

# Unified Medical Staff of McHenry, Huntley, & Woodstock Hospitals

**Bylaws**

**Rules & Regulations**

**Code of Conduct**

**Credentialing Policy**

# **UNIFIED MEDICAL STAFF BYLAWS**

Effective January 1, 2016

Amendments effective: October 3, 2016; October 2, 2017; December 6, 2017,  
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## **PREAMBLE**

The Medical Staffs of the Hospitals are unified and consolidated into an organized and self-governing body under these bylaws in order to enhance the quality and safety of care, treatment and service provided to patients.

The Hospitals and the Medical Staff have a duty to cooperate in their mutual responsibility of providing quality patient care. Only physicians, podiatrists and dentists (MD, DO, DPM, DDS, DMD) licensed to practice medicine, podiatry and dentistry under the laws of the State of Illinois, respectively, may be Members of the Medical Staff. In those areas where medical judgment and evaluation of medical competence are involved, the Hospitals and the Professional Standards Committee will rely upon the judgments and recommendations of the Medical Staff, will cooperate and provide needed assistance, and will recognize that the primary responsibility for patient care is that of the Medical Staff.

## **DEFINITIONS**

1. “Adverse decision” means a decision reducing, restricting, suspending, revoking, denying, or not renewing Medical Staff membership or clinical privileges.
2. “Board” means the governing body (the board of directors) of the Corporation.
3. “Clinical Privilege” or “Privilege” means authorization to provide direct patient care services within limits as delineated consistent with these Bylaws, based on the Practitioner’s professional license, experience, demonstrated competence, ability, and judgment, and includes access to those Hospital resources, equipment, facilities, and personnel reasonably necessary to effectively provide patient care services within the scope of the privileges granted.
4. “Corporation” means Northern Illinois Medical Center or “NIMC”, an Illinois not forprofit corporation that owns and operates the Hospitals.
5. “Credentials Committee” means that committee of the Medical Staff as described in these bylaws.
6. “Credentials Verification Office (CVO)” means the Northwestern Memorial Health Care office authorized on behalf of the President of the Medical Staff to perform primary source verification of information bearing on a Practitioner’s professional ability and other qualifications
7. “Day” means a calendar day unless otherwise specified in a particular context as “working day,” which is a non-weekend, non-holiday day.
8. “Department” means the clinical organizational divisions of the Medical Staff.
9. “Department Chair” means the Medical Staff Member duly elected in accordance with these Bylaws to serve as head of a Department, or their designee appointed for a specific purpose.

10. “Economic factor” refers to any information or reasons for decision unrelated to quality of care or professional competency.
11. “Focused Professional Practice Evaluation” the process implemented for Practitioners when they initially receive requested privileges or when the Practitioner or Advanced Practice Provider (“APP”) request an expansion of privileges. Also implemented upon recommendation of the Medical Staff to assess quality of care, patient safety, and professionalism of a Practitioner or APP.
12. “Hospitals” means Northwestern Medicine McHenry Hospital, Northwestern Medicine Huntley Hospital and Northwestern Medicine Woodstock Hospital, including all inpatient and outpatient departments and locations and “Hospital” shall mean any one of the foregoing hospitals.
13. “Good standing” means Medical Staff Members who have met the attendance requirements during the previous Medical Staff year, are not in arrears in dues payment, and are not under a suspension of their Medical Staff membership or privileges.
14. “Investigation” refers to that process initiated by the Medical Executive Committee with written notice to the Practitioner to determine the validity, if any, to a concern or complaint regarding professional conduct or competence and that terminates with the Hospital’s final action on the Medical Staff recommendation or the conclusion of that process without recommendation or adverse action. Investigation does not include activity of the Medical Staff Wellness Committee.
15. “Medical Staff” means the formal organization of physicians, podiatrists and dentists, as approved and appointed by the Professional Standards Committee for the purposes described herein. The Medical Staffs of the Hospitals are a unified and consolidated Medical Staff, and will be referred to herein singularly as the Medical Staff.
16. “Medical Staff Year” means the fiscal year beginning September 1 through August 31st
17. “Member” means, unless otherwise specified or indicated by context, a Practitioner granted Medical Staff membership consistent with these Bylaws.
18. “Northwestern Memorial HealthCare” or “NMHC” means the parent organization and sole corporate Member of NIMC.
19. “Patient Contact” shall mean the direct involvement in the care of a patient during a Hospital admission, emergency department visit or an inpatient or outpatient surgical or procedural encounter as defined in the electronic medical record. The determination whether a Practitioner’s service is a Patient Contact for purposes of these Bylaws is within the sole discretion of the Medical Executive Committee.
20. “Practitioner” refers to a physician, podiatrist or dentist who is a Member or who has or is applying for membership on the Medical Staff.

21. “President” means the President of the Corporation.
22. “Professional Standards Committee” means the committee authorized by the Board to provide oversight of the Medical Staff as described in these Bylaws and as required by applicable law and regulations.
23. “Primary Hospital” means the Hospital with which a Medical Staff Member chooses to be primarily associated.
24. “Staff category” refers to those specific categories set forth in Article III of these Bylaws.
25. “Written Notice” means notice given in writing, via email, fax, personal delivery, or delivery to the recipient’s last known home address via: certified U.S. Mail or by overnight private courier such as FedEx or UPS. For U.S. Mail, notice will be considered received two (2) days from placement with the U.S. Post office. For private courier, notice will be considered received one (1) day from placement with the courier.

## **ARTICLE I**

### **MEMBERSHIP**

#### **1. Nature of Medical Staff Membership**

Membership on the Medical Staff is a privilege extended to professionally competent physicians, dentists and podiatrists who meet the qualifications, standards and requirements set forth herein.

#### **2. Qualifications and Criteria for Membership**

- a. Only physicians, podiatrists and dentists who document their background, experience, and training, and demonstrate their clinical competence, their adherence to the ethics of their profession, their good reputation, their satisfactory utilization of health care resources generally, their pledge and commitment to adhere to the mission, vision and values of Northwestern Medicine and to provide continuous care to their patients, their ability to work with others, with sufficient adequacy to demonstrate to the Medical Staff and the Professional Standards Committee that they would provide care to patients at the generally recognized professional level of quality, taking into account the patient’s needs and the available Hospital facilities and resources, shall be considered for or allowed to retain membership and Clinical Privileges. Further qualifications include a record free from Medicare, Medicaid, TRICARE sanctions, felony convictions, occurrences of undesirable conduct and excessive professional liability claims.
- b. Each applicant for membership on the Medical Staff shall provide:
  - i. proof of an Illinois license to practice either medicine in all its branches, podiatry or dentistry;
  - ii. Illinois license and federal registration to dispense controlled substances if required to exercise requested Privileges; and

- iii. a certificate of professional medical liability insurance as evidence of coverage for the clinical privileges sought to be exercised with a company registered to do business in the State of Illinois in an amount equal to or greater than the minimum requirement established by the Professional Standards Committee, and with Northwestern Medicine identified as a Certificate Holder.
  
- c. Podiatrists: Podiatrists shall be graduates of a school of podiatry approved by the Council of Podiatric Medical Education and be board certified/board eligible by the American Board of Foot and Ankle Surgery. All podiatrists must be licensed to practice podiatry in the State of Illinois. A podiatrist may attend patients who have been admitted by a Medical Staff Member at their request. The podiatrist may write orders within the scope of their license as limited by the applicable statutes and applicable Hospital rules and regulations.
  
- d. Dentists: Dentists shall hold a DDS degree or its equivalent. All dentists must be licensed to practice dentistry in the State of Illinois. A dentist may attend patients who have been admitted by a Medical Staff Member at their request. The dentist may write orders within the scope of their license as limited by the applicable statutes and applicable Hospital rules and regulations.
  
- e. Oral and Maxillofacial surgeons: Oral and Maxillofacial surgeons shall hold a DDS/DMD degree or its equivalent, and be board certified/board qualified in oral/maxillofacial surgery. All oral surgeons must be licensed to practice dentistry in the State of Illinois. An oral surgeon may write orders within the scope of their license as limited by the applicable statutes and applicable Hospital rules and regulations.
  
- f. When the Medical Executive Committee or Professional Standards Committee has reason to believe that a physical and/or mental condition of a Member of, or an applicant to, the Medical Staff is impairing the Member's ability to provide quality patient care, the Practitioner may be required to submit to an evaluation of their physical and/or mental status by a physician or physicians acceptable to the Medical Executive Committee and to the Professional Standards Committee as a prerequisite to: further consideration of their initial application or re-appointment to the Medical Staff; the continued exercise of previously granted privileges; maintenance of Medical Staff membership. The Practitioner may be also referred to Medical Staff Wellness Committee for further evaluation.
  
- g. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of privileges merely by virtue of the fact that the Practitioner is licensed in the State of Illinois or is a Member of any particular professional organization.
  
- h. Board Certification. (a) All new applicants who apply for Medical Staff membership must be board certified, or board eligible and actively pursuing board certification, in their primary specialty or subspecialty, achieving board certification within three (3) years. (b) All existing Members of the Medical Staff

who are board certified shall maintain such board certification in their primary or subspecialty in order to be a Member. If a Member has allowed board certification in their primary specialty to lapse, that Member has three (3) years from the time that the certification lapsed to obtain re-certification. (c) All Members of the Medical Staff who were Members but not board certified at the time of the adoption of these Bylaws on January 1, 2016 shall become board certified according to any parameter previously agreed to, and if none, then no later than January 1, 2023. Appointment and privileges will automatically expire after January 1, 2023. (d) The Board upon recommendation of the Medical Executive Committee may waive the application of this Section in exceptional circumstances.

### **3. Compliance and Ethics**

Acceptance of membership and/or request for clinical privileges on the Medical Staff shall constitute the agreement that they will strictly abide by: all applicable laws and regulations of the United States and the State of Illinois; the Principles of Medical Ethics of the American Medical Association, the Principles of Medical Ethics of the American Osteopathy Association, the Code of Ethics of the American Podiatric Medical Association, or the Code of Ethics of the American Dental Association, whichever is applicable.

### **4. Basic Responsibilities of Medical Staff Membership**

Each Member of the Medical Staff shall:

- a. If granted Clinical Privileges, provide their patients with care at the generally recognized professional level of quality and participate in quality of care review.
- b. Abide by these Bylaws and any Medical Staff Rules, Regulations and Policies established hereafter and all other established standards, policies or rules of the Hospitals, including without limitation the Code of Conduct. This includes participating in focused professional practice evaluation (FPPE), performance monitoring, performance improvement, and ongoing professional practice evaluation (OPPE) as required by the Medical Staff.
- c. Discharge such Department and committee functions for which they are responsible by appointment or election.
- d. Prepare and complete in a timely and legible manner the medical and other required records for all patients they admit or otherwise provides care to in a Hospital.
- e. Abide by the ethical principles of their profession.
- f. Promptly notify the President of the Medical Staff within five (5) business days in writing of the following, whether voluntary or involuntary: revocation or suspension of their professional license, or the imposition of terms of probation



or limitation of practice by any state or other governmental body or unit, or of their loss of staff membership or loss or restriction of privileges at any hospital or other health care institution, or of receipt of notice of any formal charges or the commencement of a formal investigation by any professional regulatory or licensing agency, or the filing of charges by the Department of Health and Human Services, Peer Review Organization, or any law enforcement agency or health regulatory agency of the United States or the State of Illinois, or of the filing of a claim against the Practitioner alleging professional liability; and within 45 days notify the President of the Medical Staff of any other change in the credentialing information from the date the Practitioner knew of the change.

- g. For Members of the Active and Provisional Medical Staffs, and potentially Members of the Courtesy Medical Staff, provide emergency services through “on- call” schedule and, where necessary, provide follow-up care to patients without personal physicians in accordance with these Bylaws and Medical Staff Rules, Regulations and Policies. Once assigned call, providers are responsible for communicating any change in writing to the Department Chair and Medical Staff Office.
- h. Participate appropriately as peer reviewers in Medical Staff peer review activities as assigned, including proctoring, records review, application review, hearing committee participation, and other peer review activities as reasonably assigned by Department and Medical Staff leadership.
- i. Provide adequate supervision of house staff Members in their clinical training as requested by the appropriate Department Chair and in accordance with the House Staff Supervision Policy.

## 5. **Term of Appointment**

Absent circumstances warranting a shorter appointment, the initial appointment term, and subsequent reappointment terms, to the Medical Staff shall be made by the Professional Standards Committee upon recommendation of the Medical Executive Committee for a term not to exceed a two (2) year period.

When due process has not been exercised as outlined in Article VIII then in no case shall the Professional Standards Committee refuse to renew an appointment, suspend or terminate an appointment previously made without conference with the Medical Executive Committee. Final authority on appointment and reappointment to the Medical Staff, the granting of privileges, and the suspension or termination of Medical Staff membership or privileges shall rest exclusively with the Professional Standards Committee.

## 6. **Leave of Absence**

- a. Request for and effect of leave of absence. A Member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the President of the Medical Staff. Such notice shall state the reason(s) for the proposed leave, a commencement date, and an expected duration, which shall not

exceed twenty-four (24) months. In urgent or unexpected leave circumstances, the Department Chair or President of the Medical Staff in consultation with the Medical Staff Member, if practicable, may initiate a request for a leave of absence on behalf of the Member. A leave of absence request is granted by the Medical Executive Committee and approved by the Professional Standards Committee, with the Medical Executive Committee determining the effective date and expiration date of the leave. The Medical Executive Committee or the Professional Standards Committee may also impose such conditions or limitations in granting the leave as deemed appropriate. From and after the effective date and during the leave of absence, the Member shall not be entitled to exercise their Clinical Privileges at the Hospitals. Abuse of the privilege to obtain leaves of absence, as determined by the Medical Executive Committee, can be grounds for denial of renewal of membership.

- b. Reinstatement. If a Member on leave would like to be reinstated, then that Member must request reinstatement of their Clinical Privileges by submitting a written request to the President of the Medical Staff. The Member shall furnish along with this request a detailed written statement concerning the Member's activities during the leave of absence. The Credentials Committee shall review the request for reinstatement and may request such additional information from the Member as it shall deem fit. Notwithstanding the foregoing, in the event the leave of absence shall have extended for more than one year, the Member shall be subject to the same procedures, review, scrutiny, and criteria that would then be applicable to a request for reappointment to the Medical Staff under these Bylaws. The Credentials Committee shall make a recommendation concerning reinstatement, including the imposition of conditions or limitations, including without limitation, a Focused Professional Practice Evaluation, to the Medical Executive Committee for approval. The Medical Executive Committee can approve or deny the requested reinstatement, including the imposition of conditions or limitations as recommended by the Credentials Committee or as it otherwise deems appropriate. The Professional Standards Committee shall approve all reinstatements. In the event of an adverse recommendation by the Medical Executive Committee in connection with a request for reinstatement, the Member shall be entitled to a Written Notice of such from the Medical Executive Committee and may invoke their rights to a hearing and review of the matter in accordance with these Bylaws.

A Member who fails to request reinstatement from a leave of absence before its expiration shall be deemed to have resigned from such Medical Staff and shall have no right to a hearing and review of such termination in accordance with the procedures set forth in these Bylaws.

**ARTICLE II**  
**APPLICATION PROCESS**

**1. Application for Appointment/Reappointment and For Privileges**

Each Hospital welcomes and will consider applications from all who possess the qualifications for membership and/or clinical privileges. The Hospital will not discriminate in granting Medical Staff membership and/or Privileges on the basis of sex, gender identity, sexual orientation, race, religion, national origin, mental or physical disability or any other basis prohibited by applicable law.

The appointment and reappointment process consist of collection, verification, and assessment of information regarding education, training, experience, licensure, certification, current clinical competence, physical ability to discharge patient care responsibilities, interpersonal and communication skills, professionalism and any other specified qualifications or requirements as a foundation for objective, evidence-based decisions regarding appointment to the Medical Staff. The detailed requirements of the appointment, reappointment and privileging process are contained in the Medical Staff Credentialing Policy.

Applications for appointment and reappointment to the Medical Staff and for Privileges, shall be in such form as the Credentials Committee and Professional Standards Committee prescribe, consistent with Illinois statutory uniform credentialing forms. The application may be obtained from the NMHC CVO, which will make these Bylaws and relevant policies available to the applicant. Applications for appointment and reappointment will not be considered until completed.

- a. A completed application includes, at a minimum, the following:
  - i. a completed application identifying the clinical privileges and membership category requested;
  - ii. paid application fee, the fee being set by the NMHC CVO;
  - iii. an executed consent and release from liability consistent with paragraph 1.c. below;
  - iv. a full summary of the applicant's education, training and positions held, including the dates of each, relevant to the type of application (appointment or reappointment);
  - v. evidence of professional liability insurance in amounts as set forth herein;
  - vi. professional, peer references as applicable to the type of application (appointment or reappointment);
  - vii. documentation of or information concerning current medical and physical health status; as requested;

- viii. a complete list or statement of the applicant's malpractice claims history for the past ten years including current professional liability lawsuits pending against the Practitioner;
  - ix. Other data specific to the applicant's clinical practice, reviewed by the Medical Staff that currently privileges the applicant, if applicable and available;
  - x. information as to whether the applicant's membership and/or clinical privileges ever have been revoked, suspended, reduced, subject to pending or active investigation, not renewed, or voluntarily withdrawn/relinquished at any other hospital or institution;
  - xi. information as to whether the applicant ever has been refused professional liability insurance, or has been disciplined by any agency or governmental department or branch thereof, including the Illinois Department of Professional Regulation or has a pending or active investigation of same outstanding, or has voluntarily relinquished licensure or registration;
  - xii. a statement that applicant has read and understands these Bylaws and the rules and regulations of the Medical Staff, and agrees to be bound by the terms thereof for purposes of their application and thereafter, whether or not the Practitioner is ultimately granted membership on the Medical Staff; and
  - xiii. a statement that applicant is not currently excluded from participating in Medicare, Medicaid or any other federal health care program when such exclusion has been imposed by government enforcement authorities, or accepted by the applicant, as a sanction for unlawful conduct.
- b. Applications for reappointment are processed according to the process for initial applicants established above, with an additional review to include at least the following items:
- i. all information contained within the Member profile, including Member-specific QA/QI, and ongoing professional practice evaluation (OPPE), all as compared with aggregate data;
  - ii. participation in continuing educational activities, related to privileges granted.
  - iii. where there is insufficient data regarding the privileges requested, recommendation(s) from the Department Chair/Director from the applicant's primary facility.

In the event that an applicant for reappointment is the subject of an investigation or hearing at the time membership reappointment is being considered, a conditional reappointment may be granted pending the completion of the investigation and any related hearing process.

- c. Applicants for membership to the Medical Staff:
- i. bear the burden of establishing their qualification for such membership, and the responsibility for producing the information required in the application process is, therefore, borne solely by the applicant;
  - ii. signify willingness to appear for interviews with the Department Chair or a designee, of the Department in which the applicant seeks Privileges, and/or or a Medical Staff committee; as requested;
  - iii. authorize Members of the Medical Staff to exchange information with Members of the Medical Staffs of other hospitals with which the applicant has been or is associated and with other parties who may have information bearing on the applicant's professional competence, character, and ethical qualifications;
  - iv. release the Hospitals and its employees, agents, the Medical Staff, and each and every Member thereof, for their acts performed in good faith in evaluating the applicant's credentials and qualifications;
  - v. consent to the inspection and copying of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence, as well as to the applicant's moral and ethical qualifications;
  - vi. release from any liability to the maximum extent permitted by law all representatives of the Hospitals for their acts performed in connection with evaluating the applicant and their credentials;
  - vii. release from any liability to the maximum extent permitted by law all individuals and organizations who provide information, including otherwise privileged or confidential information, to representatives of the Hospitals concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges with permission of the applicant;
  - viii. waive voluntarily, in the case of rejected initial applicants only, any right to file a court action based on state law claims challenging the rejection. In the event that this waiver provision is dishonored in any court of law, initial applicant agrees that the substantially prevailing party or parties in any lawsuit brought by applicant against any or all representatives of the Hospitals shall be entitled to recover their reasonable attorney's fees and costs from the other party or parties;
  - ix. consent to mental, physical or toxicological examination by person(s) appointed by the President of the Medical Staff if requested to do so and to produce full reports thereof;

- x. waive voluntarily the provisions of Section 412(b) of the Health Quality Improvement Act of 1986 (Act) [42 U.S.C. 11112(b)] which waiver is expressly permitted by Section 412(b). This waiver means that no variance between these Bylaws and Section 412(b) concerning notice and hearing rights may be asserted by a Practitioner to defeat the peer review immunity provisions in Section 411(a) of the Act [U.S.C. 11111(a);]
  - xi. agree that any lawsuit that is not filed within 60 days of the Professional Standards Committee's final decision regarding the application shall be time-barred;
  - xii. fully understands that any misstatements in, or omissions from, their application may constitute cause for denial of appointment or cause for corrective action under these Bylaws. All information submitted by the applicant shall be true to the applicant's best knowledge and belief.
- d. A Practitioner who was denied Medical Staff appointment and/or Privileges in connection with a prior application for membership must wait the longer of one (1) year from the date of such denial or until the basis for refusal has been resolved, before reapplying for membership and clinical privileges.
  - e. It shall be the responsibility of the President or their designee in the appointment process to see to it that each Hospital complies with the provisions of the Illinois Hospital Licensing Act and the Health Care Quality Improvement Act, as amended from time to time, relating to obtaining information regarding licensure status of applicants and reapplicants to the Medical Staff from the Illinois Department of Professional Regulation and the National Practitioner Data Bank.

## **2. Report of the Credentials Committee**

- a. The appropriate Department Chair shall provide the Credentials Committee with a recommendation for action regarding the applicant. The Credentials Committee may also independently request an interview with the applicant.
- b. A completed application shall be directed immediately to the Credentials Committee for review.
- c. The Credentials Committee shall fully review the application of the applicant, including character, qualifications, competence and professional standing of the applicant, as well as the accuracy of all information provided.
- d. Thereafter, the Credentials Committee shall submit a final report based upon the committee's review, the recommendation of the Department Chair, and any other pertinent data to the Medical Executive Committee. The final report to the Medical Executive Committee shall include recommendations for: appointment or reappointment; staff category; delineation of Privileges, if any; and assignment to the Department to which the applicant shall be a Member.

### **3. Role of the Medical Executive Committee**

- a. Upon receipt of the final report of the Credentials Committee concerning membership and privileges, the Medical Executive Committee, no later than at its next regularly scheduled meeting, shall consider the report and accept it, reject it, or refer the issue back to the Credentials Committee for reconsideration.
- b. When the recommendation of the Medical Executive Committee is favorable, the Medical Executive Committee shall promptly forward it, together with all supporting documentation, to the Professional Standards Committee for action.

4. When the recommendation of the Medical Executive Committee is adverse, the Practitioner shall be notified by the President of the Medical Staff, in accordance with these Bylaws, of such recommendation. The Practitioner in such notice shall be further advised of their right to a hearing and appeal under these Bylaws, if any. In the event the Practitioner shall waive their right to a hearing and appeal, the recommendation shall be sent to the Professional Standards Committee for final action. Initial applicants will not have a right to a hearing or appeal; if the Medical Executive Committee recommends that an initial applicant's request for membership or privileges is denied in whole or in part, that recommendation shall be sent to the Professional Standards Committee for final action.

### **5. Role of the Professional Standards Committee in the Absence of a Hearing**

Within the timeframe specified in paragraph 6 below, after a favorable recommendation of the Medical Executive Committee, or after the Practitioner has waived their right to a hearing/appeal, the Professional Standards Committee shall adopt or reject, in whole or in part, recommendations of the Medical Executive Committee, whether positive or negative, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and optionally setting a time limit within which a subsequent recommendation shall be made. In the case of an initial applicant, if the Professional Standards Committee adopts the recommendation of the Medical Executive Committee to deny the applicant's request for membership or privileges, in whole or in part, then the Medical Executive Committee must provide the applicant a written response that explains the reason(s) for any adverse decision (including all reasons based in whole or in part on the applicant's medical qualifications or other basis, including economic factors). The President of the Medical Staff shall provide Written Notice to the applicant of the Professional Standards Committee's final action within ten (10) days of it being taken. The decision of the Professional Standards Committee shall be final.

### **6. Notice of Decision**

A notice of appointment or reappointment shall include, at a minimum: The Medical Staff category to which the applicant is assigned; the Department and service to which they are assigned; the Privileges they may exercise; and any special conditions attached to the appointment or reappointment.

7. **Application Status and Process Time Period**

Applicants shall be informed of the status of their application for appointment or reappointment upon request. Once an application is complete, and after submission of all credentials data and completion of verification of that credentials data, the application will be acted on by the Professional Standards Committee within 60 days thereafter.

8. **Procedure for Change in Category, Department or Privileges**

a. **Resignation of Membership or Voluntary Relinquishment of Privileges**

Any Member seeking to voluntarily relinquish privileges or resign membership in the Medical Staff may do so at any time by submitting Written Notice to the Medical Staff President stating the effective date of the resignation, however, the resignation shall not be effective until the Practitioner has completed all pending medical records. The Medical Executive Committee shall accept resignation pending confirmation that any outstanding Medical Staff record obligations have been met.

b. **Other Changes in Membership and Privileges**

Any Member seeking to make a change in Medical Staff category or Department or Privilege shall submit a request to the appropriate Department Chair and the Chair of the Credentials Committee stating the reasons and providing the documentation for the requested change. An application for additional Privileges must be supported by documentation of credentials relevant to and required by the criteria established for the Privilege(s) sought, including:

- i. Training, experience and continuing education;
- ii. Evidence of current competence;
- iii. OPPE and QA/QI data specific to the applicant's clinical practice, reviewed by the Medical Staff that currently privileges the applicant, if available;
- iv. Physical ability to perform the privilege as requested;
- v. Recommendation by peers or faculty; and
- vi. Professional liability insurance coverage information for the new clinical privileges if applicable requested.

Any changes in credentialing information since the most recent appointment or reappointment are also considered. Information submitted regarding training and certification as part of the request for additional Clinical Privileges is verified, including but not limited to, a National Practitioner Data Bank query. The request is processed in the same manner as an application for reappointment. If granted, a Medical Staff category, Department or Privilege



change extends to the next membership renewal date, which may be less than two years. The Member is promptly provided Written Notice of the acceptance of his/her application. If a Member's request for additional Privileges or a change in Medical Staff category or Department is denied, the hearing and appeal process will be followed as if applicable.

## **9. DUES**

Each Medical Staff Year, the Medical Executive Committee shall determine Medical Staff annual dues. Medical Staff funds will be segregated from all other funds, invested for interest in a prudent manner, utilized to discharge such Medical Staff financial obligations as the Medical Executive Committee finds appropriate and for no purpose other than Medical Staff affairs which are consistent with the restrictions imposed on tax exempt, charitable organizations. All Medical Staff Members and Allied Health Professionals shall pay dues as established by the Medical Executive Committee, which may vary based on staff category. During a Member's approved leave of absence, the Practitioner's Medical Staff privileges and responsibilities are considered in abeyance and the Practitioner will be responsible to remain current with their Medical Staff dues.

## **10. Access to Credentials and Quality Files**

Medical Staff credentials and quality files and their contents are confidential. To maintain confidentiality, Medical Staff credentials and quality files can only be accessed as described in this section.

### **a. For Medical Staff Operations**

Those Professional Standards Committee, Medical Staff officers, committee chairs and committee Members, and Medical Staff office and quality assurance and risk personnel carrying out peer review and other Medical Staff operations have access to credentials and quality files as needed to fulfill their legitimate duties.

### **b. By Members**

Individual Members have access to their own credentials and quality files (including any other files containing information regarding them) upon request to the Medical Staff Office, under the conditions described in this section. A Member can review their own file, but only in the Medical Staff office, under Medical Staff office personnel supervision to assure the integrity of the files. The Member may copy those documents provided by or addressed personally to the Member, and may also make a request for copies of other documents to the Medical Executive Committee.

A Member may request the Medical Executive Committee to correct mistakes in that Member's credentials or quality file. Information supporting the request is to be included in the written request. A copy of the request shall be provided to the Chief Medical Officer who shall have the opportunity to present information to the Medical Executive Committee. Any correction to a Member's credentials or

quality file shall require the approval of the Medical Executive Committee and the Professional Standards Committee. The Member shall be given prompt Written Notice of the decision and the reasons for the decision. The decision is not subject to any Member hearing rights.

c. Contents

All information gathered during the appointment and reappointment process will be kept in the applicant's or Member's credentialing and quality files.

d. Medical Staff Records Disposal

If a Hospital is closed, its Professional Standards Committee must place the credentials files and other Medical Staff records with an appropriate custodian for at least four years, during which time the records will be maintained as confidential but Members will be permitted access. At least thirty days in advance of closure of a Hospital, the President shall notify each Member of the arrangements for storage and appropriate access.

### **ARTICLE III** **CATEGORIES OF THE MEDICAL STAFF**

The Medical Staff shall be organized into the following categories: Active, Provisional, Courtesy, Affiliate, and Honorary.

1. **Active Medical Staff**

a. Qualifications

The Active Medical Staff of each Hospital shall consist of Members who meet all of the basic qualifications as set forth in these Bylaws who regularly admit or attend patients to the Hospital and who assume all the functions and responsibilities of membership on an Active Medical Staff. All physicians applying for membership to the Active Medical Staff must have practiced for one (1) full year as a Member of the Provisional Medical Staff. Active Medical Staff Members must have a minimum of twenty (20) Patient Contacts in any rolling twelve (12) month period.

b. Duties

- i. Active Medical Staff Members shall be required to attend Medical Staff meetings, as provided in Article XII, Section 6 of these Bylaws.
- ii. Active Medical Staff Members shall provide emergency room call coverage at their Primary Hospital and potentially other Hospitals according to legal, regulatory and patient need, as reasonably determined by the Member's department or section and as approved by the Medical Executive Committee and the Professional Standards Committee. Active Medical Staff Members on staff for a period of twenty (20) years may

request discontinuation of emergency room call. All such requests for discontinuation will be in writing and will be reviewed and approved by the Member's respective Department prior to being acted upon by the Medical Executive Committee and the Professional Standards Committee.

c. Prerogatives

Members of the Active Medical Staff shall be appointed to a specific Department in accordance with these Bylaws. Members of the Active Medical Staff shall be eligible to vote, serve on committees, and hold office. Members of the Active Medical Staff may admit patients to the Hospital if that privilege is requested.

2. **Provisional Medical Staff**

a. Qualifications

The Provisional Medical Staff shall consist of Members who meet the basic qualifications set forth in these Bylaws for Medical Staff membership and are being considered for advancement to Active Medical Staff. Changes from Provisional to Active staff are automatic with successful completion of FPPE. Alternatively, after a period of membership on the Provisional Staff of one (1) year, beginning from the time Professional Standards Committee grants initial appointment and privileges, and Member having had a minimum of twenty (20) Patient Contacts in that year, the Member may request a change in staff category to be advanced to the Active Medical Staff as provided for herein. If the Member does not have a minimum of 20 Patient Contacts, the Member may remain on the Provisional Staff for another 1 year period, or request a staff category change to Courtesy Staff or Affiliate, if they do not have any inpatient volume, as provided for herein.

b. Duties

A Provisional Staff Member will be required to discharge the same responsibilities as those specified for members of the Active Staff and failure to fulfill those responsibilities shall be grounds for denial of advancement to Active Staff status.

c. Prerogatives

Provisional Medical Staff Members shall be appointed to a specific Department and shall be eligible to serve on committees and to vote on all matters before such committees. Members of the Provisional Medical Staff shall be ineligible to hold office and to vote except for the committees to which they may be appointed. Members of the Provisional Medical Staff may admit patients to the Hospital if that privilege is requested.

### 3. **Courtesy Medical Staff**

#### a. Qualifications

The Courtesy Medical Staff shall consist of those Members who meet the basic qualifications set forth in these Bylaws for Medical Staff membership, who wish to attend private patients in a Hospital but who do not choose to become Members of the Active Medical Staff. A Courtesy Staff Member shall have less than twenty (20) Patient Contacts in the twelve (12) months before the request for a change in staff category. To admit or attend more patients, the Courtesy staff Member must request a change in staff category to the Provisional Staff as provided for herein and must intend on going through Provisional Staff process to attain Active Staff membership.

#### b. Duties

Courtesy Medical Staff Members may be requested to serve as a proctor, hearing or other committee Member, or otherwise accept medical staff duties as reasonably requested. Courtesy Medical Staff Members are welcome to attend the Medical Staff meetings.

#### c. Prerogatives

Courtesy Medical Staff Members shall be appointed to a specific Department and shall be eligible to serve on committees and to vote on all matters before such committees. Members of the Courtesy Medical Staff shall be ineligible to hold office and to vote except for the committees to which they may be appointed. Members of the Courtesy Medical Staff may admit patients to the Hospital if that Privilege is requested.

### 4. **Affiliate Medical Staff**

#### a. Qualifications

The Affiliate Medical Staff shall consist of those Members who meet the basic qualifications set forth in these Bylaws for Medical Staff membership and who wish to refer and follow private patients in a Hospital under certain limited circumstances such as outpatient departments and outpatient clinics.

#### b. Duties

While Members of each Affiliate Medical Staff shall not be obligated to attend meetings of the Medical Staff, they will be expected to do so whenever possible. Affiliate Medical Staff Members are not required to provide emergency room call coverage.

#### c. Prerogatives

Members of the Affiliate Medical Staff shall be appointed to a specific

Department in accordance with these Bylaws. Members of the Affiliate Medical Staff shall be ineligible to vote, serve on committees, or hold office. Members of the Affiliate Medical Staff may not admit patients to the Hospital, and may only hold limited Privileges as approved by the Medical Executive Committee and the Professional Standards Committee.

5. **Honorary Medical Staff**

a. **Qualifications**

The Honorary Medical Staff shall consist of former Medical Staff Members, retired or emeritus, and other Practitioners of outstanding reputation who the Medical Staff has conferred this honor. This is an honorary status only, and Practitioner may not apply for this honor. Proper recognition by the Professional Standards Committee and the Medical Staff shall be accorded such individuals for their years of service to a Hospital and the community.

b. **Duties**

Honorary Staff Members are not eligible to admit patients to a Hospital or to exercise Privileges in a Hospital and are not required to pay dues or maintain liability insurance.

c. **Prerogatives**

Those who are Members of the Honorary Medical Staff may not vote, hold office or chair a committee, but may serve on a committee if requested.

6. **Residents and Fellows**

Residents and fellows in training will be from a program approved by the Accreditation Council for Graduate Medical Education and the NMHC Academic Affairs department for which all will act under the auspices of that program in carrying out clinical care in accordance with written educational protocols delineating the roles, responsibilities, and scope of clinical activities applicable to such trainees.

Residents and fellows are not Members of the Medical Staff, do not have specific Privileges, and shall not be entitled to any of the rights granted under these Bylaws, including but not limited to hearing and appeal rights.

7. **Allied Health Staff**

Allied Health Professionals (AHP) are clinicians, other than physicians, podiatrists or dentists, who are authorized by law, and are qualified by training, experience and current competence, to provide patient care services within the Hospital pursuant to Clinical Privileges. Allied Health Professionals are not Members of the Medical Staff. The provisions of these Bylaws do not apply to AHPs unless specifically referenced as being applicable to them.

Applications for appointment and reappointment to the Allied Health Staff and for

delineated Clinical Privileges shall be processed in a manner similar to appointments and reappointments to the Medical Staff and as outlined in associated policy as approved by the Medical Executive Committee. Specific classifications of Advanced Practice Providers, qualifications, credentialing requirements and procedures, modification of Privileges, competency evaluations, responsibilities, corrective action, and hearing and appellate rights are set forth in the Provision of Healthcare Service by Advanced Practice Provider Policy.

**8. Waiver of Qualifications**

Any qualification, requirement or limitation in this article or any other article in these Bylaws not required by law or governmental regulation (with the exception of active licensure, current malpractice insurance and completion of education), may be waived at the discretion of the Professional Standards Committee upon recommendation of the Medical Executive Committee and determination that such waiver will serve the best interests of the patients and of the Hospitals.

**ARTICLE IV**  
**PRIVILEGES**

Every Practitioner and Allied Health Professional providing care and treatment in the Hospitals by virtue of Medical Staff membership or otherwise shall in connection with such practice be entitled to exercise only those Clinical Privileges specifically granted to them by the Professional Standards Committee, only for reasons directly related to quality of patient care and other provisions of these bylaws and only following the procedures outlined in these Bylaws.

**1. Initial Privileges**

The applicant must apply for Privileges in the form provided with their application for membership. Initial privileges shall be provisionally granted following:

- a. Documented verifications of the applicant's education, training, licensure, health status, competence and other relevant information;
- b. Review by the appropriate Department Chair or their designee;
- c. Recommendation by the Credentials Committee;
- d. Recommendation by the Medical Executive Committee;
- e. Approval by the Professional Standards Committee. The Quality Assurance/Quality Improvement Committee will conduct focused assessments of initial Privileges in accordance with the Medical Staff Credentialing Policy.

**2. Increase in Privileges**

Requests for increased privileges will be processed as delineated in Article II.

### 3. Temporary Privileges

Temporary privileges can be granted only to pending applicants or as necessary to meet an important patient care need, including locum tenens. All persons requesting or receiving temporary privileges are bound by these Bylaws and the Rules, Regulations and Policies of the Medical Staff. If temporary privileges are terminated for a reportable reason, hearing rights apply to such termination. Temporary privileges may be granted by the President, acting on behalf of a Professional Standards Committee, but only on recommendation by the President of the Medical Staff or their designee, for a period not to exceed 120 days.

#### a. Pending Application

The President may grant temporary privileges upon a written request from the Department Chair and the applicant following a satisfactory recommendation for approval of an application for initial Membership and Privileges by the Credentials Committee and the Medical Executive Committee. If the application has not yet been approved by the Credentials Committee and/or the Medical Executive Committee, temporary privileges may still be granted after verification of the following:

- i. A complete application for Medical Staff membership and privileges;
- ii. Current licensure;
- iii. Relevant training or experience;
- iv. Current competence;
- v. Ability to perform the clinical privileges requested;
- vi. Other criteria required by these Bylaws;
- vii. Query and evaluation of National Practitioner Data Bank information;
- viii. Absence of current or previously successful challenge to licensure or registration;
- ix. Absence of involuntary termination of medical staff membership at any hospital or other entity; and
- x. Absence of any involuntary limitation, reduction, denial or loss of clinical privileges.

Temporary privileges are not granted if the Credentials Committee has recommended against a favorable action or there are otherwise indications that an applicant will not be granted Medical Staff membership and privileges by a Professional Standards Committee. Temporary privileges automatically terminate if an applicant's initial membership application is withdrawn.

b. Important Patient Care Need

The President, on the recommendation of the President of the Medical Staff, may grant temporary privileges to fulfill an important need for patient care, treatment or service, such as providing treatment needed that no Member is able to, covering for an absent Member, or otherwise. At a minimum, current licensure and current competence are verified before such temporary privileges are granted. Requests for temporary privileges under these circumstances will be processed in accordance with these Bylaws and the Medical Staff Credentialing Policy.

4. Emergency Circumstances and Disaster Privileges

For the purpose of this Section, the term “emergency” is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

In case of an emergency, any Medical Staff Member with Clinical Privileges may be permitted and assisted to do everything possible to save a patient’s life or save a patient from serious harm. This action by the Practitioner shall be to the degree their license permits and regardless of their Department, Medical Staff status or specific Clinical Privileges.

When the emergency situation no longer exists, in order to continue to treat the patient, such Member must request the privileges necessary to continue such treatment. In the event such privileges are denied or they do not desire to request such privileges, the patient shall be assigned to an appropriate Member of the Medical Staff.

For the purpose of this Section, the term “disaster” is defined as the activation of the Hospital’s Emergency Operations Plan in response to a disaster where the immediate needs of its patients cannot be met and the use of volunteer Practitioners to meet these needs is necessary or advisable.

The President and the Medical Staff President, or their designees, may grant disaster privileges, which will remain in effect during the duration of the disaster. Refusal to grant such privileges, or revocation of such privileges before the disaster has resolved, does not give the right to the hearing and appeals process provided for in these Bylaws.

Disaster privileges will be granted upon presentation of a valid, government-issued photo identification and at least one of the following:

- a. A current Hospital picture identification that clearly identifies professional designation;
- b. A current license to practice;
- c. Primary source verification of the license;
- d. Identification establishing that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the



Emergency System for Advance Registration of Volunteer Health Professionals (ESAR- VHP), or other recognized state or federal organizations or groups;

- e. Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances; and
- f. Identification by current hospital staff or medical staff Member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent Practitioner during a disaster.

Primary source verification of the credentials of individuals given disaster privileges should be completed within 72 hours of when the disaster situation is under control, or within 72 hours from the time the volunteer presented them self to the Hospital. If primary source verification cannot be completed within this time frame, the reasons for additional time are documented and the volunteer's ability to continue to provide adequate care, treatment, and services is verified.

Individuals granted disaster privileges will be given temporary identification to designate their status. Medical Staff Members working with volunteers given disaster privileges will oversee their performance through observation.

Refusal or withdrawal of any disaster privileges does not give the right to the hearing and appeals process, unless the refusal or withdrawal results in a report to any state or national agency.

## 5. **Admission Privileges**

Privileges to admit patients to a Hospital must be specifically requested and are granted only to qualified Members or those seeking temporary privileges who satisfy the clinical criteria for admitting privileges.

### a. Allied Health Professional

Each patient of an Allied Health Professional shall be admitted to a Hospital by a physician Member with admission privileges; the attending Allied Health Practitioner may assist the physician. The physician Member will be responsible for the overall medical care of the patient.

### b. Dentists and Podiatrists

All persons admitted to a Hospital shall be under the professional care of an attending physician. Patients attended by podiatrists or dentists shall be under the care of either the podiatrist or dentist, and a co-admitting physician Member of the Medical Staff. A Doctor of Podiatric Medicine or a Doctor of Dental Surgery shall be responsible for all care within the limits of the privileges granted to them; while a physician is responsible for all aspects of general medical care.

## **6. Telemedicine Privileges**

Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services. The Professional Standards Committee will determine the clinical services to be provided through telemedicine after consultation with the Medical Executive Committee.

Individuals applying for telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in these Bylaws, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities. Qualified applicants may be granted telemedicine privileges but will not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

Applications for telemedicine privileges will be processed in accordance with these Bylaws and the Medical Staff Credentialing Policy in the same manner as for any other applicant, except that the Hospital may use the credentialing information provided by the applicant's primary hospital if that hospital is a Medicare-participating hospital and provides: (1) a list of all privileges granted to the Practitioner; (2) information indicating that the applicant has exercised such privileges in a competent manner; and (3) a signed attestation that the information is complete, accurate, and up to-date.

Telemedicine privileges, if granted, will be for a period of not more than two (2) years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed in accordance with these Bylaws and the Medical Staff Credentialing Policy.

Individuals granted telemedicine privileges may be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

## **7. Exclusive or Otherwise Contracted Privileges**

### **a. Medical Staff Role in Deciding Whether Contracts Should be Issued**

Whenever a Hospital plans to issue a contract, exclusive or otherwise, to provide services delivered under clinical privileges, it informs the Medical Executive Committee as to which specialties and services will be affected. The Medical Executive Committee (or an ad hoc committee formed for this purpose) may collect information from the Members that would be affected, from that Hospital's administration, and from other interested parties, to make an informed recommendation as to whether those services should be provided through a

contract, and, should a contract arrangement be recommended, what contract sources should be utilized. Such an analysis and recommendation, if undertaken, shall be made in a timely manner. The actual terms of any contract and any financial information related to the contract, including but not limited to the remuneration to be paid to Members under contract, are not relevant and therefore are neither disclosed to the Medical Executive Committee nor discussed as part of this contracting evaluation process. The President will thereafter determine the nature and extent of the contracted services to be provided, and the Professional Standards Committee will make the final approval of such contracted services.

To the extent that any such contract confers the exclusive right to perform Hospital specified services on the other party to the contract, no new applicant who is otherwise not employed nor a Member of such exclusive provider may be granted clinical privileges to perform the specified services while the contract is in effect.

b. Effect of Exclusive Contract

If a reduction or termination of medical staff membership or clinical privileges is the result of a Hospital's exercise of its right to enter into an exclusive contract, the Practitioner shall receive at least sixty (60) days prior Written Notice of the effect on their Medical Staff membership or clinical privileges. An affected Member desiring a hearing under these Bylaws must request the hearing within fourteen (14) days of being given notice. The requested hearing shall be commenced and completed (with a report and recommendation to the affected Member, the Professional Standards Committee and Medical Staff) within thirty (30) days after the date of the Member's request.

8. History and Physical Privileges

Only those physicians granted privileges to do so may conduct history and physicals or update histories and physicals. History and physical privileges must be carried out consistent with the requirements of these Bylaws.

a. Physicians

Physicians who are Members or who are applying for temporary privileges may be granted privileges to conduct a history and physical or an update to a history and physical upon application and approval through the privileging and credentialing processes.

b. Oral and maxillofacial surgeons

Privileges to conduct or update histories and physicals only for those patients admitted solely for oral and maxillofacial surgery are granted to qualified oral and maxillofacial surgeons who are Members of the Medical Staff or seeking temporary privileges and who apply and are approved through the privileging and credentialing processes.

**ARTICLE V**  
**REAPPOINTMENT**

**1. Renewal Process for Bi-Annual Review**

Members of the Medical Staff shall be evaluated for reappointment and extension of privileges every two (2) years. Practitioners so applying for reappointment and extension of privileges must complete and file an application comparable to that used for initial applicants. A Department Chair and the Credentials Committee shall timely review each Member's application for reappointment to permit necessary review by the Medical Executive Committee and Professional Standards Committee prior to the expiration of the Member's current appointment.

**2. Reappointment Application**

The CVO will notify each Member of the Medical Staff who qualifies to be evaluated for reappointment and renewal of clinical privileges approximately 120 days in advance of expiration. Each Member shall complete and file an application and all documents attendant thereto within sixty (60) days. If an application is not completed within sixty days, Written Notice reminding the Member of the need to complete the application within an additional fourteen (14) days will be provided. Such notice shall state that failure to submit an application with all documents attendant thereto by the designated final date shall be deemed as evidence of the desire of the Member to no longer serve on the Medical Staff. Such failure shall also be deemed the voluntary resignation of the Member from the Medical Staff at the expiration of their current reappointment period.

Upon determining that the reappointment process has been delayed for non-substantive or administrative reasons, the Credentials Committee may in its discretion allow for thirty (30) day extensions of membership and privileges to permit completion of the reappointment process and to avoid disruption of patient care.

**4. Review of Information**

Completed and verified applications for reappointment will be provided to the Member's Department Chair for consideration. Information to be reviewed includes, at a minimum, the Members professional activities, OPPE performance and conduct in the Hospital and continuing education related to the specialty. The Department Chair shall make a recommendation on reappointment and renewal of privileges to the Credentials Committee. The Credentials Committee shall then submit a final report based upon the Committee's review, the recommendation of the Department Chair, physician profile information and any other pertinent data to the Medical Executive Committee for consideration. The Medical Executive Committee shall review the report and transmit its recommendation in writing to the Professional Standards Committee for final action.

**5. Basis for Recommendations**

Each recommendation concerning the reappointment of a Medical Staff Member and the Privileges to be granted upon reappointment and the category of reappointment shall be based upon factors including but not limited to, the Member's demonstrated professional

competence and clinical judgment in the treatment of patients, quality assessment information, loss or lessening of privileges or membership at other institutions, National Practitioners Data Bank information, continuing medical education, participation in required Medical Staff affairs, compliance with these Bylaws and Rules and Regulations and policies of the Hospital and the Medical Staff, cooperation with other Practitioners, Hospital personnel and with patients taking into account patients' needs and available Hospital facilities, the number and nature of professional liability lawsuits against the Practitioner, verification of current Illinois licensure and current federal and state controlled substance licensure, timely completion of medical records, peer recommendations from their respective department, and resources and utilization standards, their participation in teaching programs and willingness to contribute to the best interests of the patients.

**6. Denial of Reappointment**

When the Medical Executive Committee's recommendation to the Professional Standards Committee is to deny reappointment, to reduce Privileges, to deny a requested increase in Privileges, or to deny a change in Medical Staff category, the Member shall be given Written Notice stating the reasons for such decision. Such notice shall also advise the Member of their right to a hearing as described in these Bylaws.

**7. Reapplication After Denial of Reappointment**

A Practitioner who has received a final Adverse Decision on reappointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years unless the decision of the Medical Executive Committee and Professional Standards Committee provides otherwise. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Medical Executive Committee or Professional Standards Committee may require.

**ARTICLE VI**  
**MEDICAL STAFF CODE OF CONDUCT**

Members and Allied Health Professionals will: treat others with respect, courtesy, and dignity; conduct themselves in a professional and cooperative manner; and avoid inappropriate, disruptive and harassing behaviors that undermine a culture of safety. The manner in which such behaviors are identified, complaints are made, and issues are addressed is provided for in the Medical Staff Code of Conduct Policy. Any corrective action taken in relation to a code of conduct issue will be in accordance with the provisions of these Bylaws.

**ARTICLE VII**  
**PROCEDURE FOR CORRECTIVE ACTION**

**1. Criteria for Initiation**

Whenever the activities or professional conduct of any Member are considered to be:

- lower than the standards of the Medical Staff; or
- disruptive to the operations of a Hospital;

- detrimental to patients' safety, or compromises the quality of care;
- inconsistent with patient care at a generally recognized professional level of quality and standard of care; or
- in violation of these Bylaws and any Medical Staff Rules, Regulations and Policies established hereafter and all other established standards, policies or rules of the Hospitals approved by the Medical Executive Committee.

Corrective action against such Member may be initiated by any officer of the Medical Staff, by the Chair of any Department to which they have privileges, by the chairman of any standing committee of the Medical Staff, by the President, or by the Professional Standards Committee in the form of a complaint. Initiation of corrective action pursuant to this section does not preclude imposition of summary suspension as provided for in these Bylaws, nor does it require the prior imposition of such a suspension.

## 2. **Procedure**

### a. Complaints

Complaints against a Member or other Practitioner with clinical privileges may be submitted by any person in writing and directed to the President of the Medical Staff, a respective Department chairman, the Medical Executive Committee, the President, or the Professional Standards Committee.

To be accepted for consideration, the complaint must describe, in detail, any allegations.

### b. Notice

A Member or other Practitioner with clinical privileges complained of will be promptly notified by an officer of the Medical Staff of the existence of, and the nature of, any complaint made against them by providing them with a legible copy of the complaint, by certified mail, within ten (10) working days of the receipt of such complaint by the President of the Medical Staff.

### c. Investigation

After consideration of any complaint, the Medical Executive Committee shall either reject the complaint and report the reasons for its decision to the Medical Staff President, or forward to an investigation team described below to conduct an investigation which may include an external review. The Medical Executive Committee may also or alternatively refer the individual to the Medical Staff Wellness Committee.

## 3. **External Peer Review**

External peer review may take place, in the circumstances listed here, in the context of departmental review, investigation, application processing or at any other time only under

the following circumstances, if and only if deemed appropriate by the relevant Department, the Medical Executive Committee or Professional Standards Committee; however, a Practitioner subject to focused review or investigation can request the appropriate Hospital or Medical Staff to obtain external peer review.

- a. Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly and adversely affect an individual's membership or privileges;
- b. Lack of internal expertise, in that no one on the Medical Staff has adequate expertise in the clinical procedure or area under review;
- c. When a Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring;
- d. To promote impartiality in peer review; and
- e. Upon the reasonable request of a Practitioner.

The Medical Executive Committee or Professional Standards Committee may require external peer review in any circumstances deemed appropriate by either of these bodies. If the report of an external review is utilized in peer review, the Practitioner being reviewed shall receive a copy of that report. Any written response provided by the Practitioner within thirty (30) days of receiving the report will be considered in the corrective action and hearing and appeal processes.

#### **4. Investigation Team**

If the Medical Executive Committee refers a complaint to an investigation team, the President of the Medical Staff in conjunction with the Medical Executive Committee shall appoint the investigation team made up of at least three (3) impartial Active Staff Members to gather information relating to the issues raised in the complaint. The person who is the subject of the complaint shall have the right to present views, opinions, and positions regarding the matter to the investigation team in the manner determined by the investigation team, which may include an invitation to personally appear before the investigation team. Any such appearance shall be informal in nature and will not include legal representation. A report on the investigation team's findings shall be forwarded to the Medical Executive Committee and to the affected Medical Staff Member.

#### **5. Medical Executive Committee Action**

Within thirty (30) days following receipt of the report of the investigation, the Medical Executive Committee shall take action upon the complaint. The affected Member and Department chairman shall have the right to appear before the Medical Executive Committee on the date it meets to act on the matter. Such action may include, without limitation:

- a. Rejecting the complaint or request for corrective action;

- b. Issuing a warning, a letter of admonition, or a letter of reprimand;
- c. Recommending terms of probation not otherwise provided for in these Bylaws or requirements of consultation, or use of a monitoring protocol for observation and review of clinical performance for a period of time, or referring the Practitioner to the Medical Staff Wellness Committee;
- d. Recommending reduction, suspension or revocation of clinical privileges;
- e. Recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care; and
- f. Recommending suspension or revocation of staff appointment.

**6. Automatic Suspension**

a. Action by Governmental Authority

Upon revocation or suspension of a license to practice, dispense medications, or DEA registration, the Member's Medical Staff privileges shall automatically be suspended.

b. Lack of Evidence of Licensure

Whenever a Member's file lacks evidence of current State licenses and Federal licenses or registrations, the privileges of that Member shall be automatically suspended until evidence is provided.

c. Lack of Compliance

Whenever a Member fails to comply with the requirements of these Bylaws to pay Medical Staff dues or maintain required professional liability insurance, the membership and privileges of the Member shall be automatically suspended until dues are paid in full or professional liability insurance is obtained.

d. Prompt Review

As soon as practicable, but in no event longer than four (4) working days, after an automatic suspension, the Medical Executive Committee shall review the suspension and meet with the suspended Member if they request. As a result of such review, the Medical Executive Committee shall find:

i. Incorrect Basis for Automatic Suspension

If it is demonstrated that the underlying reason did not actually occur or did not warrant an automatic suspension, the Medical Executive Committee shall lift the automatic suspension effective immediately.

ii. Correct Basis for Automatic Suspension



If the automatic suspension was appropriately imposed, the Medical Executive Committee may take or recommend such further corrective action as appropriate, including termination of membership due to ineligibility, or may continue the automatic suspension until the Member remedies the basis for the automatic suspension subject to final approval of the Professional Standards Committee. The President of the Medical Staff or designee shall terminate an automatic suspension upon their review of documentation that establishes that the reason for the automatic suspension no longer exists. Unless the automatic suspension is imposed because the Member's license to practice has been suspended or revoked by the State of Illinois' licensing authority, the Member may request a hearing, and such request must be made within ten (10) days of the imposition of the automatic suspension. Failure to request a hearing in ten (10) days will constitute a waiver of all hearing rights. If the Member timely requests a hearing, the hearing shall be commenced within fifteen (15) days of the imposition of the automatic suspension and be conducted in accordance with Article VIII, with the exception that the scope of the hearing shall be strictly limited to whether the decision that led to the automatic suspension was either made or not made by the respective individual, organization or entity responsible for such decision. The suspension shall continue in effect pending the completion of the hearing process, and longer until the condition giving rise to the suspension has been eliminated.

7. **Summary Suspension**

Any one of the following individuals, after securing the written or documented concurrence of the other two individuals, shall have the authority to summarily suspend all or any portion of the clinical privileges of a Member or a privileges holder: the President of the Medical Staff (or their designee), the chair of the Department involved (or their designee), and the President (or their designee), whenever the continuation of the practice of the Member or privileges holder constitutes an immediate danger to the public, including patients, visitors, hospital employees or staff. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the suspension decision is made and when the decision is reviewed by the Medical Executive Committee.

A designee of any of the above three individuals shall act only if the individual is unavailable to act on the suspension. The Medical Executive Committee shall convene within seventy-two (72) hours after such summary suspension takes effect to determine whether the suspension shall be affirmed, lifted, expunged, or modified. The Medical Executive Committee may also recommend modification, continuance, or termination, and expungement of the terms of the summary suspension.

If as a result of the Medical Executive Committee's meeting, it recommends modification, termination or expungement of the summary suspension, the Professional

Standards Committee or a subcommittee of the Professional Standards Committee shall review and consider the Medical Executive Committee's recommendation on an expedited basis within four (4) days of the date of the Medical Executive Committee's recommendation, and shall uphold it if the documentation does not support a finding that continued practice by the suspended party constitutes an immediate danger.

If Practitioner requests a hearing, such request must be made within ten (10) days of the imposition of the summary suspension. Failure to request a hearing in ten (10) days will constitute a waiver of all hearing rights.

If as a result of the Medical Executive Committee meeting, it recommends affirming and continuing the summary suspension and if the Practitioner timely requests a hearing, then a hearing shall be commenced within fifteen (15) days of the imposition of the summary suspension in accordance with Article VIII unless an extension is agreed to in writing by the parties.

The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Professional Standards Committee.

The President of the Medical Staff in conjunction with the applicable Department Chair shall make the necessary arrangements to provide alternate medical coverage for proper and necessary patient care during the period of suspension. Each patient's wishes should be considered in providing alternative coverage.

#### **8. Limited Suspension for Incomplete Medical Records**

Limited suspension of Privileges can be imposed per the Medical Staff's Medical Records Content and Completion Policy.

#### **9. Term of Suspension**

Any suspension may be of definite or indefinite duration, except that a suspension of indefinite duration which is imposed or sustained pursuant to the procedure outlined in Article VIII, or which is not timely appealed, shall thereafter be made permanent. A Practitioner for whom all privileges have been permanently suspended shall then no longer be considered a Member of the Medical Staff and shall be removed from membership.

#### **10. Reapplication for Membership or Privileges**

Any Practitioner suspended may reapply for membership or for additional privileges following a two (2) year period from the effective date of the suspension, but the entire record of the suspension or any other corrective actions shall be included as part of the application.

**ARTICLE VIII**  
**HEARING AND APPELLATE REVIEW**

**1. General Provisions**

The hearing and appeal process will be conducted in a fair and timely manner, in accordance with the Bylaws.

a. Exhaustion of Remedies

A Practitioner must attempt to exhaust all remedies afforded by these Bylaws before resorting to legal action.

b. Effective Date of Action

Other than Automatic Suspensions and Summary Suspensions, in order to allow sufficient time for the orderly provision of patient care, any adverse decision concerning a Member's clinical privileges shall not take effect until 15 days after (i) any hearings or appeals provided for in these Bylaws and requested by the Practitioner concerning the adverse decision have been completed and Written Notice of the final adverse decision is provided or (ii) the expiration of the time established in these Bylaws to request a hearing or appeal.

c. Application of Article

For purposes of this Article, the term "recommendation" may include "action," and both terms may include "adverse decision" as applicable under the circumstances.

d. Notices

Unless otherwise specifically set forth herein, notices required to be given to either side, shall be delivered in person or by Written Notice.

e. Right to One Hearing

No Member shall be entitled to more than one evidentiary hearing on any matter that shall have been the subject of an adverse decision.

**2. Grounds for Hearing**

Except as otherwise specified in these Bylaws, any one or more of only the following actions or recommended actions shall be deemed actual or potential adverse action against a Practitioner, and constitute grounds for a hearing:

- a. Denial of requested advancement in staff membership status or category;
- b. denial of medical staff reappointment;
- c. involuntary reduction in medical staff category;

- d. summary suspension of staff membership;
- e. revocation of medical staff membership;
- f. denial of a Member's requested clinical privileges;
- g. involuntary termination, revocation, reduction or restriction of a Member's clinical privileges except when the termination is a result of a Hospital's execution of an exclusive contract (which is governed by other hearing processes set forth in these Bylaws);
- h. automatic or summary suspension of a Member's clinical privileges;

### **3. Requests for Hearing**

#### a. Notice of Adverse Action or Proposed Adverse Action

In all cases in which a recommendation has been made or an adverse action is taken as set forth in Section 2 above, the Medical Executive Committee shall give the Member prompt Written Notice. This notice shall be given at least thirty (30) days prior to the effective date of the proposed action in order to allow sufficient time for the orderly provision of patient care (except for automatic and summary suspensions). If a fair hearing or appeal is requested or commenced, the adverse action shall not take effect until fifteen (15) days after the fair hearing or appeal has been completed (except for automatic and summary suspensions). The notice shall contain the following information: a) a description of all the recommendations made or all actions proposed to be taken; b) an explanation of all the reasons for the recommendation or action proposed to be taken, including the acts or omissions with which the Member is charged and all reasons based on the quality of medical care or any other basis, including economic factors and a list of all medical charts in question, where applicable; c) a statement of the right of the Member to request a hearing within thirty (30) days following receipt of notice of such recommendation; d) a summary or copy of the rights in the hearing as set forth in these Bylaws, e) a summary of the requirements to report adverse medical staff or clinical privilege decisions.

#### b. Request for Fair Hearing: Waiver of Hearing

The Member shall have thirty (30) calendar days following receipt of notice of such action or recommendation to request a hearing; provided that a hearing for any Member affected by an exclusive contract must be requested within fourteen (14) days following receipt of notice and a hearing for a Member under summary suspension shall be scheduled in accordance with these Bylaws. The request shall be in writing addressed to the President. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and to have accepted the recommendation involved.

4. **Time and Place for Hearing**

Upon receipt of a timely request for a hearing, the President shall deliver the request to the President of the Medical Staff (or to the Professional Standards Committee, if Professional Standards Committee action prompted the request for a hearing) and a hearing shall be promptly arranged and scheduled. The President shall notify the Member of the time, place and date of the hearing which, except as specifically stated otherwise herein, shall be arranged and shall commence not less than thirty (30) days from the date of the request for the hearing, unless a shorter time period is required under these Bylaws.

5. **Notice of Hearing**

The notice of hearing shall include at a minimum: 1) statements of the time, date (which shall be at least 30 days after the notice date unless waived by a Practitioner under summary suspension), and place of the hearing; 2) a statement in concise language of all the acts or omissions with which the Member is charged and/or the other reasons for the adverse recommendation or decision; 3) to the extent known, a list of the names and addresses of all witnesses (if any), so far as then reasonably known or anticipated, who may be called to testify against the Member, or give evidence in favor of the Medical Executive Committee; and 4) a statement of the Member's right to counsel, the right to inspect all pertinent information in the Hospital's possession with respect to the decision, the right to present witnesses and other evidence at hearing, and the right to a written decision and a written explanation of the decision resulting from the hearing. The Medical Staff has a continuing obligation to provide notice of any additional witnesses or pertinent information that it becomes aware of after the notice of hearing.

6. **Composition of Hearing Panel**

The Medical Executive Committee, acting through the Medical Staff President, shall inform the Professional Standards Committee of its selection of a hearing panel of not less than five (5) Members of the Medical Staff, with two (2) of the five (5) Members to be selected by the Member requesting the hearing, and one (1) of the five (5) Members so appointed designated as chair. The membership of the committee shall be subject to the approval of the Professional Standards Committee. The hearing panel shall be composed of unbiased individuals who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the same matter. Whenever practical, the hearing panel shall include an individual practicing in the same specialty as the Member, but in no event can this individual be in direct economic competition with the Member against whom charges are pending.

**Hearing Procedure**

a. **Prehearing.**

If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who may give testimony or evidence in support of the party at the

hearing. The Practitioner shall have the right to inspect and copy documents, charts, correspondence, or other evidence upon which the charges are based, and shall also have the right to receive, at least twenty (20) days prior to the hearing, a copy of the evidence forming the basis of the charges, which is reasonably necessary to enable the Practitioner to prepare a defense, including all evidence that was considered by the Medical Executive Committee. The Member and the Medical Executive Committee shall have the right to receive all evidence that will be made available to the hearing panel. The Medical Executive Committee shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges that the Member has in their possession or control as soon as practicable after receiving the request. In cases of summary suspension, automatic suspension or an exclusive contract affecting a Practitioner where the hearing is scheduled less than thirty (30) days from the date of the request this information shall be provided as soon as possible before the hearing. The right to inspect and copy by either party does not extend to information about other Members or information not relevant to the charges.

- b. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice require. In so doing, the hearing officer shall consider:
  - i. whether the information sought may be introduced to support or defend the charges;
  - ii the exculpatory or inculpatory nature of the information sought, if any;
  - iii. the burden imposed on the party in possession of the information sought, if access is granted; and
  - iv. any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- c. It shall be the duty of the Member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the hearing panel and/or the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

## **7. The Hearing Officer**

A hearing officer mutually agreed upon by the Medical Staff President and President shall be retained by the Hospital to preside at any hearing. The hearing officer shall be an attorney at law experienced in hospital/medical staff relations and be qualified to preside over a quasi-judicial hearing. The Hospital shall be responsible for compensating the hearing officer. Aside from such compensation for services, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote. The hearing officer shall not be in direct economic competition with the Practitioner and shall not have participated in the

investigation or any other part of the process giving rise to the hearing. They shall, for immunity purposes, be considered an agent of the Hospital and of the Medical Staff. They shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. They shall determine the order of or procedure for presenting evidence and arguments during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances.

**8. Waiver**

If at any time after receipt of notice under this Article a Member fails to timely make a required request or appearance or otherwise fails to timely comply with this Article, they shall be deemed to have consented to the action identified in the notice and to have voluntarily waived all rights to which they might otherwise have been entitled under these Bylaws then in effect including under this Article with respect to the matter involved.

**9. Postponements and Extensions**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the hearing officer, within their sole discretion, on a showing of good cause.

**10. Rights of the Parties**

Both the Member and the Medical Executive Committee have the right:

- a. to be represented at any phase of the hearing or preliminary procedures by an attorney at law or by any other person of that party's choice;
- b. to have an accurate record of the hearing kept by a court reporter or electronic recording unit, copies of which may be obtained by the Member upon payment of any reasonable charges associated with the preparation thereof;
- c. to call, examine, cross-examine and impeach witnesses, and the Medical Executive Committee may call the Member as if under cross-examination;
- d. to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and
- e. to submit a written statement at the close of the hearing.

**11. Conduct of Panel Hearing**

a. Presence of Member

No hearing shall be conducted without the personal presence of the Member for

whom the hearing has been scheduled unless the Member waives such appearance or fails without good cause to appear for the hearing after notice of the hearing. A Member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived their rights under these Bylaws. The question of good cause shall be within the sole discretion of the hearing officer.

b. Representation of Member

The affected Member shall be entitled to select a Member in good standing, a Member of their professional society, or an attorney to accompany and/or represent them at the hearing.

c. Determination of Procedure

The hearing officer shall determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

d. Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objections in civil and criminal actions. All privileged and confidential information shall be excluded. The Member for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure, or of fact, and such memoranda shall become part of the hearing record.

e. Representation of Medical Executive Committee and Professional Standards Committee

The Medical Executive Committee, when its action is the subject of the hearing, shall appoint one of its Members, counsel for the Medical Staff, or some other attorney to present its action or adverse recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Professional Standards Committee, when its action is the subject of the hearing, shall appoint one of its Members or counsel to present the facts in support of the adverse decision and to examine witnesses. Said person shall not be entitled to vote in the adoption of a recommendation.

f. Oath

The hearing officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

g. Burdens of Presenting Evidence and Proof



Either the Medical Executive Committee or the Professional Standards Committee, whichever-body whose adverse recommendation or action occasioned the hearing, shall have the initial obligation to present evidence in support of its position. Thereafter, the Member shall have the burden of proof and shall otherwise be responsible for supporting a challenge to the adverse recommendation or action by a preponderance of evidence that the recommendation was arbitrary, capricious, or not supported by substantial evidence.

h. Recess, Adjournment, and Conclusion

The hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if they are to be submitted, the hearing shall be closed.

i. Deliberations and Basis for Recommendation

Upon the closing of the hearing, the hearing panel may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened. Any hearing officer may participate in the deliberations of the hearing panel and offer advice, but the hearing officer shall not be entitled to vote. These deliberations are to be completed within fourteen (14) days of the closing of the hearing. The recommendation of the hearing panel shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. After the close of the hearing, the hearing panel shall not engage in any ex parte discussions with any of the parties to the hearing.

j. Report and Recommendations

Within fourteen (14) days after completing its deliberations, the hearing panel shall make a written report and recommendation with reasons and facts upon which the recommendation is based and shall forward the same together with the hearing record and all other documentation to the Professional Standards Committee and the Practitioner. Copies shall be sent to the Medical Executive Committee and President. If the Member is affected by an exclusive contract, then the time for the decision and report shall be within thirty (30) days after the date that the Member requests the hearing. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Professional Standards Committee. The report does not have to recommend a penalty but can state conclusions only as to whether a cause for action exists. The appointing body may at its discretion request the presence or absence of a recommended penalty in its appointment.

Both the Member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision or a copy of

these Bylaws. The decision of the hearing panel shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be subject to final action by the Professional Standards Committee as set forth below.

**12. Appeal to Board**

a. Time for Appeal

Within ten (10) days after receipt of the Hearing Panel's decision, either party may appeal to the Board. A written request for such review shall be delivered to the Medical Staff President, the President, and the other party in the hearing. If a request for appellate review is not received within such period, then any further rights to appeal or challenge the action are waived and the parties will be deemed to have accepted the action as provided in these Bylaws.

b. Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. Grounds are limited to: (1) a substantial failure to comply with the Bylaws so as to deny a fair hearing; or (2) the recommendation of the Hearing Panel was not supported by substantial evidence. The affected Member shall have access to the report and record of the hearing panel that was considered in making the adverse recommendation or decision.

c. Time, Place, and Notice

If an appellate review is to be conducted, the Board shall, within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, and where feasible not to exceed fifteen (15) days from the date of the notice unless the Member has waived the time limits. The time for appellate review may be extended by the Appellate Review Panel for good cause.

d. Appellate Review Panel

The Chair of the Board shall appoint an Appellate Review Panel composed of not fewer than three (3) members, at least one of whom shall be a Member of the Active Medical Staff. No person serving on the Appellate Review shall be in direct economic competition with the Practitioner involved or have actively participated in the consideration of the matter at any previous level. General knowledge of the matter shall not preclude service on the Appellate Review Panel. The Appellate Review Panel shall select a Chair and the Panel shall be entitled to obtain the assistance of legal counsel, which shall be or shall be selected by the Hospital's

Office of General Counsel, at the discretion of the Office of General Counsel.

e. Appeal Procedure

- i. Each Party shall have the right to present a written statement in support of its position on appeal. The Party bringing the appeal shall submit its written statement at least fifteen (15) days before the time of the appellate review. The Party responding to the appeal shall submit its written statement at least seven (7) days before the time of the appellate review. In its sole discretion, the Appellate Review Panel may allow each Party or its representative to appear personally and make a time-limited thirty (30) minute oral argument. The Appellate Review Panel has the sole discretion to determine the conduct and decorum of the appellate review, including the order of presentations, the time limits of presentation. The Appellate Review Panel may ask questions of the parties and the parties are required to answer. The Appellate Review Panel shall have all the power granted to a Hearing Panel, and such additional powers as reasonably necessary to discharge its responsibilities. The Appellate Review Panel shall make its recommendation to the Board in writing with a copy to the parties.

f. Final Decision by the Board

- i.) Except as provided in below, within thirty (30) days after the conclusion of the appellate review proceedings, the Board/Professional Standards Committee shall render a final decision and shall affirm the decision in writing with copies to the parties. The decision shall specify the reasons for the action taken. The Board/Professional Standards Committee may affirm, modify or reverse the recommendation of either the Hearing Panel (if neither party appealed) or the Appellate Review Panel or make its own decision on the basis of its ultimate legal responsibility to grant medical staff appointments and clinical privileges.
- ii.) This decision shall be final and effective fifteen (15) days after receipt by the affected Member, and shall not be subject to further hearing or appellate review.

g. Conclusiveness of Hearing and Appellate Review

Notwithstanding any other provision of these Bylaws, no Member shall be entitled by right to more than one hearing and one appellate review on any matter that shall have been the subject of action by the Medical Executive Committee or by the Professional Standards Committee.

**ARTICLE IX**  
**COMMITTEES OF THE MEDICAL STAFF**

There shall be an Executive Committee of the Medical Staff, referred to as the Medical Executive Committee, and such other standing and special committees of the Medical Staff, accountable to the Medical Executive Committee and the Professional Standards Committee, as may be established by the Medical Executive Committee, or otherwise, in accordance with these Bylaws.

**1. General Requirements**

Unless specified otherwise herein, or in a committee charter if not part of these Bylaws, all Committees of the Medical Staff must meet as frequently as the committee chair determines is necessary. Credentials Committee and Medical Executive Committee will meet at least ten (10) times per year. 50% of the voting members of a committee shall constitute a quorum; a quorum is required for matters requiring a vote. Minutes from committee meetings shall be taken, reflecting the basic information covered and actions taken.

Voting committee Members must attend at least fifty percent (50%) of the scheduled committee meetings per Medical Staff Year. Non-voting Members of a committee should attend as many committee meetings as possible. A voting Member's failure to meet the meeting attendance requirements, unless excused by the committee chair, may result in removal and replacement.

Unless specified otherwise herein, and excepting the Medical Executive Committee, the President of the Medical Staff shall nominate all committee chairs and voting committee Members for approval by the Medical Executive Committee. A Member's refusal to serve as voting Member of a committee they are appointed to, unless excused by the President of the Medical Staff for good cause, may be cause for removal from the committee and/or considered at the time of reappointment to the Medical Staff.

A committee chair shall be entitled to vote on all matters, unless otherwise specified herein. Meeting agenda, content and the date, time and location of committee meetings is set by the committee chair. The committee chair shall appoint a vice-chair to act in their absence, or to perform other duties as assigned by the chair. Unless otherwise specified herein, the term of appointment for a committee chair, and committee Members, is one (1) Medical Staff Year.

**2. Medical Executive Committee (MEC)**

The Medical Executive Committee shall be composed of the following voting Members:

- President of the Medical Staff, who shall serve as the chair
- Vice-President of the Medical Staff
- Secretary/Treasurer of Medical Staff
- Surgery Department Chair
- Orthopedics Department Chair
- Medicine Department Chair

- Medicine Department Vice-Chair
- Medicine Department, Co Vice-Chair
- Cardiovascular Services/Critical Care Department Chair
- Radiology/Pathology Department Chair
- Obstetrics & Gynecology Department Chair
- Emergency Medicine Department Chair

Non-Voting Members of the MEC shall include:

- President
- Chief Medical Officer
- Chief Nursing Officer
- General Counsel or designee
- Immediate Past President of the Medical Staff

The duties and responsibilities of the MEC include:

- a. To represent, to initiate action and act on behalf of Members of its Medical Staff in fulfilling the duties of Medical Staff self-governance, credentialing/privileging and quality/peer review, after seeking input and recommendations from Sections and/or Departments affected by MEC action (if applicable).
- b. To receive recommendations from the Credentials Committee and the Quality Assurance/Quality Improvement Committee and make recommendations to the Professional Standards Committee (or other mechanism established by the Professional Standards Committee) concerning:
  - i. appointments, reappointments and granting of clinical privileges;
  - ii. necessity for special investigations of issues pertaining to Practitioner competence or behavior;
  - iii. needed performance improvements and peer review results; policy and procedure development and enforcement; Medical Staff Department and committee structure; and
  - iv. other matters relevant to the provision of patient care, operation of the Medical Staff or proposed amendments to these Bylaws.
- c. Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities;
- d. Recommend to the Professional Standards Committee specific programs and systems to perform Medical Staff peer review, quality monitoring, communication, governance, credentialing/privileging and planning functions;

- e. Coordinate the implementation of policies and procedures adopted by the Hospitals and the Professional Standards Committee;
- f. Oversee Hospital multi-specialty peer review and quality monitoring activities in a manner consistent with federal and state law;
- g. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance of Members at the Hospitals
- h. Participate in identifying community health needs and in setting Hospital specific goals and implementing programs to meet those needs;
- i. Design and implement specific rules, regulations and policies that will further the goals of these Bylaws and not conflict with them;
- j. Work with Hospital administration to promote effective, efficient and safe patient care practice within the Hospital;
- k. Ensure competent clinical performance on the part of Practitioners and Allied Health Professionals including initiating investigations, and pursuing corrective action, when warranted;
- l. Provide oversight concerning the quality and safety of the care provided by residents, fellows, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and the Professional Standards Committee;
- m. Regular review of the Bylaws, Medical Staff Rules and Regulations and Policies to ensure they are furthering the goals and responsibilities of the Medical Staff and meeting legal, regulatory and accreditation requirements;
- n. Keep the Medical Staff up to date concerning the licensure and accreditation status of the Hospitals;
- o. Request evaluations of Practitioners privileges through the Medical Staff process in instances in which there is question about an applicant or Member's ability to perform Privileges requested or currently granted;
- p. Consult with Hospital administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital;
- q. Hold Medical Staff leaders, committees, Departments and Sections accountable for fulfillment of their duties and responsibilities;
- r. To determine the yearly dues for Members, and to levy assessments on Members as may be necessary to discharge Medical Staff responsibilities, including the cost of legal advice and representation from independent Medical Staff counsel for meetings and actions;

- s. Grant, deny or rescind exemptions related to emergency department call responsibility;
- t. Provide oversight of the promotion of Practitioner Wellness

### 3. **Credentials Committee**

The Credentials Committee shall be composed of the following Active Staff voting Members:

- Committee Chair
- One physician from the Surgery Department
- One physician from the Orthopedics Department
- Two physicians from the Medicine Department
- One physician from the Cardiovascular/Critical Care Department
- One physician from the Radiology/Pathology Department
- One physician from the Obstetrics & Gynecology Department
- One physician from the Emergency Medicine Department

Non-Voting Members of the Credential Committee shall include:

- Chief Medical Officer
- General Counsel or designee

The duties and responsibilities of the committee include:

- a. Review credentialing-related requests (initial appointment, reappointment, requests for clinical privileges and leaves of absence etc.) on behalf of each of the Medical Executive Committees and forward recommendations regarding the same;
- b. Monitor the granting of temporary privileges to assure that temporary privileges are granted in compliance with approved policies and procedures;
- c. Oversee the processes related to focused professional performance evaluations and related proctoring and other mechanisms and tools employed to evaluate competency;
- d. Assure uniformity in both the development and application of privileging criteria;
- e. Monitor compliance with all credentialing and privileging policies and procedures;
- f. Be responsible for evaluating recommendations made by Department Chairs. The Committee is looking for completeness, thoroughness and

adherence to credentialing and privileging policies and criteria. Assure the Medical Executive Committees that specialty specific criteria for clinical privileges comply with Medical Staff Bylaws, credentialing policies and procedures, and criteria is applied fairly and uniformly to each Practitioner; and

- g. Address those files that are determined to need clarification or additional information (i.e. time gaps, problems with references, malpractice claims etc.) and assure that all issues have been appropriately addressed and that there is complete and thorough documentation for the recommendation(s) that have been made to the Medical Executive Committee.

#### 4. **Joint Advisory Committee**

The Joint Advisory Committee will be comprised of an equal number of Professional Standards Committee Members and Members of the Medical Executive Committee. The committee will conduct itself as a forum for discussion of matters of a medico-administrative nature requiring agreement among the Professional Standards Committee, the Medical Staff, and Hospital administration, and will address any disagreements subject to the dispute resolution process described in Article XIII.

#### 5. **Quality Assurance / Quality Improvement Committee (QA/QI)**

The Quality Assurance / Quality Improvement Committee shall be composed of the following voting Members:

- Committee Chair
- At least one physician from the Surgery Department
- At least one physician from the Orthopedics Department
- At least two physicians from the Medicine Department
- At least one physician from the Cardiovascular /Critical Care Department
- At least one physician from the Radiology/Pathology Department
- At least one physician from the Obstetrics & Gynecology Department
- At least one physician from the Emergency Medicine Department

Non-Voting Members of the QA/QI Committee shall include:

- Director of Quality
- Hospital Directors of Patient Care Services
- Chief Medical officer
- Chief Nurse Executive

##### a. **Composition**

Physician voting Members should have equal representation, to the extent possible. Additionally, the physician voting Members should have broad representation of medical and surgical specialties to the greatest extent possible.



The Medical Executive Committee will approve membership annually.

b. Duties

The QA/QI Committee shall oversee, evaluate, and make recommendations concerning the quality and appropriateness of medical care provided in the Hospitals to facilitate implementation of internal quality control and the engagement of medical study in order to reduce morbidity and/or mortality and improve patient care, as a qualified peer review committee, under the Illinois Medical Studies Act. The QA/QI Committee shall coordinate all Medical Staff department/committee quality improvement activities. The QA/QI Committee may also create subcommittees, with approval from the Medical Executive Committee, to discharge its functions for specific or sub-specialized areas, any such subcommittees being accountable to the QA/QI Committee. Information reports of the activities and findings of the QA/QI Committee and any of its subcommittees will be presented to the Medical Executive Committee and/or other appropriate Medical Staff Committees or Departments.

6. **Health Informatics and Documentation Committee**

- a. Composition - The Committee shall consist of a Chair and at least three (3) Members of the Active, Provisional or Courtesy Staffs. In addition, the Director of Health Information Management and the shall serve as non-voting Members of this Committee.
- b. Meetings - This Committee shall meet on a quarterly basis or as deemed necessary by the Chair.
- c. Duties - The duties of the Committee shall be to oversee clinical documentation requirements and guidelines, including the imposition of administration suspensions relating to documentation, and to supervise and evaluate the quality of medical documentation. This Committee shall also monitor and evaluate the electronic medical record systems utilized by the Hospitals and assist Members in their adoption and use of such system to enhance patient care and meet legal and regulatory requirements.

7. **Utilization Review Committee**

- a. Composition - The Committee shall consist of a Chair and at least three (3) voting Members of the Active Staff or Provisional Staff. In addition, certain Hospital representatives shall serve as non-voting Members, including the Medical Director for Physician Utilization, and the Director of Care Coordination.
- b. Duties - The Committee shall promote quality patient care, and the effective and efficient utilization of Hospital resources. To this end, the Committee shall evaluate the medical necessity for admission and continued use of Hospital services for patients as specified in the Utilization Review Plan. The Committee shall also conduct utilization review studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices,

use of medical and Hospital services and all related factors that may contribute to the effective utilization of services. The Committee shall communicate the results of its studies and other pertinent data to the Medical Executive Committee and other appropriate Medical Staff Committees or Departments, and shall make recommendations for the optimal utilization of Hospital resources and facilities commensurate with quality care and safety.

**8. Critical Care Committee**

- a. Composition - The Committee shall consist of a Chair and at least four (4) voting Members of the Active Staff or Provisional Staff. At least three (3) of the voting Members must be physicians who regularly practice in the critical care units of the Hospitals, and at least one (1) of the voting Members must be a physician who does not practice in the critical care units, but otherwise has regular contact with patients requiring critical care services. In addition, certain Hospital representatives appointed by the President shall serve as non-voting Members. Voting Members shall elect the Chair.
- b. Duties - The Committee shall promote quality patient care for critically ill patients. The Critical Care Committee will review and implement policies and procedures for Critical Care Units of the Hospitals. Quality assurance statistics and other relative statistical information from nursing and other clinical disciplines involved with patient care in the Critical Care Units are to be presented and reviewed by the Committee. The Committee will forward information to the Medical Executive Committee and/or other appropriate Medical Staff Committees or Departments.

**9. Infection Prevention and Control Committee**

- a. Composition - The Committee shall consist of a Chair who shall be the Director of Infection Prevention and Control, appointed by the President, and The Committee shall consist of a Chair and at least three (3) voting Members of the Active Staff or Provisional Staff. The Chair may appoint other non-voting Members as appropriate.
- b. Duties - This Committee shall be responsible for the investigation and recommendation for the control and prevention of infection within the Hospitals, including surveillance of inadvertent hospital infection potential, and review and analysis of actual infections. The Committee will forward information to each Hospital Medical Staff Oversight Committee and/or other appropriate Medical Staff Committees or Departments.

**10. Cancer Committee**

- a. Composition - The Chair shall select Members from the Active, Provisional or Courtesy Staffs which must consist of one board certified physician representative from each specialty of surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology, and must include the cancer liaison physician. Non-voting Member must include at least representation

from administration, nursing, social services, cancer registry, pharmacy, and quality assurance, all of whom shall be non-voting and be appointed by the President or his designee.

- b. Duties - The duties and responsibilities of the Cancer Committee are defined in the American College of Surgeons, Commission on Cancer, Volume 1: Cancer Program Standards. The Cancer Committee shall submit reports to the Medical Executive Committee.

## **11. Trauma Committee**

- a. Composition - The Committee shall consist of a Chair who shall be the Director of Trauma, appointed by the President, and at least six (6) voting Members of the Active or Provisional Staffs, including physicians with specialties of trauma surgery, emergency medicine, orthopedics, anesthesiology, radiology, and neurosurgery. Emergency department physicians are encouraged to attend Committee meetings. The Chair may appoint other non-voting Members as appropriate.
- b. Duties - The committee, under the final determination and accountability of the Chair, has the responsibility and accountability for: implementing, reviewing, revising and implementing policies and procedures pertaining to trauma; development and implementation of the Trauma Quality Assessment and Improvement Plan; ensuring regulatory compliance. Any quality issue that is not resolved is to be forwarded to the QA/QI Committee for consideration. Chair has the authority to create or activate subcommittees of the Committee as necessary.

## **12. Pharmacy and Therapeutics Committee**

### **a. Composition**

The Committee shall consist of a Chair and at least six (6) voting Members of the Active, Provisional or Courtesy Staff. The Director of the Pharmacy for the Northwest Region shall be an ex-officio voting Member of this Committee and will serve as Secretary of the Committee. Non-voting Members of the Committee will include representatives from administration, Pharmacy Services, Nursing and Quality Improvement, all of whom shall be appointed by the Chair.

### **b. Duties**

Duties of the Committee shall include but not be limited to the following:

- i. Assist in the formulation of policies and procedures pertaining to the selection, evaluation, and distribution, administration and all other matters of drug therapy throughout the Hospitals;
- ii. Serve as an advisory body to the Hospitals and Medical Staff regarding educational programs on drug therapy as well as establish the guidelines for the education, in-service training, and supervision of all personnel

administering drugs and medications;

- iii. Develop policies and procedures in conjunction with the Medical Staff and nursing staffs to provide for the administration of drugs by qualified health care professionals authorized by law to administer such medications within the scope of their professional practice;
- iv. Develop and review the Department of Pharmacy Services Policy and Procedure Manual and Hospital Formularies;
- v. Review and act on recommendations, drug usage evaluations, medication error or incident reports, adverse drug reaction reports and all other issues relative to drug distribution, storage, safety, and usage throughout the Hospitals;
- vi. Establish control and reporting procedures for the use of investigational drug therapy in compliance with all federal and state regulations governing the use of these agents within the Hospitals; and
- vii. Report to the Medical Executive Committee.

**13. Medical Staff Wellness Committee**

a. Composition

In order to improve the quality of care and promote the competence of the Medical Staff, there shall be a Medical Staff Wellness Committee comprised of a Chair and at least three (3) voting Members of the Active, Provisional or Courtesy Staffs. Members of this Committee shall not serve as active participants on the Medical Executive Committee, the Medical Staff Oversight Committees, an investigation committee of the Medical Staff, or any other peer review or quality improvement committees while serving on this Committee.

b. Meetings

The Medical Staff Wellness Committee shall meet as often as necessary as called by its Chair. The Medical Staff Wellness Committee shall maintain such records of its proceedings and actions as it deems advisable, but shall report its activities in their entirety to the Medical Executive Committee. Reports shall be as brief as possible relating to actions taken by the Committee and protecting the confidentiality of all proceedings.

c. Duties

The Medical Staff Wellness Committee shall have as its purpose the improvement of the quality of care and the promotion of the health and competence among Members. The Committee may receive reports related to the health, well-being or impairment of Members and, as it deems appropriate, may investigate such reports. The Committee's duties shall be:

- i. To recognize the responsibility of the Medical Staff for the provision of competent patient care and to provide assistance to those Members who, because of a physical, emotional, or mental impairment, are in need of assistance and monitoring in order to restore optimal functioning and competent patient care;
- ii. To implement and recommend updates to the Practitioner Wellness Policy and assist in addressing appropriate self-referral intervention, denial, revocation, or limitation of clinical privileges, follow-up assessments, and the reinstatement of clinical privileges for impaired applicants or Members upon their re-entry;
- iii. To receive any report relating to the mental or physical health, well-being, or impairment of any applicant or Member, as relevant to such person's ability to exercise the clinical privileges granted to, or requested by, such person;
- iv. To investigate such reports to the extent necessary to protect the health, welfare, and safety of patients, other Members, and Hospital personnel;
- v. To provide such advice, counseling, or referrals as it determines may be necessary;
- vi. Upon the occurrence of any accident or incident in which a Member's performance cannot be discounted as a contributing factor, to request such chemical test or tests of blood, breath, urine, or other bodily substances as it may deem necessary for the purpose of determining alcoholic or other drug content of the Member's system, as relevant to such Member's ability to exercise the clinical privileges granted to, or requested by, such Member; and further to request such psychiatric or other medical evaluations as it shall deem necessary to determine the Member's ability to exercise the clinical privileges granted to, or requested by, such Member;
- vii. Upon receipt of documentation of specific, contemporaneous physical, behavioral or performance indicators consistent with probable substance abuse, psychiatric or other medical conditions so as to create a reasonable suspicion that an applicant or a Member is using or is under the influence of alcohol or other drugs while rendering or participating in patient care or the exercise of clinical privileges or is suffering from some other psychiatric disorder, to request such tests or evaluations described in Paragraph (vi) above as it deems necessary;
- viii. To consider, in conjunction with the Credentials Committee and the QA/QI Committee, the results of any such tests or evaluations or the refusal to consent to such testing or evaluation; to implement any intervention or other action in accordance with the Practitioner Wellness policy as adopted by the Medical Staff; and to request corrective action in accordance with the provisions of these Bylaws when appropriate; and

- ix. To study matters relating to the general health and well-being of the Medical Staff and to develop such educational programs as may be approved by the Medical Executive Committee.

The activities of the Medical Staff Wellness Committee shall be confidential. The refusal to consent to such testing or evaluation as is requested by the Medical Staff Wellness Committee shall constitute grounds for denial of an application for Medical Staff membership or clinical privileges or for immediate suspension or revocation of all or any portion of a Member's Medical Staff membership or clinical privileges; however, any Member against whom any action is taken with respect to Medical Staff membership or clinical privileges as a result of the refusal to consent to testing or as a result of any test results shall have the right to a hearing and appellate review in accordance with these Bylaws.

#### **14. Ethics Committee**

- a. Composition - The Committee shall consist of a Chair and at least three (3) voting Members of the Active, Provisional Staff or Courtesy, with equal representation, to the extent possible, of Members with a Primary Hospital affiliation from each Hospital. Non-voting Member must include at least representation from administration, nursing, pastoral care, care coordination, and a Member of the communities served by the Hospitals, all of whom shall be non-voting and be appointed by the President or his designee.
- b. Duties - This Committee shall offer consultation, as requested, to Members of the healthcare team, patients and/or families, and substitute patient decision makers concerning issues that pose ethical considerations or difficult decision-making situations. The Committee will also consider, as necessary, various bioethical issues associated with medical practice, including those that affect the care of patients and the encouragement of the use of advance directives. The Committee will provide a process for ethical consultations and will review consultations provided.

#### **15. Nominating Committee**

The Nominating Committee shall be comprised of a Chair and four (4) Active Staff voting Members. The term of voting Members shall be two (2) years, and no voting Member may serve consecutive terms. The Chief Medical Officer shall serve as a non-voting Member.

The membership of this committee shall be as follows:

- Chair, Physician Member at large
- Physician with Primary Hospital affiliation of Northwestern Medicine McHenry Hospital
- Physician with Primary Hospital affiliation of Northwestern Medicine Woodstock Hospital
- Physician with Primary Hospital affiliation of Northwestern Medicine

- Huntley Hospital  
Immediate past Medical Staff President

Nominations for officer positions will be solicited from the Medical Staff for consideration prior to the committee meeting. The committee meeting must occur at least sixty (60) days before the election. The committee shall offer nominations for all open officer positions. Nominations must be announced, and the names of the nominees distributed to all Members of the Active Medical Staff in accordance with Article XI.

## 16. Ad-Hoc Committees

Ad-Hoc Committees will be created or activated as deemed necessary by the Medical Executive Committee to perform special functions.

## **ARTICLE X** **DEPARTMENTS OF THE MEDICAL STAFF**

The Medical Staff shall be organized and divided into the following clinical departments:

- Surgery
- Orthopedics
- Medicine
- Cardiovascular/Critical Care
- Radiology/Pathology
- Obstetrics & Gynecology
- Emergency Medicine

Each department shall be an organizational division of the Medical Staff and shall have a qualified Department Chair and Vice-Chair(s) that have the authority, duties, and responsibilities set forth in these Bylaws. The Department shall have the responsibilities, through its Chair, as set forth in these Bylaws. Each Department, and any Clinical Section therein, is accountable to the oversight and authority of the Medical Executive Committee and the Professional Standards Committee. Departments shall meet as frequently as needed to fulfill assigned duties and when requested by the Medical Executive Committee.

1. **Clinical Sections.** A Department may organize clinical sections to supplement the performance of departmental responsibilities. The Medical Staff may also create sections (as specified in these Bylaws) within a Department in order to facilitate Medical Staff activities.
  - a. Based on American Board of Medical Specialties (ABMS) approved specialties (or similar group approved specialties), if at least three (3) Members wish to organize themselves into a Clinical Section. A Clinical Section shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Clinical Section is making a formal report. A Clinical Section shall elect a Clinical Section Chief.

The Clinical Section Chief is responsible for fulfilling the activities listed in these Bylaws. The procedure for removal of a Clinical Section Chief shall be the same as for the removal of a Department Chair. If removal is required, the President of the Medical Staff shall appoint an interim replacement Chief until the Section elects a new Chief. When a Clinical Section is making a formal report, the report shall be submitted to the Medical Executive Committee documenting the specific position of the Clinical Section. The President of the Medical Staff and Clinical Section Chief (or designee) will decide if the report/issue is placed on the Medical Executive Committee agenda and whether the Clinical Section Chief (or designee) will attend the Medical Executive Committee meeting to present the report/issue to the Medical Executive Committee on that specific report/issue. Clinical Section Chiefs shall also be required to attend Department Meetings. Clinical Sections are optional and shall exist to perform any of the following activities:

- i. continuing education /discussion of patient care;
  - ii. formulation of emergency department on-call and inpatient consultation and coverage recommendations in consultation with the Hospitals;
  - iii. discussion of policies and procedures and equipment needs;
  - iv. development of recommendations for the Department Chair or the Medical Executive Committee;
  - v. participation in the development of criteria for clinical privileges when requested by the Department Chair or the Credentialing Committee; and
  - vi. discussion of a specific issue at the request of the Medical Executive Committee.
- b. The Medical Executive Committee shall approve the creation of Clinical Sections, and may implement or dissolve Clinical Sections as it determines will best meet Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

## **2. Qualifications, Selection, Term, and Removal of Department Chair**

- a. Each Department Chair and Vice-Chair shall serve a term of two (2) years commencing on January 1. All Chairs must be Members in Good Standing of the Active Medical Staff with relevant clinical privileges and be certified by an appropriate specialty board.

All Vice-Chairs must be Members in Good Standing of the Active or Provisional Medical Staffs with relevant clinical privileges and be certified by an appropriate specialty board. There shall be a Vice-Chair for each Department.

- b. Department Chairs and Vice-Chairs will be elected by majority vote of Active Staff Members of the Department. Each Department shall establish procedures



for identifying and electing candidates and these procedures must be ratified by the Medical Executive Committee.

- c. Notwithstanding the requirements set forth in paragraphs 2.a. and 2.b. of this Article, Departments whose Members solely consist of Practitioners exercising Clinical Privileges under an exclusive contract or relationship with the Hospitals, may establish different term limits, less Vice-Chair positions, and a different election process as set forth in procedures ratified by the Medical Executive Committee.
- d. Department Chairs and Vice-Chairs shall immediately be removed from office by the President of the Medical Staff if the Chair fails to be a Member in Good Standing of the Active Medical Staff. Department Chairs may also be removed from office by the Medical Executive Committee upon receipt of a recommendation of two-thirds (2/3) of the Members of the Department or, in the absence of such recommendation, the Medical Executive Committee may remove a Chair on its own by a two-third (2/3) vote of a majority of Members present and voting, if any of the following occurs:
  - i. The Chair suffers an involuntary loss or significant limitation of Privileges;
  - ii. The Chair fails, in the opinion of the Medical Executive Committee, to demonstrate to the satisfaction of the Medical Executive Committee or the Professional Standards Committee that they are effectively carrying out the responsibilities of the position;
  - iii. If removal is required, a new election will be held according to established Departmental procedures. In the interim, the President of the Medical staff shall appoint an interim Chair or Vice-Chair until the Department elects a new Chair or Vice-Chair.
- e. Department Chairs shall carry out the following responsibilities:
  - i. to oversee all clinically-related activities of the Department;
  - ii. to oversee all administratively related activities of the Department otherwise provided for by the Hospital;
  - iii. to provide ongoing surveillance of the performance of all individuals in the Department who have been granted Clinical Privileges, including without limitation clinical, utilization and behavioral aspects of the Practitioners' performances;
  - iv. to make recommendations to the Credentialing Committee;
  - v. to recommend clinical privileges for each Member of the Department and Allied Health Providers practicing with Privileges within the scope of the Department;

- vi. to assess and recommend to the Medical Executive Committee and Hospital Site Administrator off-site sources for needed patient care services not provided by the Department or the Hospital;
- vii. to monitor and evaluate the quality and appropriateness of patient care provided in the Department in concert with the QA/QI Committee, and to implement action following review and recommendations by the QA/QI Committee and/or the Medical Executive Committee;
- viii. to integrate the Department into the primary functions of the Hospital;
- ix. to coordinate and integrate interdepartmental and intradepartmental services and communication;
- x. to participate in the administration of the Department through cooperation with nursing services and Hospital administration in matters affecting patient care;
- xi. to develop and implement Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services;
- xii. to recommend to the applicable Hospital Site Administrator the sufficient numbers of qualified and competent persons to provide patient care and service;
- xiii. to provide input to the applicable Hospital Site Administrator regarding the qualifications and competence of Department or service personnel who are not licensed independent Practitioners but provide patient care, treatment, and services;
- xiv. to provide continuous assessment and improvement of the quality of care, treatment, and services provided by Practitioners and AHPs within the Department;
- xv. to assign responsibilities to Vice-Chairs consistent with the Chair's responsibilities, focusing on Hospital specific functions and metrics;
- xv. to orient and educate Practitioners and AHPs within the Department;
- xvi. to make recommendations to the Medical Executive Committee and to Hospital Site Administrator for space and other resources needed by the Department to provide patient care services;
- xvii. formulation of emergency department on-call and inpatient consultation and coverage recommendations in consultations with the Hospitals.

### **3. Assignment to Department**

A Department assignment will be requested at the time of appointment or reappointment. The Department Chair will recommend Department assignment in accordance with their

qualifications and the Medical Staff Credentialing policy for review and approval by the Credentials Committee and Medical Executive Committee. Each Member will be assigned to one primary Department. Clinical Privileges are independent of the Department assignment.

## **ARTICLE XI**

### **MEDICAL STAFF OFFICERS**

#### **1. Officers of the Medical Staff**

The officers of the Medical Staff shall be:

- President
- Vice President
- Secretary/Treasurer

#### **2. Qualifications of Officers**

- a. Officers must be board certified Members of the Active category of the Medical Staff in Good Standing for at least four (4) years, have previously served in a significant leadership position on the Medical Staff, (e.g. Department Chair, Section Chief or Committee Chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges, have a history of attendance at continuing education programs (provided by the Hospitals) relating to Medical Staff leadership and/or be willing to do so during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the Medical Staff, and should have excellent administrative and communication skills. Employees of competing health systems may not serve as a Medical Staff officer.
- b. Officers must disclose leadership positions on another hospital's medical staff.

#### **3. Election of Officers**

- a. The Nominating Committee will offer at least one nominee for each open officer position.  
Nominations must be announced, and the names of the nominees distributed to all Members of the Active Medical Staff, at least forty-five (45) days prior to the election. A petition signed by at least 20% of the Members of the Active Medical Staff may also make nominations. Such petitions must be submitted to the President of the Medical Staff at least twenty (20) days prior to the election for placement on the ballot.
- b. Officers shall be elected, as needed every year, at the Annual Meeting of the Medical Staff. Only Active Staff Members shall be eligible to vote. No proxy voting will be permissible. The nominee receiving the greatest number of votes will be elected. In the event of a tie vote, repeat vote(s) will occur until one candidate receives a greater number of votes.

#### **4. Term of Office**

Officers shall serve a two (2) year term. Officers shall take office January 1. Officers may not be re-elected to the same office for consecutive terms.

#### **5. Vacancies of Office**

The Medical Executive Committee shall fill vacancies of office during an Officer's term, except the office of President, with approval of the Professional Standards Committee. If there is a vacancy in the office of President, the Vice President of the Medical Staff shall become President and shall serve the remainder of the term, and the Medical Executive Committee shall appoint a new Vice President, with the approval of the Professional Standards Committee.

#### **6. Duties of Officers**

- a. The President shall represent the interests of the entire Medical Staff and fulfill the duties specified in these Bylaws, as well as additional duties as reasonably requested by the Medical Executive Committee in order to implement and/or enforce all provisions of these Bylaws and the interests of the Medical Staff.
- b. Responsibilities of the President.

The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships with the Professional Standards Committee, the Board, the President and Hospital administration. The President, jointly with the Medical Executive Committee provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in these Bylaws, and any Rules, Regulations and Policies of the Medical Staff. Specific responsibilities and authority include:

- i. Call and preside at all general, annual and special meetings of the Medical Staff;
- ii. Serve as Chair of the Medical Executive Committee and as ex-officio Member of all other Medical Staff committees without vote;
- iii. Enforce these Bylaws, and any Rules, Regulations and Policies established hereunder and all other established standards, policies or rules of the Hospitals in relation to the Medical Staff;
- iv. Except as stated otherwise in these Bylaws, appoint committee chairs and all Members of Medical Staff standing and ad hoc committees; in consultation with Hospital administration, appoint Medical Staff Members to appropriate Hospital committees; in consultation with the chair of the Professional Standards Committee, appoint Medical Staff Members to appropriate Professional Standards Committee committees

when those are not designated by position or by specific direction of the Professional Standards Committee or otherwise prohibited by state law;

- vi. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
  - vii. Report to the Professional Standards Committee, through the Quality and Service Committee or such other mechanism established by the Professional Standards Committee, the Medical Executive Committee's recommendations concerning appointment, reappointment, delineation of Clinical Privileges or specified services and corrective action with respect to Practitioners and Allied Health Professionals;
  - viii. With the support of the Credentials Committee, evaluate and periodically report to the Medical Executive Committee and the Professional Standards Committee regarding the effectiveness of the credentialing and privileging processes;
  - ix. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Members in their relations with each other, the Professional Standards Committee, Hospital administration, other professional and support staff, and the community the Hospital serves;
  - x. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting hospital operations to the President, Hospital administration, the Medical Executive Committee and the Professional Standards Committee;
  - xi. Attend Professional Standards Committee meetings and serve as an *ex officio* non-voting Member of the Professional Standards Committee;
  - xii. Ensure that the decisions of the Professional Standards Committee are communicated and carried out within the Medical Staff;
  - xiii. Perform such other duties, and exercise such authority commensurate with the office as are set forth in these Bylaws.
- d. Vice President - In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President. They shall perform such duties to assist the President as the President may request from time to time.
- e. Secretary/Treasurer – This officer will collaborate with the Medical Staff office, assure maintenance of minutes, attend to correspondence, act as treasurer and be responsible for maintaining the financial records and funds of the Medical Staff, and coordinate communication within the Medical Staff for which they are appointed. They shall perform such further duties to assist the President as the President may from time to time request. The Secretary/Treasurer shall provide a report at each annual Medical Staff meeting.

## **7. Removal and Resignation of Officer**

- a. The Medical Staff may remove any of its Officers by petition of 20% of Active Medical Staff Members and a subsequent affirmative vote by two-thirds (2/3) of those active Medical Staff Members' casting votes.
- b. The Medical Executive Committee may remove any of Officer for conduct detrimental to the interests of the Medical Staff or if such Officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office. An Officer will be given Written Notice, at least ten (10) days before the meeting where the Medical Executive Committee will consider removal. The Officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal. For recall of an Officer, a two-thirds (2/3) vote of approval is required with three-fourths (3/4) of the Medical Executive Committee Members present and voting. An Officer being considered for removal does not count toward quorum, and does not vote. Any such removal must be approved by the Professional Standards Committee.
- c. Any elected Officer may resign at any time by giving Written Notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or any later time specified therein.

## **ARTICLE XII**

### **MEDICAL STAFF MEETING**

#### **1. Annual Meetings**

Annual Meetings of the Medical Staff shall be held in December. At these meetings, the retiring Officers and committees shall make their annual reports. Officers of the Medical Staffs shall be elected to office, as provided in these Bylaws.

#### **2. Special Meetings**

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, or at the written request of the Professional Standards Committee or the President, or by written requests of one-third (1/3) of the Members of an Active Medical Staff. At any special meeting, no business shall be transacted, except that which is stated in the notice of the meeting.

##### **a. Regular Meetings**

Regular meetings of the Medical Staff will be held quarterly, and include the Annual Meeting. These meetings will cover administrative, clinical, professional, or community topics of interest to the Medical Staff.

All Members may speak to issues, but only Active Staff Members may vote at Medical Staffs' meetings.

b. **Quorum and Voting Requirements**

One-third (1/3) of the total Active Staff of the Medical Staff shall constitute a quorum at Regular, Special and Annual meetings of the Medical Staff. For all Medical Staff committees, fifty (50%) percent of voting Committee Members shall constitute a quorum. There shall be no quorum requirements for Department meetings.

Medical Staff Members may vote on matters according to their staff category. A simple majority vote of voting Members present shall control on all issues. Voting methods shall be according to Robert's Rules of Order (see paragraph 10 below).

5. **Meeting Notice and Information**

Electronic notices for Annual, Regular and Special Meetings of the Medical Staff will be generated at least five (5) working days prior to the date set for the meeting, and such notice shall also be posted in the Physician Lounge at each Hospital. Notice for all other Medical Staff meetings shall be within a reasonable timeframe as provided for in the Rules and Regulations.

The Chair for the Medical Staff meeting will determine the supporting and informational materials needed to permit meaningful discussion and consideration. Such materials will be made available to Members within a reasonable time in advance of the meeting, and in a format (e.g. paper or electronic) as provided for in the Rules and Regulations.

6. **Attendance Requirements**

All Members are encouraged to attend all Regular (which includes the Annual Meeting) and Special Meetings.

7. **Special Attendance**

When a Medical Staff department or committee requires a Practitioner's presence to discuss professional or ethical performance, the Member is expected to attend unless excused by the President of the Medical Staff for good cause. Practitioner shall be given reasonable notice in the manner set forth in these Bylaws. Failure to appear without good cause may result in the initiation of corrective action.

If the Member fails to appear, the meeting will proceed, resolve the issue and transmit a record of the finding, along with any recommended corrective action to the Medical Executive Committee, and simultaneously to the Member who was the subject of discussion.

8. **Agenda**

The agenda is determined by the chair of the Medical Staff meeting and shall be consistent with the following content:

- Call to order.

- Reading and acceptance of the minutes of the last regular meeting, and of all special meetings.
- Report of the President.
- Unfinished Business.
- Communications.
- Report of the Medical Executive Committee and other committees as required.
- New Business.
- Adjournment.

**9. Executive Session**

The Medical Staff or any committee or department may meet in executive session. The list of non-Members present at any such meeting is subject to the advance approval of the chair of the meeting. At the call of its chair, or acting on a Member’s motion carried by a simple majority vote by eligible Members, the Medical Staff and any Medical Staff committee or department may meet in executive session, with attendance restricted to voting Members of the Medical Staff. The chair may specifically request a recording secretary, and such advisors or other attendees to attend executive session, which request is subject to ratification by majority vote of the Members present.

**10. Parliamentary Procedure**

All meetings shall be conducted in accordance with the current “Robert’s Rules of Order” insofar as the same do not conflict with these Bylaws, or the Rules and Regulations of the Medical Staff, and in the event of such conflict, the latter shall govern.

**11. Disputes within the Medical Staff**

At any Medical Staff meeting, its Members may or shall, if the Medical Staff votes to do so, address and as feasible manage or arrange for the management of, conflicts between the Medical Executive Committee and the Medical Staff, or otherwise within the Medical Staff. Conflicts may also be resolved by a simple majority vote of the Medical Staff on the issue causing conflict, recognizing the authority and responsibilities of the Medical Executive Committee and the Professional Standards Committee.

**ARTICLE XIII  
DISPUTE RESOLUTION**

In the event of a disagreement between the Medical Staff and the Professional Standards Committee or between the Medical Staff and the Medical Executive Committee, such parties are to attempt to resolve such disagreements. Such disagreements may include matters relating to, without limitation, general (not individual) membership or clinical privileges decisions, cost



containment decisions, utilization review decisions, health care safety and quality issues and conflicts arising under these Bylaws. Whenever such a disagreement exists, Members of the Medical Staff, the Medical Executive Committee or the Professional Standards Committee, as the case may be, may refer the matter to the Joint Advisory Committee for discussion and possible resolution. Upon the referral of the matter to the Joint Advisory Committee, the Committee shall convene a meeting of the involved parties as early as possible to identify the issues, gather information regarding the dispute, and work with the parties to manage and, when possible, resolve the conflict. Those individuals who assist the Joint Advisory Committee shall be skilled in conflict management, and may be from inside or outside of the Hospital. The Joint Advisory Committee may establish procedures to implement the foregoing.

## **ARTICLE XIV**

### **IMMUNITY AND INDEMNIFICATION**

#### **1. Authorization and Conditions**

By applying for, or exercising clinical privileges or providing specified patient care services in a Hospital, a Practitioner:

- a. Authorizes representatives of the Hospital and its Medical Staff to solicit, provide and act upon information bearing on their professional ability and qualifications;
- b. Agrees to be bound by the provisions of this Article and to waive all legal claims against any such representative who acts in accordance with the provisions of this Article; and
- c. Acknowledges that the provisions of this Article are express conditions to their application for, or acceptance of, Medical Staff membership and the continuation of such membership or to their exercise of clinical privileges or provision of specified patient services at the Hospital.

#### **2. Immunity from Liability**

##### **a. For Action Taken**

A Hospital, its agents, officers, employees, and its Medical Staff shall not be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of their duties, if the Hospital, its agents, officers, employees, or Medical Staff acts in good faith and without malice after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts.

##### **b. For Providing Information**

A Hospital, including its agents, officers, employees, Medical Staff, or any third party, shall not be liable to a Practitioner for damages or other relief by reason of providing any information, including otherwise privileged or confidential information, to a representative of a Hospital or the Medical Staff or to any other

health care facility or organization of health professionals concerning a Practitioner who is or has been an applicant to the Medical Staff or who did or does exercise clinical privileges or provides specified services at the Hospital, provided that such representative or third party acts in good faith and without malice.

c. Activities and Information Covered

i. Activities

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with the activities of a Hospital or any other health care facility or organization including, but not limited to:

- (a) Application for appointment, clinical privileges or specified services;
- (b) Periodic reappraisals for reappointment, clinical privileges or specified services;
- (c) Corrective action;
- (d) Hearings and review;
- (e) Utilization reviews; and
- (f) Any Hospital, Department, committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

d. Information

The acts, communications, reports recommendations, disclosures and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

e. Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

f. Confidentiality

A Hospital and its employees, directors and contractors, the Medical Staff and its Members and applicants, departments, sections and committees are obligated to maintain the confidentiality of all Medical Staff records to the fullest extent permitted by law. Breach of confidentiality subjects a Member to corrective

action under these Bylaws and Hospital personnel to disciplinary action under Hospital policies.

**3. Indemnification**

A Hospital shall either defend, or assume the costs incurred for defense, in its sole discretion, and pay any claims, settlements, judgments or damages on behalf of any Member of its Medical Staff to the extent that such claims proximately result from that Member's service on any Hospital or Medical Staff committee or assistance in peer review or quality management activities involving care provided at such Hospital, so long as such Member acted in good faith and in a manner reasonably believed to be in, or not opposed to, the best interests of the Hospital or its Medical Staff, and provided further that the Hospital shall have no obligation to defend or to pay claims or damages on behalf of a Member to the extent that such claims arise out of alleged intentional wrongful acts or willful misconduct.

**ARTICLE XV**

**ADOPTION AND AMENDMENT OF POLICIES, RULES AND REGULATIONS**

Medical Staff rules, regulations and policies shall be adopted in accordance with this Article, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, to maintain a uniform standard of quality patient care, treatment and services, and as may be otherwise necessary for the proper conduct of the Medical Staff's work.

The initial set of Medical Staff rules, regulations and policies to be adopted under these Bylaws shall be presented for approval at a Regular, Annual or Special meeting of the Medical Staff and approved upon simple majority vote where a quorum is present. The initial set of Medical Staff rules, regulations and policies so adopted shall become effective after Professional Standards Committee approval, effective January 1, 2016.

Thereafter, proposals to adopt, amend, or repeal a Medical Staff rule, regulation or policy may be initiated by the request of any Medical Staff Member, the Medical Executive Committee, other standing Medical Staff committees, Department Chairs or the Professional Standards Committee. Such Proposals shall be considered and approved by the Medical Executive Committee and shall become effective upon Professional Standards Committee approval. Alternatively, such proposals may be submitted for Medical Staff voting approval upon the written request of at least twenty (20) Active Staff Members. In such event, the proposal shall be put to vote at the next Regular or Annual meeting, or at a Special meeting, of the Medical Staff, as reasonably determined by the Medical Executive Committee.

In the event the Professional Standards Committee declines to approve adoption, amendment or repeal of a Medical Staff rule, regulation or policy, the Professional Standards Committee shall send the proposal back to the Medical Executive Committee with a written recommendation for revisions that would meet Professional Standards Committee approval. If deemed advisable by the President of the Medical Staff or the Professional Standards Committee Chair, either or both may refer the matter to the Joint Advisory Committee for further review and consideration.

**ARTICLE XVI**  
**AMENDMENTS TO THE BYLAWS**

Amendments to these Bylaws shall become effective upon Professional Standards Committee approval.

Proposed amendments to the Bylaws may be initiated by written request of at least twenty (20) Active Staff Members, the Medical Executive Committee, other standing Medical Staff committees, or the Professional Standards Committee. The Medical Executive Committee shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote, the proposed amendment shall be put to vote at the next Regular or Annual meeting, or at a Special meeting, of the Medical Staff, as reasonably determined by the Medical Executive Committee.

The Medical Executive Committee may make corrections and changes to these Bylaws when such correction or change is necessary due to spelling, punctuation, grammar, context or for statutory or regulatory compliance. No prior notice of such changes are required, but such changes will be presented for approval by the Medical Staff at its next Regular Meeting, with Professional Standards Committee approval thereafter.

In the event the Professional Standards Committee declines to approve an amendment or change to these Bylaws, the Professional Standards Committee shall send the amendment or change back to the Medical Executive Committee with a written recommendation for revisions that would meet Professional Standards Committee approval. If deemed advisable by the President of the Medical Staff or the Professional Standards Committee Chair, either or both may refer the matter to the Joint Advisory Committee for further review and consideration.

**ARTICLE XVII**  
**DISUNIFICATION**

As Medical Staff Members must designate one Hospital as their Primary Hospital, the Members designating a particular Hospital as their Primary Hospital have the right to opt out of the unified and integrated medical staff after a majority vote of those Members entitled to vote. If the vote to disunify is successful for a Hospital, all Medical Staff Members designating that Hospital as their Primary Hospital will be opted out of the Medical Staff, and will no longer hold Membership nor Clinical Privileges at any other Hospital.

The process for the Medical Staff Members designating a particular Hospital as their Primary Hospital to opt out of the unified and integrated Medical Staff is as follows:

- 1) a proposal to disunify may be initiated by a written request to the Medical Executive Committee by either twenty (20) Active Medical Staff Members, or twenty-five percent (25%) of Active Medical Staff Members, whichever is greater, designating a particular Hospital as their Primary Hospital to disunify for that Hospital (the "Disunified Hospital");
- 2) the Medical Executive Committee will validate the request and submit the request to disunify for vote at the next regular Medical Staff Meeting;

- 3) a vote to disunify will be successful upon a majority vote of the Active Medical Staff Members of the Disunified Hospital;
- 4) the vote to disunify will be effective upon the approval of a new set of bylaws for the Disunified Hospital;
- 5) the new bylaws must be approved by a majority of those Active Staff Members of the Disunified Hospital, and the Professional Standards Committee.

If the medical staff of a Disunified Hospital wishes to re-unify and re-integrate with the Medical Staff, that shall occur on a simple majority vote of those Members eligible to vote according to the bylaws adopted by the Disunified Hospital.

# **UNIFIED MEDICAL STAFF RULES AND REGULATIONS**

Effective January 1, 2016

Amendments effective: June 6, 2016; September 5, 2016; December 5, 2016; June 5, 2017; October 20, 2017; April 2, 2018; September 5, 2018; November 4, 2021

## **CHAPTER 1: GENERAL REQUIREMENTS**

### **1.1 Definitions**

Terms defined in the Unified Medical Staff Bylaws shall have the same meaning in these Rules and Regulations. For purposes of these Rules, Member means Members of the Medical Staff and the Allied Health Professional Staff.

### **1.2 Orientation of New Staff Members**

There shall be an orientation for new Members organized by and initiated by the Member's Department in collaboration with Hospital administration.

### **1.3 Professionalism**

Members are expected to treat each patient with courtesy and respect, to listen carefully to each patient, and to explain the patient's diagnosis and treatment plan in a way the patient understands. The patient experience is greatly impacted by a physician's attitude and communication style. Patient-centered communication skills, a "good bed-side manner", are associated with improved health outcomes and improved patient and clinician satisfaction.

Members are expected to adhere to the antimicrobial stewardship guidelines for hand hygiene and infection prevention. Physicians should appear professionally appropriate for their practice setting/location and comply with any specific guidelines regarding professional attire. While in the Hospitals, Members must wear an identification badge issued by NMHC Security Services where it can be readily seen.

Members must ensure that all their decisions – clinical and otherwise – are based on the integrity of their professional judgment and are not influenced by the nature of their relationships with outside parties. The NMHC Corporate Integrity Program applies to Members, and sets forth expected behaviors and provides guidance on legal and ethical questions

Members must facilitate an environment that is free from harassment, discrimination, intimidation and violence. Using and insisting upon good manners, professional behavior and the exercise of good sense will go a long way to avoiding and preventing inappropriate conduct and disruptive behavior. The NMHC Medical Staff Code of Conduct applies to all Members and sets forth expected behaviors and provides a framework for addressing concerns.

### **1.4 Access and Use of Computer Information**

Security and confidentiality is a matter of concern for all persons who have access to information owned by or in the custody of the Hospitals or NMHC Systems. Each person accessing patient data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Members will be given access to information systems and data according to the health policies. All individuals seeking access must read and comply with Hospital policies relating to computer use and access to information.

### **1.5 Patient Privacy**

Each Member has an independent duty to maintain the confidentiality of medical information revealed by a patient or discovered by the Member in connection with the treatment of a patient.

Additionally, under the Health Insurance Portability and Accountability Act (HIPAA), Member's

and the Hospitals must protect the security and privacy of protected health information (PHI). PHI includes patient information acquired through a healthcare provider-patient relationship that enables the healthcare provider to treat the patient in a professional setting, including information received as a result of treatment, examination and observation. Patients have numerous rights relating to their PHI, including access to their information. Disclosure of PHI may only be done to appropriate individuals or entities in appropriate circumstances in accordance with Hospital policies following applicable laws and regulations.

#### 1.6 Care of Immediate Family Members “Related” Patients

With limited exception, Practitioners are prohibited from providing direct patient care to immediate family members on either the attending or consulting services. In emergency settings or isolated settings where there is no other qualified physician available, Practitioners may care for immediate family members until another physician becomes available.

#### 1.7 Communication

Members shall provide a primary electronic mail address and a primary telephone number for all medical staff communications to the Medical Staff Office. The primary electronic email address will be used for all medical staff and administrative communications, including initial and recredentialing. Each Member is responsible for ensuring that communication with the Member is possible 24/7 through the primary telephone number provided.

#### 1.8 Back-Up Coverage

Every medical staff Member with inpatient privileges shall designate a back-up medical staff Member with comparable privileges who will provide substitute care in the event the Member is unexpectedly unavailable. This coverage information will be kept in the Member’s credentials file and will be verified at the time of reappointment. If the Member changes their designated back-up, the change must be timely communicated to the Medical Staff Office. In the event of an emergency where the Member and their back-up are not available, the Department Chair or Vice-Chair shall appoint a Member to assume interim responsibility for the patient.

#### 1.9 Medical Staff Meetings

All Members are encouraged to attend all Regular (which includes the Annual Meeting) and Special Meetings of the Medical Staff. Active and Provisional Medical Staff Members must attend at least two (2) Regular or Special meetings each Medical Staff Year. A failure to meet this two-meeting requirement may result in a \$200.00 fine each Medical Staff Year as determined by the Medical Executive Committee. The Medical Staff Member’s meeting attendance will be a component of reappointment and renewal of privileges. A failure to comply with the meeting requirement may result in a Status change to Courtesy or a reduction to Provisional Active Status for the next reappointment term, without allowance for excused absence of scheduled meetings. Reinstatement of status may be made at the next reappointment with consideration of meeting attendance without excused absences.

### **CHAPTER 2: PATIENT CARE**

#### 2.1 Privileges

Clinical Privileges granted pursuant to the Bylaws shall be consistent with the applicant’s training and experience. Members will only care for those patients with medical problems that are within the scope of the Members Privileges.



## 2.2 Emergency Medical Services

All patients presenting to the Hospital seeking emergency medical treatment will receive a medical screening examination. The medical screening examination shall be performed by a Physician or Allied Health Professional with Privileges to practice in the emergency department setting. Additionally, for obstetrical patients, the medical screening examination may be performed by a Physician or Allied Health Professional with obstetrical privileges, and also may be performed by a qualified obstetrical registered nurse. Treatment will be provided for an emergency medical condition on a non-discriminatory basis, regardless of the patient's ability to pay, in accordance with Hospital policy. A patient may be transferred from the Hospital to another facility to receive a higher level of care, or at their request, according to Hospital policy.

## 2.3 On-Call Coverage

Each Department shall establish an on-call list of physicians who are available to provide specialty treatment necessary to stabilize patients with emergency medical conditions within the capabilities of the Medical Staff and the resources available to the Hospital. Pursuant to the Bylaws, each Member must designate a Primary Hospital(s) where call will be taken. Additionally, a Member who performs 20 or more patient encounters or procedures requiring anesthesia services per Medical Staff year at a Hospital may be required to take call at that Hospital. Each Department shall also establish a policy setting forth the requirements for on-call coverage, including but not limited to: the responsibilities of the on-call physician to respond, examine and treat patients; steps to take if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond their control. Departments shall collaborate with each other for coverage of specialty services that may be provided by Members in different Departments. The on-call list and on-call rules shall meet all applicable Federal and Illinois state laws and regulations, and shall be created and implemented in collaboration with Hospital administration in accordance with the Bylaws and these Rules and Regulations. The on-call list and on-call rules shall be documented in the Medical Staff Office and updated routinely when Medical Staff Members or Department on-call rules change.

## 2.4 Admission of Patients

Excluding emergencies, all patients admitted to the Hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible. Members are responsible to obtain or provide all necessary pre-authorizations and orders in a timely fashion prior to non-emergent admissions.

A patient may be admitted to the Hospital only by a Member of the Active, Provisional or Courtesy Medical Staffs. Members admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self-harm. Each patient shall have an Attending Physician, who will be responsible for the management and coordination of the patient's care, treatment and services. The Attending Physician, in concert with any Consultants involved in the patient's care, shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment.

Additionally, please see Section 2.15 in relation to classification and admission of trauma patients.

## 2.5 General Consent

The Hospital shall obtain a general consent for patients receiving care and treatment from/in the Hospital. Consent will be obtained according to Hospital policy, approved by the Medical Executive Committee.

## 2.6 Informed Consent

It is the responsibility of the Member to obtain informed consent for surgeries and other procedures according to Hospital policy, approved by the Medical Executive Committee. Obtaining informed consent is an active process in which the Member participating in the treatment of a patient provides all material information to enable the patient to make an informed decision in regard to any proposed procedure.

Material information is defined as:

- the nature of the procedure or treatment
- the risks, complications and expected benefits or effects of the procedure
- any alternatives to the treatment and their risks and benefits;
- the likelihood of achieving treatment or care goals.

## 2.7 Documenting Informed Consent

The Member shall document in the patient's medical record that a discussion was held that included discussion of all material information as described above, that the patient indicated understanding of the material information and agreed to proceed, that is, that informed consent was obtained. The documentation of informed consent may be made in a variety of ways according to Hospital policy, approved by the Medical Executive Committee.

## 2.8 Requirements for Patient Examination

Every patient admitted to an acute care area of the Hospital shall be seen by a Member or Allied Health Professional at least once every 24 hours. Patients for whom a consultation has been ordered must be seen by the Consultant within 24 hours of the consultation order being entered or sooner if medically indicated. All patients admitted to a Critical Care Unit shall be seen by an appropriately privileged physician within 12 hours of the admission order being entered, or sooner if medically indicated.

## 2.9 Orders

Members shall give orders for medication and treatment only to the licensed, registered or certified professional persons who are authorized by law as described in Hospital policy to administer or dispense the medication or treatment in the course of practicing their discipline.

Orders for laboratory, radiology or other diagnostic services made by a non-Member may be accepted by the Hospital if the ordering provider is allowed under applicable law to make such an order, holds a valid license to make such an order and that license is not under suspension.

Orders for rehabilitation therapy and ambulatory treatment services made by a non-Member may be accepted by the Hospital if the ordering provider is allowed under Illinois law to make such an order, holds a valid Illinois license and that license is not under suspension.

## 2.10 Restraints

Hospital strives to maintain a restraint-free environment. Restraints shall be ordered as a measure to prevent a patient from harming themselves or others after all other less restrictive alternatives have been exhausted. Every effort will be made to preserve the patient's rights and dignity. Use of patient restraints by Members is governed by Hospital policy, approved by the Medical Executive Committee.

## 2.11 Consultation

Consultations must be requested for any patient when the problem is outside the area of the Member's expertise. The Attending Physician orders and coordinates consultations. A Consultant caring for a patient who believes another specialty consultant would be advisable should communicate with the Attending, directly if possible, about such a recommendation. Whenever possible, the Attending Physician ordering a consultation should speak directly with the Consultant concerning the patient and the reason for the request.

A Consultation report should contain, at a minimum: history of present illness/reason for consultation; past medical history; review of relevant systems; assessment/plan/recommendations; treatment and/or follow-up. A consultation report may be used in lieu of a history and physical as long as it contains all the documentary requirements and the Member holds history and physical privileges.

## 2.12 Transfer

Patients who have been admitted to the Hospital but later require a higher level of care shall be transferred to an appropriate facility. No patient shall be transferred to another facility unless arrangements have been made in advance for admission to such facility and the person legally responsible for the patient has been notified, and such transfer is not medically contraindicated or inconsistent with legal requirements. The Attending Physician is responsible for communicating directly with an accepting physician at the receiving facility.

## 2.13 Discharge

Patients shall be discharged only on order of the Attending Physician as outlined in the Medical Records Content and Completion Policy. Should a patient leave the hospital against the advice of the Attending Physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record. The Attending Physician and Hospital staff shall ensure that the patient (or appropriate family Member or legally designated representative) is provided with relevant information, including but not limited to

- Conditions that may result in the patient's transfer to another facility or level of care;
- Alternatives to transfer, if any;
- The clinical basis for the discharge;
- The anticipated need for continued care following discharge;
- When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and
- Written discharge instructions in a form and manner that the patient or family Member can understand.

## 2.14 Autopsies

Members should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. Examples include, but are not limited to: deaths in which autopsy may help to explain unanticipated complications; deaths in which the cause of death or a major diagnosis is unknown with reasonable certainty on clinical grounds; unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction; obstetric, prenatal and pediatric deaths. Autopsies will be obtained with consent and according to current Hospital policy, as-reviewed and approved by the Medical Executive Committee.

## 2.15 Classification and Admission of Trauma Patients

A patient presenting to the emergency department will be assessed and classified as a trauma patient or a non-trauma patient by an emergency medicine physician. Trauma patients are classified as Level I, Level II or Other. Patients classified as Level I and Level II will be admitted to the trauma service and the trauma surgeon on call. Patients classified as Other will be admitted to the appropriate service at the discretion of the emergency medicine physician. Patients classified as non-trauma will be admitted to the appropriate service at the discretion of the emergency medicine physician. The decision of the emergency medicine physician is final.

If the emergency medicine physician determines a trauma patient requires admission to the trauma service, the trauma surgeon on call will admit and attend the patient, and cannot sign-off of the patient as the attending until at least 24 hours has passed, and the surgeon has personally communicated with a substitute attending physician who has accepted the patient.

If the emergency medicine physician determines the patient is non-trauma, or is another trauma and does not require admission to the trauma service, the patient will be admitted and attended by the appropriate specialty, most often internal medicine. The attending physician cannot sign-off of the patient as the attending until at least 24 hours has passed, and the attending has personally communicated with a substitute attending physician who has accepted the patient.

## CHAPTER 3: CLINICAL RECORD

### 3.1 The Medical Record

The Hospitals utilize an electronic medical record (“EMR”). The record also includes some limited paper elements, such as consents. Medical record entries, information and images should not be printed or downloaded to a portable storage device; information should be accessed on site or remotely through the appropriate information portal. Pathology specimens may not be removed from the Hospital except after proper authorization, as defined in Hospital policy approved by the Medical Executive Committee.

### 3.2 Abbreviations/Symbols

Symbols should generally not be used in the medical record, and abbreviations used may only be those identified in Hospital policy, approved by the Medical Executive Committee.

### 3.3 Authentication

All entries in the medical record must be authenticated, including the Member’s name, identification number, date and time of entry. Each Member receives a unique identification number at the time of Medical Staff appointment, which also serves as the Member’s computer sign-in identification. Direct entries in the EMR are automatically authenticated by the Member’s sign-in to the EMR. Dictated entries must be reviewed and separately electronically authenticated.

### 3.4 Orders

Orders should be entered by the Member directly into the EMR. Telephone and verbal orders are the exception, and should be used sparingly in those instances where an emergent situation or a lack of computer access exists.

Verbal orders must be authenticated before the Member leaves the clinical area where given. Telephone orders must be authenticated by the Member, or another Member who is responsible for the care of the

patient as soon as practicable, but no later than 72 hours after the order was given.

Admission orders must be authenticated before the patient is discharged.

### 3.5 History and Physical Examinations

A history and physical (H&P) examination may be performed by a physician, an oral and maxillofacial surgeon or other qualified Members with the Privilege to do so. An office-based H&P performed by such a Member is acceptable and may be made a part of the record. An H&P submitted by a referring physician not on the Medical Staff may be utilized if a Member with H&P privileges attests to the validity of the content of the H&P and countersigns the document after registration within 24 hours of admission, or prior to the performance of a non-emergent surgery or procedure requiring anesthesia services.

The H&P must contain sufficient information to support the diagnosis or differential diagnosis and justify the treatment plan. The H&P must contain, at a minimum, the following:

- 1) Chief complaint;
- 2) History of the current illness;
- 3) Relevant past medical history, including when appropriate, assessment of emotional, behavioral and social status;
- 4) Relevant social history appropriate to patient's age;
- 5) List of current medications and dosages;
- 6) Known allergies;
- 7) Existing co-morbid conditions;
- 8) Review of body systems;
- 9) Physical examination;
- 10) Provisional diagnosis;
- 11) Initial plan.

Notwithstanding the foregoing, an H&P for an obstetrical patient will consist of the prenatal record, and will be updated by a Member, confirming review of the prenatal record, examination of the patient, and documentation of no change, or documentation of changes noted. The H&P update must occur, and be in the medical record, within 24 hours of admission and prior to the performance of a non-emergent surgery or procedure requiring anesthesia services. If the H&P is older than 24 hours but was completed fewer than 30 days before admission or planned procedure, an updated H&P will be entered into the medical record. The Member updating the H&P must review the H&P, examine the patient and either confirm there are no changes, or document such changes. The H&P update must occur, and be in the medical record after registration, within 24 hours of admission and prior to the performance of a non-emergent surgery or procedure requiring anesthesia services.

### 3.6 Operative Reports

An operative report or an operative post-op note (progress note) is entered into the Medical Record immediately after a surgery or procedure requiring anesthesia services before the patient is transferred to the next level of care. If the operative report cannot be in the record before patient transfer (for example if it is being dictated it will not be in the record before transfer), then an operative post-op note must be entered in the EMR by the performing Member.

The Post-Op Note must contain at a minimum the following:

- 1) Name(s) of the Member(s) who primarily performed the procedure and any assistant(s);
- 2) Procedure performed and a description of each procedure finding;
- 3) Estimated blood loss;

- 4) Specimens removed, and;
- 5) Postoperative diagnosis.

The Operative Report must contain at a minimum the following:

- 1) Name(s) of the Member(s) who primarily performed the procedure and any assistant(s);
- 2) The name of the procedure performed;
- 3) Description of the procedure performed;
- 4) Findings of the procedure;
- 5) Description and findings of the procedure;
- 6) Estimated blood loss;
- 7) Specimens removed; and
- 8) Postoperative diagnosis.

If a Post-Op Note is prepared, an Operative Report must also be dictated or entered directly into the EMR within 24 hours of the procedure.

### 3.7 Progress notes

Progress notes shall be written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission, unless the patient's condition warrants further progress notes on that date. The progress note shall contain information sufficient to permit continuity of care, and whenever possible, each of the patient's clinical problems should be clearly identified and correlated with specific orders, as well as results of tests and treatment.

### 3.8 Discharge Summary

A discharge summary is required for all inpatients admitted for more than 48 hours and shall include at a minimum:

- 1) Reason for admission;
- 2) Information relative to pertinent findings;
- 3) Procedures performed and treatment rendered;
- 4) The condition of the patient on discharge; and
- 5) Instructions given to the patient and/or family, particularly in regard to physical activity limitations, medications, diet and follow-up visits.

For observation patients, and patients admitted for less than 48 hours, a final progress note may be substituted for the discharge summary, provided the note contains the following minimum information:

- 1) Outcome of hospitalization;
- 2) Disposition of the case;
- 3) Provisions for follow-up care.

In the event of a patient death, a final progress note must be made that includes the time of death, events or conditions leading to the death, and information communicated to the patient's family and/or the medical examiner, if applicable.

### 3.9 Medical Record Deficiencies and Suspension

Patient medical records are required to be completed within 21 days of discharge, unless a shorter time frame is provided for herein, or is implemented by the Health Informatics and Documentation Committee. A record becomes delinquent after 30 days post discharge if not completed in accordance with Medical Records Content and Completion Policy. A Practitioner is eligible for automatic suspension in accordance with the Bylaws if records are deficient at 21 days post discharge. The Health Information Management Department will regularly provide each Member with information concerning incomplete medical records.

A Member will be notified 2 days in advance of a suspension. On the effective date of the suspension, the Member may not: provide any hands-on patient care, whether inpatient or outpatient; perform any procedures or surgeries scheduled or otherwise; admit patients; schedule procedures or surgeries. All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

The suspended Member is obligated to provide to their Department Chair the name of another Member who will take over the care of their hospitalized patients, take their call, consultations and any other services that they may provide.

An exception to the suspension will be permitted when the Member is on ED call rotation and suspension will be lifted for the duration of the ED call obligation only. Any other suspension exception must be approved by the President of the Medical Staff and the Hospital President.

Any Member who remains on suspension for 7 calendar days or longer will be subject to additional fines, and potentially further disciplinary action, as determined by the Medical Executive Committee in consultation with the Health Informatics and Documentation Committee.

## **CHAPTER 4: DUTIES OF MEDICAL DIRECTOR**

Members with demonstrated competence may be appointed as Medical Directors by the Hospitals on a paid or voluntary basis to provide direction and guidance for clinical service lines and departments. In addition to administrative duties, such a director's duties may include, but are not limited to: clinical direction; surveillance of performance by individuals with clinical privileges; recommendations for quality metrics and privileging.

## **CHAPTER 5: COMMITTEES**

The standing committees of the Medical Staff are set forth in the Unified Medical Staff Bylaws. Any Ad Hoc committee created under the Bylaws shall have a charter describing its composition, duties, and expected meeting schedule and duration.

Medical Staff committees may recommend policies applicable to the Medical Staff, which must be approved by the Medical Executive Committee. Any such policies effecting Hospital operations will also be approved by Hospital leadership as described in Hospital policy.

The chair of any standing committee should have previous experience on that committee. Unless otherwise provided for in the Bylaws, if a Member is unable to serve on a committee for good cause and a vacancy occurs, the committee chair shall nominate a replacement for Medical Executive Committee approval. Unless otherwise provided for in the Bylaws, if the chair of a committee is unable to serve on a committee for good cause and a vacancy occurs, the President of the Medical Staff shall nominate a new chair for Medical Executive Committee approval.

Minutes and/or action items from committee meetings shall be reported to the Medical Executive Committee, and when appropriate, to other Medical Staff Committees. All recommendations and actions of Medical Staff committees shall be approved by the Medical Executive Committee before implementation.

## **CHAPTER 6: DEPARTMENTS**

The process for electing Department Chairs and Department Vice-Chairs for all departments besides Radiology/Pathology and Emergency Medicine is as follows.

The Department Chair and Vice-Chairs shall be elected, as needed, at a Department meeting held in November. Only Active Staff Members shall be eligible to vote. No proxy voting will be permissible. The nominee receiving the greatest number of votes will be elected. In the event of a tie vote, repeat vote(s) will occur until one candidate receives a greater number of votes.

Three (3) Active Staff Members of the Department will be appointed by the Department Chair and Vice Chairs (one Member each), confirmed by the Medical Executive Committee, to act as a nominating committee for the election of the Department Chairs and Vice-Chairs. This Department Nominating Committee will solicit names for Department Chair and Vice-Chairs at least 60 days before the election, and shall meet at least 45 days before the election to offer at least one (1) nominee for an open Chair and Vice-Chair position(s).

Medical Staff Departments may recommend policies applicable to Members of the Department, and/or to the Medical Staff, which must be approved by the Medical Executive Committee. Any such policies effecting Hospital operations will also be approved by Hospital leadership as described in Hospital policy.

Minutes from Department meetings shall be taken, reflecting the basic information covered and actions taken. Actions and recommendations from Department meetings shall be reported to the Medical Executive Committee, and when appropriate, to other Medical Staff Committees. All recommendations and actions of Medical Staff Departments shall be approved by the Medical Executive Committee before implementation.

The basic nature and composition of the Departments of the Medical Staff is as follows. Specialties falling into specific Departments are identified below. The Chief Medical Officer will recommend Department appointment for specialties not identified below as part of the application process, subject to approval of the Department Chair, or their designee, when considering an applicant.

### **CARDIOVASCULAR/CRITICAL CARE**

The Department provides invasive and non-invasive procedures, diagnostic and therapeutic interventions, testing and interpretation for inpatients and outpatients in various care settings. Specialties in the Department include, but are not limited to: Cardiology; Cardiothoracic Surgery; Critical Care; Pulmonology.

### **EMERGENCY MEDICINE**

The Department provides invasive and non-invasive, diagnostic and therapeutic interventions for adult and pediatric patients. Members are exclusive providers of services through contractual relationships. Members specialize in emergency medicine providing services in a Hospital emergency department, and Members also specialize in internal medicine and family practice providing services in a Hospital based immediate care setting.

### **MEDICINE**



The Department provides primary and specialty medical care for adult and geriatric patients. Besides general internal medicine, specialties in the Department include, but are not limited to:

- Allergy/Immunology
- Dermatology
- Endocrinology
- Family Practice
- Gastroenterology
- Geriatric Medicine
- Hematology/Oncology
- Hospice/Palliative
- Hospitalists
- Infectious Disease
- Nephrology
- Neurology
- Physical Medicine & Rehabilitation
- Psychiatry
- Rheumatology

A Section of Internal Medicine will also exist under the Department of Medicine. The Section consists of Members, whose practice is devoted to general internal medicine, including hospitalists and any other Department Member participating in medical student or resident education programs. The Section will be focused on the advancement of internal medicine, education and patient care.

#### OBSTETRICS & GYNECOLOGY

The Department provides obstetrical and gynecological services to women aged adolescent through geriatric. Besides general obstetrics and/or gynecology, specialties in the Department include, but are not limited to: Gynecology/Oncology; Hospitalist; Reproductive Endocrinology; Urogynecology.

A Section of Pediatrics will also exist under the Department of Obstetrics & Gynecology to service inpatients and outpatients from newborn to 17 years of age, with exceptions up to 21 years of age.

#### ORTHOPEDICS

The Department provides care, treatment and surgical services for inpatients and outpatients at all levels of care and is composed of a Level II Trauma Service. Besides general orthopedics, specialties in the Department include, but are not limited to: Foot and Ankle; Hand; Shoulder and Elbow; Sports Medicine.

#### RADIOLOGY/PATHOLOGY

The Department provides diagnostic pathology services, and invasive and non-invasive diagnostic and therapeutic radiological interventions for adult and pediatric patients. Members are exclusive providers of services through contractual relationships. Members of the following specialties make up the Department: Anatomic Pathology; Clinical Pathology; Diagnostic Radiology; Interventional Radiology; Nuclear Medicine; Radiation Oncology.

#### SURGERY

The Department provides care, treatment and surgical services for inpatients and outpatients at all levels of care and is composed of a Level II Trauma Service. Specialties in the Department include, but are not limited to:

Anesthesia  
Dental  
General Surgery  
Neurosurgery  
Ophthalmology  
Otolaryngology  
Oral & Maxillofacial Surgery  
Pain Management  
Plastic  
Podiatry  
Spine  
Trauma Services  
Urology

## **CHAPTER 7: CLINICAL SECTIONS**

In the event a Clinical Section is created in a Department pursuant to the Bylaws or is referenced herein, Members meeting the clinical focus of the Section will be invited to join by the Department Chair. Thereafter, those participating Members will elect a Section Chief.

Each Clinical Section Chief shall serve a term of two (2) years commencing on January 1 and may be elected to serve no more than two (2) successive terms. A Clinical Section Chief must be a Member in Good Standing of the Active Medical Staff with relevant clinical privileges and be certified by the applicable specialty board to the focus of the Clinical Section. The Section Chief will be elected by majority vote of Active Staff Members who are Members of the Section.

Only Active Staff Members shall be eligible to vote. No proxy voting will be permissible. The nominee receiving the greatest number of votes will be elected. In the event of a tie vote, repeat vote(s) will occur until one candidate receives a greater number of votes.

Two (2) Members of the Section and one (1) Member of the Department will be appointed by the Department Chair and confirmed by the Medical Executive Committee to act as a nominating committee for the election of the Section Chief. This Section Nominating Committee will solicit names for Section Chief at least 60 days before the election, and shall meet at least 45 days before the election to offer at least one (1) nominee for an open Section Chief position.

# **UNIFIED MEDICAL STAFF CODE OF CONDUCT POLICY**

## **POLICY STATEMENT:**

Behaviors which undermine a culture of safety will not be tolerated. Any such behavior that is directed against patients and their support network, the organized medical staff, a medical staff Member or allied health professional, a hospital employee, administrator, board Member, contractor, or other Member of the hospital community shall be reported pursuant to hospital policy and addressed by the Medical Staff for medical staff and allied health professional staff issues.

## **SCOPE:**

All Members of the Medical Staff (Members) and all Allied Health Professionals (AHPs) on the AHP Staff, including all those with temporary privileges.

## **DEFINITIONS:**

**"Appropriate behavior"**: any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline. See Addendum A for examples.

### **Behavior that undermines a culture of safety includes:**

**"Inappropriate behavior"**: conduct that is unwarranted and is reasonably interpreted by a reasonably prudent person under similar circumstances to be demeaning or offensive. Persistent, repeated inappropriate behavior will be subject to treatment as "disruptive behavior." See Addendum A for examples.

**"Disruptive behavior"**: any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety likely would be compromised. It does not include reasonable behavior by the physician in the context of a care environment that has become unsettled by the behavior of a patient or an individual served. See Addendum A for examples.

**"Harassment"**: means conduct toward others based on their race, religion, gender, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment.

**"Sexual harassment"**: means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive intimidating or otherwise hostile work environment.

## **PROCEDURE:**

### **A. COMPLAINTS**

Complaints about a Member or AHP regarding alleged behavior that undermines a culture of safety should be directed to any Medical Staff Officer, Department Chair or Vice-Chair or to the Chief Medical Officer (CMO). To the extent feasible, the complaint should contain the following information:

1. The date(s), time(s) and location of the behavior that undermines a culture of safety;
2. A factual description of the behavior that undermines a culture of safety;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or patient's family Member who was involved in or witnessed the incident;
5. The consequences, if any, of the behavior that undermines a culture of safety; and
6. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

### **B. REVIEW**

The individual receiving the complaint should conduct an initial assessment and forward it to the CMO for processing and evaluation. The CMO will make a recommendation to the applicable Department Chair, or a Vice-Chair as designated by the Chair (both collectively referred to as "Chair" herein), about whether the complaint appears to have merit, requiring further communication and/or action.

The Chair will review the complaint and determine whether the CMO's recommendation will be taken. The Chair may also undertake an additional investigation of the complaint, which must be completed within 14 days of its receipt. If the Chair determines that a complaint is unfounded, the Chair will notify both the CMO and the President of the Medical Staff, providing a basis for the decision. Either the CMO or the President may forward the complaint to MEC for further consideration.

### **C. INTERVENTION**

Depending on the severity of the misconduct, interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending Member or AHP, and protecting patient care and safety. The Medical Staff supports tiered, non-confrontational intervention strategies, starting with discussion of the matter with the appropriate section chief or department chairperson.

Further interventions as determined by MEC can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes disruptive.

The use of summary suspension in the context of a behavior that undermines a culture of safety should follow the criteria and process established in the Bylaws. If there is reason to believe that such behavior is due to illness or impairment, the matter should be evaluated and managed confidentially according to the established procedures of the Medical Staff Wellness Committee.

If the Chair determines the complaint is well founded, the Chair shall personally communicate with the subject Member or AHP within 30 days of receiving the complaint from the CMO. The Chair shall provide the individual subject of the complaint with an oral and written explanation of the complaint.

The Chair will generally address complaints with a Member or AHP as follows:

1. If this is the first incident of *inappropriate behavior*, the Chair shall discuss the matter with the offending medical staff Member, and emphasize that the behavior is inappropriate and must cease. The approach during this initial intervention should be collegial and helpful, while impressing on the offending medical staff Member the need to take definitive action to address the problem.
2. Further isolated incidents of *inappropriate behavior* will be handled as provided for in 1) above, with a clear reminder that the individual is expected to comply with this Code of Conduct.
3. If the Chair believes the individual has engaged in *disruptive behavior*, which includes persistent and/or repeated *inappropriate behavior*, on the first offense, the Chair will communicate with the subject individual and advise that the matter is being referred to MEC for consideration. The Chair shall send a communication to MEC and the subject individual making any findings and/or recommendations for rehabilitation and/or corrective action.
4. If MEC takes action based on a violation of this Code of Conduct, and further *inappropriate* or *disruptive behavior* recurs, the Chair shall refer such a complaint directly to MEC for communication with subject individual. MEC may take such further investigatory action as it deems appropriate. The subject individual shall appear before MEC to review the complaint, and MEC may take reasonable action in response, including corrective action according to the Bylaws.
5. A confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending Member or AHP, shall be retained in the subject individual's credentials file.

6. All documents, data, information, reports, communications, minutes, and similar materials relating to the Member or AHP shall be considered privileged and confidential peer review materials.

#### D. ABUSE OF PROCESS

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by a Member or AHP against complainants will give rise to corrective action pursuant to the Bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

#### E. PROMOTING AWARENESS OF CODE OF CONDUCT

The Medical Staff shall, in cooperation with the Hospital, promote continuing awareness of this Code of Conduct among the medical staff and the hospital community, by:

- A. Sponsoring or supporting educational programs on behaviors that undermine a culture of safety to be offered to medical staff Members and hospital employees;
- B. Disseminating Code of Conduct Policy to all current medical staff Members upon its adoption and to all new applicants for membership to the medical staff and as part of the credentialing process;
- C. Informing the Members and the hospital staff of the procedures the medical staff and hospital have put into place for effective communication to hospital administration of any medical staff Member's concerns, complaints and suggestions regarding hospital personnel, equipment, and systems.

### **ADDENDUM A TYPES OF CONDUCT**

#### **A. Appropriate Behavior**

Medical staff Members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

1. The exercise of personal or professional judgment in voting, speaking, or advocating on any matter regarding:
  - a. Patient care interests (i.e., criticism communicated within a reasonable manner and offered in good faith with the aim of improving patient care and safety; expressions of concern about a patient's care and safety; and, professional comments to any professional, managerial, supervisory, or administrative staff, or to Members of the Board of Directors, about patient care or safety provided by others).

- b. Health care in the community, medical staff matters (e.g., active participation in medical staff and hospital meetings such that comments made during or resulting from such meetings cannot be used as the basis for a complaint under this Code of Conduct Policy, referral to the Health and Wellbeing Committee, economic sanctions, or the filing of an action before a state or federal agency), or
  - c. The independent exercise of medical judgment.
2. Encouraging clear communication;
3. Expressions of dissatisfaction with policies through appropriate grievance channels or other civil means of communication;
4. Use of cooperative approach to problem resolution;
5. Constructive criticism conveyed in a responsible and appropriate manner;
6. Use of directive or evocative tone or language in the context of emergent patient care;
7. Membership on other medical staffs; and
8. Seeking legal advice or the initiation of legal action for cause.

**B. Inappropriate Behavior**

Inappropriate behavior by medical staff Members is discouraged. Persistent inappropriate behavior will be subject to treatment as "disruptive behavior." Examples of inappropriate behavior include, but are not limited to, the following:

1. Belittling or berating statements to patients, patient family Members, or Members of the patient care team;
2. Use of profanity or disrespectful language in a patient care context or environment;
3. Inappropriate comments written in the medical record;
4. Blatant failure to respond to patient care needs or staff requests;
5. Deliberate lack of cooperation with other Members of the patient care team without good cause;
6. Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
7. Intentionally condescending language that negatively impacts patient care; and
8. Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital;



9. Failure or refusal to comply with Medical Staff Bylaws.

**C. Disruptive Behavior**

Disruptive behavior by medical staff Members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

1. Physically threatening language directed at anyone in the hospital including patients, physicians, nurses, other medical staff Members, or any hospital employee, contractor, administrator or Member of the Board of Directors;
2. Intentional physical contact with a patient, a patient family Member, or Member of the patient care team that is threatening or intimidating;
3. Throwing instruments, charts or other things;
4. Threats of violence or retribution against the patient, a patient family Member, or Member of the patient care team;
5. Sexual harassment with respect to a patient, a patient family Member, or Member of the patient care team;
6. Other forms of harassment toward a patient, a patient family Member, or Member of the patient care team, including, but not limited to, repeated frivolous threats of litigation; and,
7. Persistent and/or repeated inappropriate behavior.

# **UNIFIED MEDICAL STAFF CREDENTIALING POLICY**

Effective January 1, 2016  
Amendments effective December 5, 2016, September 21, 2018, August 26, 2021,  
November 4, 2021

## **DEFINITIONS**

Terms defined in the Unified Medical Staff Bylaws shall have the same meaning in this Policy.

“Applicant” means a Physician, Dentist, Podiatrist or Allied Health Professional applying either for initial appointment or reappointment, with or without privileges.

“Practitioner” means all Members of the Medical Staff and Allied Health Professional staff with Clinical Privileges.

“Practitioner Profile” means the report compiled for every Practitioner providing information and comparative data to allow review and measurement of a Practitioner’s competence and performance.

## **DEPARTMENT ASSIGNMENTS**

Members of the Medical Staff and Allied Health Professional Staff will be assigned a staff category and to a department according to the Unified Medical Staff Bylaws (the “Bylaws”).

## **INITIAL APPLICATION PROCESS**

The Unified Medical Staff comply with all applicable legal, regulatory and accreditation standards in utilizing a uniform credentialing process for new Practitioner applicants in accordance with the Bylaws in order to assure that:

1. Practitioners providing care are appropriately qualified and competent;
2. Eligible applicants are treated equally and fairly;
3. The appropriate individuals and committees are involved in the credentialing review and approval process prior to final approval by the Professional Standards Committee.

## **PROCEDURE**

1. Upon receipt of a request, an application and instructional information about the application process, including membership requirements, will be sent to a potential applicant. The criteria for determining eligibility for application are as described in the Bylaws.
2. The appointment application will seek a full summary of the Applicant’s qualifications in accordance with Article II of the Bylaws.
3. Minimum documentation/evidence necessary to complete processing of an application consists of the following:
  - Completed, signed application form and delineation of privilege form(s), (if applicable)
  - Current Illinois license(s) - State and Controlled Substance
  - Current DEA registration, if applicable
  - Current certificate of professional liability insurance coverage
  - Certification from appropriate specialty board(s) confirming board certification status
4. The Applicant must submit the required appointment application fee to the CVO in order for the application to be processed.

5. Upon receipt of a completed application form, a verification and an investigation process will be conducted as follows:
  - a. Verify license status in all states of licensure.
  - b. Verify DEA registration, if applicable.
  - c. Verify ECFMG (Educational Commission for Foreign Medical Graduates) certification, if applicable.
  - d. Conduct a criminal background check.
  - e. Query the National Practitioner Data Bank (NPDB) for reportable actions.
  - f. Query the applicable Federal exclusion data bases.
  - g. Query the American Medical Association (AMA) and/or the American Osteopathic Association (AOA) for physician profile and verification of credentials.
  - h. Obtain malpractice claims' history for the past ten (10) years.
  - i. Obtain three (3) professional references as submitted by the applicant on the application form who can provide reliable information regarding the applicant's current clinical ability, ethical character and ability to work with others unless waived pursuant to NM CMO endorsement.
  - j. Obtain letters of inquiry from all past and present clinical affiliations for the past five (5) years to include verification of applicant's expertise in privileges requested unless waiver pursuant to CMO endorsement.
  - k. Obtain letters of inquiry from residency and fellowship (if applicable) program director(s) for verification of training if training completed less than five (5) years from date of application unless waiver pursuant to CMO endorsement.
6. In the event of undue delay in obtaining required information, assistance will be requested from the Applicant. During this time period, the "time period for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance will, after thirty (30) days; will be considered a voluntary withdrawal of the application and result in termination of the application process.
7. The verification and review process for Applicants seeking telemedicine privileges only is as provided for in the Bylaws.
8. At the discretion of the Chief Medical Officer ("CMO"), the CMO will interview the Applicant.
9. The Chief Nursing Executive or designee will review and approve completed applications for all Advanced Practice Nurses.
10. The completed application will be forwarded to the applicable Department Chair, or their designee (referred to herein as the "Department Chair"), for review. The Department Chair may interview the Applicant and make a recommendation on the application to the Credentials Committee. The interview shall be in person or via videoconferencing whenever possible. The Department Chair may seek additional information from the Applicant in order to make such recommendation.
11. The Credentials Committee, followed by the Medical Executive Committee and the Professional Standards Committee shall act on the application in accordance with the Bylaws. Any of the foregoing may place conditions on an appointment, including but not limited to, a shortened appointment period. Additionally, the term of an appointment may be less than two years for administrative reasons corresponding to ability to synchronize terms for the Applicant's Department or other NM entity terms.
12. The Medical Staff Services Department will facilitate communication to the Applicant of their

appointment, including any conditions that may have been put on it.

## **REAPPOINTMENT PROCESS**

To assure continuity of patient care and ensure that eligible Members and AHPs are appropriately reappointed, adequate information will be obtained to process an application for reappointment in accordance with Medical Staff Bylaws.

### **PROCEDURE**

1. Approximately 6 months prior to the expiration date of a current appointment period, an Applicant will be invited to reapply using the electronic reappointment application portal.
2. The reappointment application will seek a full summary of the Applicant's qualifications in accordance with Article II of the Bylaws.
3. The Applicant must complete the application within only (60 days of receipt. The Applicant will be provided with communication about the status of the application, including information needed or information that needs to be corrected/revised on the application. If the application is not completed at the 60-day mark, the Applicant will be sent a certified letter stating: Failure to submit an application with all documents attendant thereto by the designated final date shall be deemed as evidence of the desire of the Applicant to relinquish membership through expiration of appointment; the Applicant shall be provided the expiration date of the current appointment.
4. The Applicant will be required to submit evidence of the following with the application:
  - Current Illinois license(s) - State and Controlled Substance
  - Current DEA registration if applicable
  - Current certificate of professional liability insurance coverage
5. Complete the Updated delineation of privilege form(s) requesting only those privileges the Applicant has performed and is competent to perform during their appointment.
6. The following verifications and queries will be made:
  - a. Obtain verification from the Applicant's primary other hospital and/or surgery center affiliation as needed.
  - b. Malpractice claims' history since last appointment.
  - c. Query the National Practitioner Data Bank (NPDB) for reportable actions.
  - d. Query the applicable federal exclusion databases.
7. The Applicant's current OPPE Practitioner Profile will be made a part of the reappointment application.
8. The Chief Nursing Executive or their designee will review and recommend the reappointment for all Advanced Practice Nurses.
9. Once an application has been completely reviewed and verified, it will be forwarded to the applicable Department Chair, or their designee (referred to herein as the "Department Chair"), for review.
10. The Department Chair must make a recommendation on the application and requested privileges to the

Credentials Committee. The Department Chair may seek additional information from the Applicant, including a personal interview, in order to make such recommendation.

11. The Credentials Committee, followed by the Medical Executive Committee and the Professional Standards Committee shall act on the application in accordance with the Bylaws. Any of the foregoing may place conditions on a reappointment, including but not limited to, a Focused Practice Evaluation and a shortened appointment period. Additionally, the term of a reappointment may be less than two years for administrative reasons corresponding to the time frame in which the Applicant's Department or other system NM Hospital falls in the reappointment credentialing cycle.
12. The Medical Staff Services Department will facilitate communication to the Applicant of their reappointment, including any conditions that may have been put on it.

## **ONGOING PROFESSIONAL PRACTICE EVALUATION**

Under the authority and at the direction of the Professional Standards Committee and the Medical Executive Committee, Practitioners' performance will be continuously evaluated to ensure the provision of effective, quality care. This ongoing professional practice evaluation (OPPE) monitors clinical competence and professional behavior and is confidential according to the Illinois Medical Studies Act.

### **PROCEDURE**

1. Elements utilized in the Practitioner Profile are primarily based on information in the medical record, compiled through an automated process, which provides data that allows a Practitioner's performance to be measured generally and against peers. The general categories of information contained in the Practitioner Profile include:
  - a. Clinical Activity
  - b. Utilization
  - c. Quality Measures
  - d. CMS Value Based Purchasing Measures
  - e. Complications
  - f. Mortality
  - g. Privilege Variances
  - h. QA/QI classifications
  - i. Medical Record Deficiencies
  - j. Practitioner Code of Conduct Inquiries
2. The Quality and Patient Safety Department will recommend specific data elements to include in the general categories identified in 1) above for approval by the Credentials Committee.
3. The Practitioner Profile information is compiled every six months and provided to the Practitioner and their Department Chair.
4. If the Chair identifies a concern about a Practitioner's performance, the Chair should address such concern directly with the Practitioner. If patterns or trends are identified by the Chair, then the Practitioner's Profile should be forwarded to the QA/QI Committee or to the UR Committee depending on the nature of the concern, for review and/or Chair may outline a triggered FPPE plan to address any concern.
5. This process allows for any potential concerns with a Practitioner's performance to be

identified and resolved as soon as possible. Additionally, it fosters a more efficient, evidence-based process. If there is a need for corrective action identified, the process will be performed as outlined in the respective Medical Staff Bylaws.

6. The Practitioner Profile will be utilized for Practitioner reappointment to the Medical Staff or Allied Health Professional Staff.
7. Practitioners have the right to review their quality information at any time with reasonable notice to the Quality and Patient Safety Department.

## **FOCUSED PROFESSIONAL PRACTICE EVALUATION**

All newly appointed Members and AHPs, and Members and AHP's requesting additional Privileges after appointment, will receive a focused review and evaluation of their performance by their peers. The goal of this Focused Professional Practice Evaluation (FPPE) is to evaluate practice competence and privilege specific competence. This process is applied consistently and fairly to all Members and AHPs and is confidential under the Illinois Medical Studies Act.

### **PROCEDURE**

1. The review will be facilitated by the Quality and Patient Safety Department under the direction of the QA/QI Committee, which will perform the final analysis.
2. Four (4) cases will be reviewed for each Member or AHP. In no instance will the review extend for more than one (1) year. If Practitioner volume does not allow for the review to be completed in this time frame, alternative methods of review shall be considered, including but not limited to, direct observation of care encounters or procedures.
3. The Practitioner will be advised of any significant competence concern during the period of review. Otherwise, the Practitioner will receive a summary report of the results of the review when concluded.
4. The QA/QI Committee may recommend actions concerning the review to the Medical Executive Committee, including but not limited to, an extended FPPE, proctoring, and limitation of Privileges. All such recommendations will be made with the intent of improving the Practitioner's performance, while ensuring patient safety.

## **FOCUSED CLINICAL EVALUATION**

When there are concerns regarding a Practitioner's clinical performance, a focused review and evaluation of a Practitioner's performance by peers may be initiated. The goal of a focused review is to improve a Practitioner's performance. This process is applied consistently and fairly to all Medical Staff Members and Allied Health Professionals and is confidential under the Illinois Medical Studies Act. The review will be facilitated by the Clinical Effectiveness Department at the direction of the Credentials Committee, the QA/QI Committee or the Medical Executive Committee.

## PROCEDURE

1. Reviews will be performed internally with the QA/QI Committee performing the final analysis. In the event of a lack of internal clinical expertise, or of a conflict of interest, an external review may be sought with the approval of the Medical Executive Committee.
2. When a focused review is initiated, the number of cases to be reviewed will be determined by the Committee requesting the review. Practitioner volume should be accounted for in selecting the number of cases to review so that the review is concluded within a reasonable time frame.
3. The Practitioner will be:
  - a. Notified of the decision for a focus review, rationale, time frames involved, privileges impacted (if any), and how the review will be conducted, i.e.; internally or externally;
  - b. Kept informed when specific quality issues are identified through the review;
  - c. Informed of the final outcome of the review;
  - d. May be invited to attend the applicable Medical Staff Committee meeting to discuss the review process and results.
4. Any recommended actions concerning the review will be made to the Medical Executive Committee, with the intent of improving the Practitioner's performance, while ensuring patient safety.

## **HEALTH TESTING AND VACCINATIONS:**

Requirements for health testing and vaccinations, including without limitations seasonal influenza, shall be in accordance with NMHC policies and practices.