Privileges.

(5) Recommendation of reduction of Medical Staff category or limitation of any Medical Staff Prerogatives directly related to the Appointee's delivery of patient care.

(6) Recommendation of revocation of all, or any part, of the Medical Staff Appointee’s Privileges.

(7) Recommendation of such other action as may be deemed necessary by the circumstances.

11.2-6 EFFECT OF MEC ACTION

(a) The Practitioner shall be notified of the MEC’s determination or recommendation, as applicable.

(1) Adverse MEC Recommendation. If the recommendation of the MEC is Adverse to the Medical Staff Appointee, the recommendation shall be forwarded to the Chief of Staff who shall promptly notify the affected Appointee, in writing, by Special Notice. The Chief of Staff shall then hold the recommendation until the Medical Staff Appointee has exercised or waived the right to a hearing and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board for action.

(2) Board Referral; Failure of MEC to Act. If the MEC (i) refers the matter to the Board for investigation; or (ii) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC. If the Board's decision is not Adverse to the Appointee, the action shall be effective as its final decision and the CEO shall inform the Appointee of the Board's decision by Special Notice. If the Board's decision is Adverse to the Appointee, the CEO shall inform the Appointee, by Special Notice, and the Appointee shall be entitled, upon timely and proper request, to the procedural due process rights set forth in the Fair Hearing Policy.

(b) Other Action. The commencement of corrective action against an Appointee shall not preclude the summary suspension, automatic suspension, or automatic termination of the Medical Staff appointment and/or all, or any portion, of the Appointee's Privileges in accordance with the procedures set forth in Sections. 11.3, 11.4, or 11.5.**SUMMARY SUSPENSION**

11.3-1 CRITERIA FOR INITIATION

(a) Whenever a Practitioner engages in conduct that requires that immediate action be taken to protect or to reduce the substantial likelihood of injury or imminent danger to the life, health, or safety of any individual at the Hospital (*i.e.* patient, employee, visitor, *etc.*), any of the following has the authority to summarily suspend the Medical Staff appointment and/or all, or any portion, of the Privileges of such Practitioner:

(1) The Chief of Staff

(2) The MEC

(3) The chair of the Department in which the Practitioner holds Privileges

(4) The CEO

(5) The Board or its executive committee or the Board chair

(b) Such summary suspension shall become effective immediately upon imposition. The person or group imposing the summary suspension (if other than the CEO) shall immediately inform the CEO of such summary suspension and the CEO shall promptly give Special Notice of the summary suspension to the Practitioner.

11.3-2 ACTION FOLLOWING IMPOSITION OF SUMMARY SUSPENSION

(a) As soon as possible, but not later than five (5) days following the original imposition of the summary suspension, the MEC, if it did not impose the summary suspension, shall convene to review the matter and consider the need, if any, for formal corrective action pursuant to Section 11.2. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in the Bylaws or Fair Hearing Policy, even if the Practitioner involved attends the meeting, and no procedural due process requirements shall apply. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the CEO. In the case of a summary suspension imposed by the Board or the CEO, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

(b) Not later than fourteen (14) days following the original imposition of the summary suspension, the Practitioner shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board or CEO, of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or sustained, and of the Practitioner's rights, if any, pursuant to the Fair Hearing Policy.

(c) A summary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an Adverse action and shall not give rise to any procedural due process rights pursuant to the Fair Hearing Policy.

11.4 **AUTOMATIC SUSPENSION**

11.4-1 GROUNDS FOR AUTOMATIC SUSPENSION/LIMITATION

(a) License

(1) Limitation/Restriction. Whenever a Practitioner's license to practice his/her profession is limited or restricted by the applicable licensing authority, his/her Medical Staff appointment and Privileges shall be immediately and automatically limited or restricted consistent with such action.

(2) Suspension. Whenever a Practitioner's license to practice his/her profession is suspended by the applicable licensing authority, his or her Medical Staff appointment and Clinical Privileges shall be automatically suspended.

(3) Probation. Whenever a Practitioner is placed on probation by the applicable licensing authority, his/her Medical Staff appointment and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation.

(4) Failure to Renew/Expired. Whenever a Practitioner's license expires solely as a result of the Practitioner's inadvertent failure to renew such license on a timely basis, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 11.5-1 (a)(2).

(b) Controlled Substance Authorization

(1) Suspension. Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is suspended by the DEA or other applicable federal or state authority, his/her Medical Staff appointment and Privileges shall be automatically suspended.

(2) Restriction. Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is limited/restricted by the DEA or other applicable federal or state authority, his/her Medical Staff appointment and Privileges shall be automatically suspended.

(3) Failure to Renew/Expired. Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) expires solely as a result of the Practitioner's inadvertent failure to renew such registration on a timely basis, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 11.5-1 (b)(2).

(c) Professional Liability Insurance

(1) If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's appointment and Privileges shall be automatically suspended until adequate Professional Liability Insurance coverage is restored or until the Practitioner's appointment and Privileges are automatically terminated pursuant to Section 11.5-1 (e) below.

(2) Medical Staff Services shall be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the Practitioner's non-compliance with the Professional Liability Insurance requirement, any limitation on the new policy, and a summary of relevant activities during the period of non-compliance. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

(d) Suspension From Federal Healthcare Program

Whenever a Practitioner is suspended from participation in any Federal Healthcare Program, or a federal procurement or non-procurement program, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically suspended.

(e) Delinquent Medical Records

Whenever a Practitioner fails to complete medical records in accordance with the Delinquent Medical Record Policy, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended in accordance with such policy subject to the limited exception set forth in Section 11.4-2 (b) below.

11.4-2 EFFECT OF AUTOMATIC SUSPENSION/LIMITATION

(a) During such period of time when a Practitioner's appointment and/or Privileges are suspended or limited pursuant to Section 11.4-1 (a)-(d), he/she may not, as applicable, exercise any appointment Prerogatives or Privileges at the Hospital.

(b) A Practitioner whose Medical Staff appointment and Privileges are automatically suspended pursuant to Section 11.4-1 (e) (*i.e.,* for delinquent medical records) is subject to the same limitations as set forth in Section 11.4-2 (a) except that such Practitioner may attend to the management of any patient under his/her care requiring emergency care and intervention upon request of the Chief of Staff.

11.4-3 ACTION FOLLOWING AUTOMATIC SUSPENSION/LIMITATION

(a) An automatic suspension or limitation under Section 11.4-1 does not give rise to any hearing/appeal rights under the Fair Hearing Policy.

(b) As soon as practical after an automatic suspension or limitation occurs, the MEC shall convene, as appropriate, to review and consider the facts under which such automatic action was taken and to determine if formal corrective action is necessary pursuant to Section 11.2.

(c) The lifting of the action or inaction that gave rise to an automatic suspension or limitation of the Practitioner's appointment and/or Privileges shall result in the automatic reinstatement of such appointment and/or Privileges, as applicable; provided, however, that the Practitioner shall be obligated to provide such information as reasonably requested to assure that all information in the Practitioner's credentials file is current.

(d) It shall be the Practitioner's duty to notify Medical Staff Services of satisfaction of the action or inaction that gave rise to the automatic suspension or limitation.

11.5 **AUTOMATIC TERMINATION**

11.5-1 GROUNDS FOR AUTOMATIC TERMINATION

(a) License

(1) Revocation. Whenever a Practitioner's license to practice his/her profession is revoked, the Medical Staff appointment and Clinical Privileges of that Practitioner shall be immediately and automatically terminated.

(2) Expiration. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 11.4-1 (a)(4) for an expired license) fails to renew his/her license within thirty (30) days after its expiration, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated as of the thirty-first (31st) day.

(b) Controlled Substance Authorization

(1) Revocation. Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is revoked, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(2) Expiration. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 11.4-1 (b)(3) for an expired DEA registration or other authorization to prescribe controlled substances) fails to renew his/her registration within thirty (30) days after its expiration, his/her Medical Staff appointment and Privileges shall be automatically terminated as of the thirty-first (31st) day.

(c) Abandonment of Practice

In the event a Practitioner abandons his or her practice at the Hospital, the Practitioner's Medical Staff appointment and Clinical Privileges shall be automatically terminated.

(d) Exclusion From Federal Healthcare Program

Upon exclusion, debarment, or other prohibition from participation in any Federal Healthcare Program, or a federal procurement or non-procurement program, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated.

(e) Professional Liability Insurance

Failure to provide written proof of reinstatement of the required amount of Professional Liability Insurance within ninety (90) days after an automatic suspension pursuant to Section 11.4.1 (c) shall result in automatic termination of the Practitioner's appointment and Privileges.

(f) Plea of Guilty to Certain Offenses

If a Practitioner pleads guilty or no contest to, or is found guilty of: (i) a felony or (ii) other serious offense that involves violence or abuse upon a ;person; conversion; embezzlement; misappropriation of property; fraud, bribery; evidence tampering; perjury; or a drug offense, the Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated.

11.6 CONTINUITY OF PATIENT CARE

11.6-1 In the event of a summary suspension, automatic suspension, or automatic termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff or applicable Department Chair.

11.6-2 The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

11.7 CONDUCT AND IMPAIRMENT MATTERS

11.7-1 The Medical Staff may also take action under the Practitioner/APP Impairment Policy or the Practitioner/APP Conduct Policy when appropriate.

11.7-2 Nothing in such Medical Staff Policies, however, shall prevent the imposition of a summary suspension or initiation of corrective action under these Bylaws when determined to be necessary.

ARTICLE XII

HEARINGS AND APPELLATE REVIEW

All hearings and appellate reviews conducted with respect to Applicants and Appointees shall be conducted pursuant to the provisions of the Medical Staff's Fair Hearing Policy.

ARTICLE XIII

CONFIDENTIALITY, AUTHORIZATION, AND IMMUNITY/RELEASE OF LIABILITY

13.1 CONFIDENTIALITY OF INFORMATION

13.1-1 Information with respect to any Practitioner submitted, collected, or prepared by any Representative, or by any other health care facility, organization of health professionals, or medical staff for the purpose of: evaluating, monitoring, or improving the quality, appropriateness, and efficiency of patient care; evaluating the qualifications and performance (*e.g.,* conduct, clinical competence, *etc.*) of a Practitioner; acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in compliance with the applicable standards of care; or, establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential.

13.1-2 Such Information shall not be disclosed or disseminated to anyone other than a Representative, or other health care facility, organization of health professionals, or medical staff engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as provided in the Medical Staff governing documents, applicable Health System/Hospital policies, or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to Third Parties.

13.1-3 This Information shall not become part of any particular patient's medical record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for corrective action.

13.2 IMMUNITY FROM LIABILITY

13.2-1 Submission of an application for, and/or exercise of, Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges at the Hospital constitutes a Practitioner's express release of liability for the following:

(a) For Action Taken. The Hospital and each Representative and Third Party shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner for damages or other relief for any action taken or decision, opinion, statements, or recommendations made regarding such Practitioner provided that the Hospital/Representative (within the scope of his/her duties as a Representative) or Third Party does not act on the basis of false information knowing it to be false.

(b) For Gathering/Providing Information. The Hospital and each Representative and Third Party shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner for damages or other relief by reason of gathering or providing Information, including otherwise confidential or privileged Information, regarding such Practitioner provided that the Hospital/Representative (within the scope of his/her duties as a

Representative) or Third Party does not act on the basis of false information knowing it to be false.

13.3 ACTIVITIES AND INFORMATION COVERED

13.3-1 ACTIVITIES

(a) The confidentiality and immunity provided by this Article shall apply to all Information in connection with activities of this Hospital or any other health care facility, organization of health professionals, or medical staff concerning, but not limited to:

(1) Applications for appointment, reappointment, and/or Clinical Privileges

(2) Corrective action

(3) Hearings and appellate reviews

(4) Utilization reviews

(5) Peer review organizations, licensure board, and similar reports

(6) Performance improvement/quality assessment/peer review activities.

(7) Other Medical Staff, Department, Section, or Medical Staff committee activities related to evaluating, monitoring, and maintaining quality and efficient patient care at the Hospital.

13.3-2 INFORMATION

(a) The Information referred to in this Article may relate to any matter with respect to a Practitioner that might directly or indirectly affect patient care including, but not limited to, the Practitioner's professional qualifications, conduct, and clinical competence.

13.4 AUTHORIZATIONS AND RELEASES

13.4-1 Each Practitioner shall, upon request of the Hospital, execute general and specific authorizations and releases in accordance with the express provisions and general intent of this Article subject to applicable law. Such authorizations and releases will operate in addition to the provisions of this Article.

13.4-2 Execution of such authorizations and releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.4-3 By submitting an application for, and/or exercising, Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges at the Hospital, a Practitioner:

(a) Authorizes, as needed, the Hospital, Representatives, and Third Parties, as applicable, to solicit, provide, and act upon Information regarding the Practitioner including, but not limited to, his/her professional qualifications, conduct, and clinical competence.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against the Hospital, any Representative, and/or Third Party who act(s) in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his or her application for and acceptance, exercise, and continuation of Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges at the Hospital.

13.5 SPECIAL DEFINITIONS

13.5-1 For purposes of this Article, the following special definitions shall apply:

(a) "Information" means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other documentation, disclosures, or communications, whether in written or oral form, relating to any of the subject matter specified in Section 13.3.

(b) "Representative" means the Board, the Hospital, the Medical Staff, and their agents (*e.g.,* Board members/directors/officers; Hospital executives and other employees, Practitioners - including, but not limited to, the Medical Staff officers, Department/Section Chairs, Medical Staff committees and their members/chair/agents - APPs, *etc.*) authorized to perform specific Information gathering, analysis, use, or disseminating functions with respect to a Practitioner's qualifications for Medical Staff appointment/reappointment and/or Privileges, performance (*e.g.,* conduct, clinical competence, quality of care, *etc.*), or any other matter regarding a Practitioner that might directly or indirectly affect patient care.

(c) "Third Parties" means any individual or organization providing Information to any Representative with respect to Practitioners.

13.6 CUMULATIVE EFFECT

Provisions in the Medical Staff Bylaws, Policies, or Rules & Regulations, and in Medical Staff application forms relating to authorizations, confidentiality of Information, and release of/immunity from liability shall be in addition to other protections provided by law.

ARTICLE XIV

GENERAL PROVISIONS

14.1 DUES

The MEC shall determine the amount of annual dues or assessments, if any, for each category of Medical Staff appointment and determine the manner of expenditure of such funds received.

14.2 CONFLICT OF INTEREST

14.2-1 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff or a Department, Section, or Medical Staff committee, the Practitioner is expected to disclose the conflict to the individual in charge of the meeting. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.

14.2-2 A Department Chair shall have the duty to delegate review of applications for appointment, reappointment, or Privileges/regrant of Privileges to another member of the Department or to the applicable Section Chair if the Department Chair could reasonably be perceived as not being able to review such application objectively.

14.2-3 For purposes of this Section 14.2, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

14.3 PRACTITIONERS PROVIDING PROFESSIONAL SERVICES BY CONTRACT

14.3-1 A Practitioner who is engaged by the Hospital pursuant to a contract to provide patient care must be granted Privileges to do so. A Practitioner who is, or will be, providing professional services pursuant to a contract with the Hospital is subject to all qualifications for Medical Staff appointment/reappointment and Privileges, periodic appraisals, and must meet all of the obligations of Medical Staff appointment and Privileges as do Practitioners without a contractual relationship with the Hospital.

(a) In the absence of language in the contract to the contrary, if an exclusive contract under which such Practitioner is engaged is terminated or expires, or if the relationship of the Practitioner with the entity that has the exclusive contractual relationship with the Hospital is terminated or expires, then the Practitioner's Medical Staff appointment and those Privileges covered by the exclusive contract shall also be automatically terminated, and the procedural due process rights afforded by the Fair Hearing Policy shall not

apply; provided, however, that the Hospital, in its sole discretion, may waive this automatic termination result.

(b) In the absence of language in the contract to the contrary, if a non-exclusive contract under which such Practitioner is engaged is terminated or expires, or if the relationship of the Practitioner with the entity that has the non-exclusive contractual relationship with the Hospital is terminated or expires, then the Practitioner's Medical Staff appointment and those Privileges covered by the non-exclusive contract shall continue.

14.3-2 Notwithstanding the foregoing, a Practitioner shall be entitled to the procedural due process rights afforded by the Fair Hearing Policy, if applicable, if the basis of the contract termination is such that the Hospital is obligated to report the Practitioner's actions to the National Practitioner Data Bank. In this latter circumstance, the Practitioner will be entitled, if applicable, to the rights set forth in the Fair Hearing Policy only with respect to those issues that formed the basis for the reporting requirement.

14.3-3 If the Hospital adopts a policy involving a closed Department/Section or an exclusive arrangement for a particular service(s), any Practitioner who holds Privileges to provide such service(s) but who does not meet the closed Department/Section criteria or who is not a party to the exclusive arrangement (or otherwise employed by or contracted with the group that holds the exclusive contract with the Hospital), may not continue to exercise such Privileges as of the effective date of the Department/Section closure or exclusive contract irrespective of any remaining time on his/her appointment/reappointment and/or Privilege term.

14.4 UNIFIED MEDICAL STAFF

14.4-1 Separate Medicare certified hospitals that share the same governing body may be authorized by the governing body to direct the medical staffs to hold a vote to either accept a unified medical staff structure (*i.e.,* to opt in) or to maintain separate and distinct medical staffs for their respective hospitals (*i.e.,* to opt out) in accordance with the process described in this Article.

14.4-2 Each such medical staff must initially vote to opt in or out of a unified medical staff consistent with the method for amending these Bylaws set forth in Section 15.1-3. Only medical staff members authorized to vote on medical staff matters and granted privileges to practice on-site at his/her respective hospital may vote on whether to accept or reject a unified medical staff.

14.4-3 There shall be one set of medical staff governing documents applicable to a unified medical staff that reflects the unique needs, circumstances, patient populations, and services of the hospitals and medical staffs that elect a unified medical staff.

(a) Representatives of each unified medical staff hospital will serve on medical staff committees and provide input with respect to the unique needs, circumstances, patient populations, and services provided at each of the unified medical staff hospitals. Documentation of the outcome of a medical staff committee’s review of concerns and needs raised is set forth in meeting minutes.

(b) Members of a unified medical staff may communicate unique needs/circumstances regarding a unified medical staff hospital's patient population and/or services to a medical staff officer, a department chair/section chair, or any member of an appropriate medical staff committee to be addressed in accordance with the applicable medical staff governing documents.

(c) Members of a unified medical staff are provided access to the unified medical staff governing documents, and amendments thereto, which serve to inform the medical staff of the process by which unique needs/circumstances regarding a unified medical staff hospital's patient population and/or services may be raised.

14.4-4 Should a medical staff elect to become part of a unified medical staff but at a later date wish to opt out of that relationship, a vote to opt out of the unified medical staff may be called consistent with the methodology for opting out set forth below:

(a) For purposes of opting out of a unified medical staff, a medical staff member will only be deemed eligible to vote if appointed to the active medical staff category with privileges to practice on-site at the hospital that is deciding whether to opt out of the unified medical staff.

(b) An opt out vote may not be called more often than the two (2) year anniversary of the last date that a vote to opt in or opt out of a unified medical staff has been taken.

(c) A petition requesting that an opt out vote be called must be signed by not less than twenty-five (25%) of the medical staff members eligible to vote at the hospital that is deciding whether to opt out of the unified medical staff (not the entire unified medical staff). Such petition must be submitted to the unified medical staff chief of staff who shall convene a meeting of the medical staff members eligible to vote at the hospital that is deciding whether to opt out of the unified medical staff (not the entire unified medical staff).

(d) Action to opt out of a unified medical staff requires a majority vote of the total number of medical staff members entitled to vote at the hospital that is deciding whether to opt out of the unified medical staff.

(e) An opt out decision may not be delegated to the executive committee of the unified medical staff.

14.4-5 Members of a unified medical staff will be advised, in writing, at the time of initial medical staff appointment/grant of privileges and, thereafter, at the time of each reappointment/regrant of privileges, of the right to opt out of the unified medical staff and the process by which to do so.

ARTICLE XV

ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS, POLICIES, AND RULES & REGULATIONS

15.1 MEDICAL STAFF BYLAWS AND RULES & REGULATIONS

15.1-1 REQUEST

(a) Upon the request of the Chief of Staff, the MEC, or upon timely written petition signed by at least one third (1/3) of the Practitioners eligible to vote, in Good Standing, consideration shall be given to adoption or amendment of the Medical Staff Bylaws and/or Rules & Regulations.

(b) The Medical Staff Bylaws and Rules & Regulations shall be reviewed on a triennial basis or more often as needed.

15.1-2 NOTICE

(a) Following review and recommendation from the MEC, the Medical Staff Bylaws and/or Rules & Regulations may be adopted or amended by giving at least thirty (30) days advance written notice to all Appointees, in Good Standing, eligible to vote.

(b) The notice shall include the existing language in the Medical Staff Bylaws and/or Rules & Regulations, if any, as well as the proposed changes. The notice shall also contain a description of the voting procedure and the deadline for casting a vote.

15.1-3 PROCEDURE

(a) Action to adopt or amend the Medical Staff Bylaws and/or Rules & Regulations shall be taken in one of the following ways at the direction of the MEC:

(1) At a regular or special Medical Staff meeting at which a quorum is present following the required notice period set forth in Section 15.1-2. The affirmative vote of a majority of the votes cast at such meeting by the Medical Staff Appointees eligible to vote is necessary for adoption or amendment of the Medical Staff Bylaws and/or Rules & Regulations.

OR

(2) By written or electronic ballot without a Medical Staff meeting. In such event, ballots shall be distributed to each Medical Staff Appointee eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The affirmative vote of a majority of the votes returned by the stipulated date is necessary for adoption or

amendment of the Medical Staff Bylaws and/or Rules & Regulations.

15.1-4 BOARD APPROVAL

(a) Adoption or amendment of the Medical Staff Bylaws and/or Rules & Regulations by the Medical Staff shall become effective following approval by the Board.

(b) In the event the Medical Staff fails to exercise its responsibility in good faith and in a reasonable and timely manner, and after written notice from the Board to such effect including a reasonable time for response, the Board may take action pursuant to these Bylaws. Should the Medical Staff fail to respond under such circumstances or should the Board disagree with any responses or recommendations from the Medical Staff for adoption or amendment of the Medical Staff Bylaws and/or Rules & Regulations, the matter shall be referred to the Joint Conference Committee for consideration prior to final action by the Board.

(c) The Joint Conference Committee shall make a recommendation to the Board within thirty (30) days after receipt of the matter for review. At its next regularly scheduled meeting after receipt of a recommendation from the Joint Conference Committee, the Board shall take final action with respect to the proposal under consideration. Such action by the Board may include ratifying or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

15.1-5 EXCLUSIVITY

(a) Except as provided in Section 15.3, the mechanism described herein shall be the sole method for adoption or amendment of the Medical Staff Bylaws and Rules & Regulations.

15.2 **MEDICAL STAFF POLICIES**

15.2-1 The Medical Staff delegates to the Medical Executive Committee the authority to adopt or amend such Medical Staff Policies as it may deem necessary for the proper conduct of the Medical Staff. The MEC shall periodically review and revise the Medical Staff Policies to comply with current Medical Staff practice, the Medical Staff Bylaws, Rules & Regulations, and the Health System's/Hospital's governing documents and applicable policies.

15.2-2 Action to adopt or amend Medical Staff Policies shall be taken in one of the following ways at the discretion of the MEC.

(a) At a regular or special MEC meeting at which a quorum is present. The affirmative vote of a majority of the votes cast at such meeting by the MEC members eligible to vote is necessary for adoption or amendment of a Medical Staff Policy.

OR

(b) By written or electronic ballot without a MEC meeting. In such event, ballots shall be distributed to each MEC member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The affirmative vote of a majority of the votes returned by the stipulated date is necessary for adoption or amendment of a Medical Staff Policy.

15.2-3 Adoption or amendment of Medical Staff Policies shall become effective following approval of the Board.

15.3 TECHNICAL AND EDITORIAL AMENDMENTS

15.3-1 The MEC shall have the power to adopt such amendments to the Bylaws and Rules & Regulations as are, in its judgment, technical or editorial modifications or clarifications such as renumbering; corrections to punctuation, spelling, or other errors of grammar or expression; correcting inaccurate cross-references, pagination, or headings; or to reflect changes in names of committees or officers, *etc.*

15.3-2 The action to make technical or editorial amendments to the Medical Staff Bylaws and/or Rules & Regulations may be taken by motion acted upon in the same manner as any other motion before the MEC. After MEC action, such technical or editorial amendments to the Medical Staff Bylaws and/or Rules & Regulations shall be made available for review by the Medical Staff and Board.

15.3-3 Such MEC technical or editorial amendments to the Medical Staff Bylaws and/or Rules & Regulations shall be effective immediately and shall be deemed adopted by the Medical Staff and Board if not objected to within sixty (60) days after action by the MEC.

15.4 APPOINTEE ACTION

15.4-1 Any Appointee, in Good Standing, eligible to vote may raise a challenge to any Medical Staff Policy adopted or amended by the MEC and approved by the Board. In order to raise such challenge, the Practitioner must submit to the MEC a petition signed by not less than twenty percent (20%) of the Medical Staff Appointees, in Good Standing, eligible to vote.

15.4-2 Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such Policy; and/or (b) schedule a meeting with the petitioners to discuss the issue.

15.4-3 In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote prior to review and action by the Board.

15.5 CONFLICT BETWEEN DOCUMENTS

15.5-1 In the event the Health System's/Hospital's governing documents or a Health System/Hospital policy conflicts with the Medical Staff Bylaws, Policies or Rules &

Regulations, then the Health System's/Hospital's governing documents and/or Health System/Hospital policy shall control; provided, however, such conflict shall then be referred to the Joint Conference Committee for recommendation to the Board as to how such conflict can be resolved.

15.5-2 In the event the Medical Staff Bylaws conflict with the Medical Staff Policies or Rules & Regulations, the Medical Staff Bylaws shall control; provided, however, that a meeting of the Medical Staff/MEC shall be called as soon as practicable after learning of the conflict in order to resolve it**.**

15.6 ACCESS TO MEDICAL STAFF DOCUMENTS

The Medical Staff Bylaws, Policies, and Rules & Regulations, and any amendments thereto, shall be made available to those individuals with a Medical Staff appointment and/or Privileges at the Hospital.

ADOPTED AND APPROVED

ADOPTED by the Medical Staff on May 29, 2024.

APPROVED by the Board on May 30, 2024.