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Henry Ford Macomb Hospital Medical Staff Bylaws

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Henry Ford Macomb Hospitals Medical Staff Bylaws

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- 01-19-10 Medical Executive Committee
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- 10-16-12 Medical Executive Committee
- 10-16-12 Chief Executive Officer
- 11-20-12 Medical Executive Committee
- 11-20-12 Chief Executive Officer
- 02-17-15 Medical Executive Committee
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Part I: Governance

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Section 1. Definitions

A. **Administration**: The senior leadership team of Henry Ford Macomb Hospital.

B. **Allied Health Professional**: An Allied Health Professional (AHP) is an individual other than a licensed physician of medicine or osteopathy, podiatry, or dentistry who provides services only under the supervision of a physician. The AHP exercises judgment within the areas of his/her professional competence and the limits established by the governing body, the Medical Staff and statutes governing licensure and certification. AHP's are not eligible for Medical Staff membership.

C. **Advanced Practice Providers**: An Advanced Practice Provider (APP) is an individual other than a licensed AHP, physician of medicine or osteopathy, podiatry, or dentistry who provides services only under the supervision of a physician. The APP exercises judgment within the areas of his/her professional competence and limits established by the governing body, the Medical Staff and state and federal statutes governing licensure and certifications.

D. **Advanced Practice Provider Membership:** Advance Practice Provider membership is limited to certain professionals who must demonstrate the necessary evidence of licensure, relevant training/ experience, competence, and abilities for the category of membership requested. The qualifications for membership are found in the medical staff bylaws. The advanced practice professional membership is a formal organization of practitioners having the responsibility and authority, delegated by the Board, to maintain proper standards of patient care and to plan for the continued improvement of that care.

E. **Independent Practitioners:** Independent practitioners are those practitioners who, in accordance with their license, Henry Ford Macomb Hospital credentialing and privileging requirements and when their services are initiated upon written order in accordance with hospital policy, are able to practice without supervision, within the scope of their license.

F. **Board of Trustees or Governing Board:** The governing body of Henry Ford Macomb Hospital.

G. **Chief Executive Officer (CEO):** The individual appointed by the Board to serve as chief administrative officer of Henry Ford Macomb Hospital.

H. **Chief of Staff (COS):** The elected chief officer of the medical staff.

I. **Chief Medical Officer (CMO):** The member of Administration of the Henry Ford Macomb Hospital charged with encouraging a cooperative and collaborative relationship between the Medical Staff and the Hospital.

J. **Clinical Privileges or Privileges:** Clinical privileges or privileges refers to the permission granted to independent and dependent healthcare practitioners by the Board to provide patient care within the scope of their practice and license and includes reasonable access to those hospital resources (including equipment, facilities and personnel) which are necessary to effectively exercise those privileges. Granting of privileges is based on periodic competency assessment in accordance with accrediting body regulations and best practices for patient safety.

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K. **Clinical Activity:** a summary of a practitioners' patient encounters.

L. **Competency:** A determination of an individual's capability to perform up to defined expectations and clinical privileges requested. Measurement examples may include but are not limited to: formal education and training, participation in performance improvement activities and quality controls, measurement of skills, ongoing assessment and evaluation, medical records clinical review, volume of patients treated, documented continuing education, presentations, publications, and peer review. For appointment/reappointment, a judgment of current competency is made by the Division Chief / Clinical Service Chair / Medical Director or designated physician leader dependent upon the information submitted by the applicant, with recommendation from the Credentials Committee and Medical Executive Committee and to the Board, which will take action as appropriate. Initial and ongoing assessment of competency for healthcare professionals ensures alignment with quality of care and patient safety goals of Henry Ford Macomb Hospital.

M. **Designated Physician Leader:** physician leader designated for review and input on behalf of the Service Line Chair or Division Chief.

N. **Emergency:** 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. Health care practitioners are not required to be specifically privileged to provide "emergency" care. All personnel are expected and authorized to render care necessary to save the life or protect the welfare of a patient in an emergency situation, to the degree permitted by their licensure, training, and applicable laws.

O. **Exclusive Contract:** A contract between Henry Ford Macomb Hospital and a member or members providing for the exclusive delivery of certain services by the member or members.

P. **Ex Officio**: Service as a member of a body by virtue of an office or position held, without voting rights unless expressly provided in the medical staff bylaws and related documents of the medical staff.

Q. **Henry Ford Macomb Hospital**: The collection of legal entities, of which Henry Ford Macomb Hospital is one member, all governed by the entity Henry Ford Health System. Together these entities establish a continuum of healthcare services in support of the mission of Henry Ford Macomb Hospital and Henry Ford Health System.

R. **Good standing:** Term refers to staff member that meets and continues to meet qualifications, responsibilities and obligations defined in the medical staff bylaws and related medical staff documents which may include, attendance requirements, current staff dues payments, complete medical records, and is not under suspension of his/her appointment or admitting privileges at the time the issue of good standing is raised.

S. **Hospital or Henry Ford Macomb Hospital:** Henry Ford Macomb Hospital of Clinton Township, Michigan (an entity of Henry Ford Health System) including its ambulatory surgery centers, clinics, urgent care centers and behavioral medicine sites.

T. **Investigation:** A process initiated by the Medical Executive Committee to determine the

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validity of a concern or complaint raised against a medical staff member or individual holding clinical privileges.

U. **Joint Conference Committee:** A committee constituting a forum for review of matters of the medical staff, the medical executive committee, the hospital and the board. The committee may consider matters on its own initiative or as suggested by individuals of the Medical Staff, the Administration or the Board of Trustees.

V. **Leader:** An individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, clinical, and support functions and processes. Leaders include, when applicable to the organization's structure, the owners, members of the governing body, the chief executive officer and other senior leaders, and the elected medical staff leaders.

W. **Medical Director:** A physician contracted by administration, after presentation to the Medical Executive Committee, for medical expertise in specified area(s).

X. **Medical Executive Committee (MEC):** The governing body of the medical staff.

Y. **Medical Staff Bylaws:** Refers to and consists of Part I - Governance, Part II – Investigations, Correction Action, Hearing and Appeal Plan, Part III – Credentials Procedure Manual and Part IV – Organization and Functions Manual, table of contents and definitions.

Z. **Medical Staff or Staff:** The formal organization of all licensed physicians, dentists, podiatrists and oral surgeons who have been granted recognition as members of the Medical Staff in their respective capacities pursuant to the terms of the medical staff bylaws.

AA. **Medical Staff Membership:** The Medical Staff membership is a formal organization of practitioners having the responsibility and authority, delegated by the Board, to maintain proper standards of patient care and to plan for the continued improvement of that care. Medical Staff membership is limited to certain professionals who must demonstrate the necessary evidence of licensure, relevant training/ experience, competence, and abilities for the category of membership requested. The qualifications for membership are found in the medical staff bylaws.

AB. **Medical Staff Year:** The period from January 1st through December 31st.

AC. **Member:** Any physician, dentist, podiatrist or psychologist holding a current license to practice his or her profession who has been granted membership on the Medical Staff or any APP holding a current license to practice his/her profession who has been granted membership on the Advanced Practice Provider staff.

AD. **Patient Encounter:** Contact with a Henry Ford Macomb Hospital patient under any of the following scenarios, noting in all cases the burden is on the member to establish requisite patient encounters:

1. An admission of a patient to the Hospital on an inpatient basis by the admitting physician;

2. A consultation on a Hospital inpatient or Ambulatory Care patient, involving actual

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physical examination of the patient and preparation of appropriate formal notes; or

3. The performance of medical, surgical or psychological procedures upon a Hospital patient on an inpatient or outpatient basis.

4. Referrals for inpatient or ambulatory services are counted as patient encounters when determining medical staff category.

AE. **Peer Review or Professional Review:** As used in these Bylaws and any of its appendices, the terms “Peer Review” and/or “Professional Review” have the meaning assigned to them under the Michigan Public Health Code relating to professional review activities and functions to review, monitor and reduce morbidity and mortality and improve the quality of care provided to patients.

AF. **Physician:** An individual with an M.D. or a D.O. degree who is currently licensed to practice medicine in the state of Michigan.

AG. **Special Notice:** Written notification sent by certified or registered mail, return receipt requested, to the address of record. A special notice may be personally delivered in lieu of being sent by certified or registered mail.

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Section 2. Medical Staff Purpose and Authority

2.1 Purpose

The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Henry Ford Macomb Hospitals in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital Board of Trustees.

2.2 Authority

Subject to the authority and approval of the Board of Trustees, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the Henry Ford Macomb Hospitals. Henceforth, whenever the term "the hospital" is used, it shall mean Henry Ford Macomb Hospitals; and whenever the term "the Board" is used, it shall mean Board of Trustees.

Section 3. Medical Staff Membership

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3.1 Nature of Medical Staff Membership

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

3.2 Qualifications for Membership

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

3.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, age, sexual orientation or disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified as specified in these bylaws and associated policies of the medical staff and the hospital. The hospital will not discriminate in granting staff appointment and /or clinical privileges on the basis of the types of patients in which a practitioner specializes.

3.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the medical staff. The Board shall act on appointment and reappointment only after the medical staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and reappointment to the

medical staff shall be for no more than thirty-six (36) calendar months.

3.5 Medical Staff Membership and Clinical Privileges

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

3.6 Medical Staff Members Responsibilities

1. Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.
2. Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.
3. Each staff member, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical service line or hospital service specialty, to assist in meeting the patient care needs of the community.
4. Each staff member must submit to any pertinent type of health evaluation as requested by the officers of the medical staff, Chief Executive Officer (CEO), CMO and/or committee/Service Line Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.
5. Each staff member must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.
6. Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member shall notify the CEO or designee immediately of any and all malpractice claims threatened in writing or filed against the medical staff member.
7. Each staff member agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct for acts done in good faith and not done in willful and wanton manner in connection with investigating and/or evaluating the quality of care provided by the medical staff member and his/ her credentials.

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

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

    b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

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

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

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

11. Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest policy.

3.7 Medical Staff Member Rights

1. Each staff member in the active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Service Line Chair or other appropriate medical staff leader(s), that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue. The member will be allowed to vote, on that issue only, at the MEC

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meeting in which the issue is discussed.

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

3. Each staff member in the active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by ten percent (10%) of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

4. Each staff member in the active category may challenge any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by ten percent (10%) of the members of the active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

5. Each staff member in the active category may call for a Service Line meeting by presenting a petition signed by ten percent (10%) of the members of the Service Line. Upon presentation of such a petition the Service Line Chair will schedule a Service Line meeting.

6. The above sections 3.7.1 to 3.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

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

3.8 Staff Dues

1. Annual staff dues, if any, shall be determined by the MEC. Failure of a medical staff member to pay dues shall be considered a voluntary resignation from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

3.9 Indemnification

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

2. Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff.

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However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 4. Allied Health Professionals

4.1 Qualifications

1. Allied Health Professionals include practitioners defined by medical staff policy and must possess a license to practice their profession in Michigan and shall apply for specified delineation of privileges on a form prescribed by the MEC and approved by the board. Applications for initial and renewed specified privileges will be processed using the procedures set forth in Sections 3, 4 and 5 of Part III of the Credentials Procedure Manual based on the criteria stated in the applicable delineation of privileges(to the extent applicable to the practitioners profession) and other requirements contained in these Bylaws. The Board, upon recommendation of the MEC and the CEO, may grant Allied Health Professionals specified privileges. An AHP may provide direct patient care at the Hospital only within the scope of his or her specified privileges.

4.2 Assignment, Supervision and Compliance

1. Although responsible to the Medical Staff and the Board, Allied Health Professionals are not members of the medical staff. Each Allied Health Professional shall function at the Hospital under the overall supervision of a designated medical staff member. An Allied Health Professional's specified privileges may not exceed the scope of the privileges held by his or her supervising physician. Allied Health Professionals shall consist of practitioners defined by medical staff policy approved by MEC.

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4.3 Meeting Attendance

1. Allied Health Professionals may attend General Staff meetings, at the request of their supervising member and with the permission of the Chief of Staff. Allied Health Professionals may attend Clinical Service and / or Medical Staff Committee meetings, at the request of their supervising member and subject to the approval of the appropriate clinical service chairperson or committee chairperson. If so permitted to attend a meeting Allied Health Professionals may not vote, nor may they participate unless so requested by the presiding officer of the meeting.

4.4 Suspension and Termination

1. An Allied Health Professional may have his or her specified privileges, suspended, revoked, or not renewed in the same manner as a a medical staff member, as well as in accordance with the terms of any written contract the Allied Health Professional may have with the Hospital. If (a) the designated supervising member ceases to be a member or (b) the supervising arrangement (e.g. collaboration agreement or employment) between the Allied Health Professional and designated supervising member terminates, then the Allied Health

Professional's specified privileges will terminate automatically, without hearing or appeal, unless an alternative supervising physician is assigned. If the designated supervising member's privileges are voluntarily or involuntarily reduced, there shall be an automatic corresponding reduction in the Allied Health Professional's specified privileges, without hearing or appeal. If the practitioner is a hospital employee, the hospital's existing fair treatment policy will be applied.

Section 5. Advanced Practice Professionals

5.1 Nature of Advanced Practice Professional Staff Membership

1. The Advanced Practice Professional Staff shall consist of practitioners who are not members of the medical staff, includes practitioners defined by medical staff policy and:
    a. Are located closely enough to the hospital to provide continuous care to their patients and
    b. Assume all the rights and responsibilities of appointment to the Advanced Practice Professional staff
    c. Shall be assigned to advanced practice provider categories of Active, Affiliate or Telemedicine pursuant to Part I, Governance, Section 6. May be appointed to Honorary category if requirements in Part I, Governance, Section 6.5 are met, and recommendation is supported by MEC and the Board.
    d. Possess a license to practice their profession in Michigan and shall apply for specified delineation of privileges on a form prescribed by the MEC and approved by the Board. Applications for initial and renewed specified privileges will be processed using the procedures set forth in Sections 2, 3, 4 and 5 of Part III of the Credentials Procedure Manual, as applicable for Advanced Practice Providers, and based on the criteria stated in individual delineations of privileges (to the extent applicable to the practitioner's profession). The Board, upon recommendation of the MEC and the CEO, may grant Advanced Practice Professional specified privileges. An APP may provide direct patient care at the Hospital only within the scope of his or her specified privileges.
2. Each Advanced Practice Professional shall function at the Hospital under the overall supervision of a designated physician member. An Advanced Practice Professional's specified privileges may not exceed the scope of the privileges held by his or her supervising member. Advanced Practice Professionals shall comply with these Bylaws and the Rules to the extent relevant in light of their scope of practice, and any Hospital and medical staff policies intended to govern their activities.

5.2 Rights and Obligations

1. Advanced Practice Professional appointees shall be eligible to:

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a. apply for clinical privileges and meet all eligibility requirements defined on the specific delineation of privileges in their specialty area of practice.

b. apply for Advanced Practice Professional membership without clinical privileges.

c. vote to elect an MEC Advanced Practice Provider at-large member and vote on matters presented to the Advanced Practice Professionals by MEC for vote.

d. serve as voting member on committees to which the member is appointed.

e. attend meetings of the Medical Staff and/or Clinical Service if specifically requested by the Chief of Staff or Clinical Service Chair to do so.

f. Pay staff dues as assessed by the Medical Executive Committee.

2. Any Advanced Practice Provider has a right to a hearing and appeal pursuant to conditions and procedures described in the medical staff's hearing and appeal plan described in Part II of these bylaws.

3. Advanced Practice Providers shall not be eligible to:

    a. Apply for admitting privileges.

    b. Hold Medical Staff Office or Clinical Service Office.

    c. Vote on matters presented by the Medical Staff, except as noted in Section 5.2.1. (a) above.

4. As may be required by the Medical Executive Committee or the Governing Body, Advanced Practice Professional appointees must actively participate in recognized functions of Staff appointment, including but not limited to, participating in quality improvement and other monitoring activities, serving on Medical Staff committees, and discharging other functions as may be required from time to time.

5. All policies and procedures, as well as any applicable clinical protocols and guidelines governing the practice of individuals granted privileges without medical staff membership, must be reviewed and approved by the Division Chief and/or Chair of the Service Line in which the practitioner is granted privileges. For nurses practicing in an expanded role, the institution's chief nursing officer must also review and approve such policies and procedures, clinical protocols, and guidelines. The expanded nursing role clinical protocols and guidelines must also be reviewed and approved by the Medical Executive Committee and the Board.

5.3 Suspension and Termination

1. An Advanced Practice Professional may have his or her specified privileges suspended, revoked, or not renewed in the same manner as a medical staff member, as well as in accordance with the terms of any written contract the Advanced Practice Professional may have with the Hospital. If (a) the designated supervising member ceases to be a member or (b) the supervising arrangement (e.g. collaboration agreement or employment) between the Advanced Practice Professional and the designated supervising member terminates, then the

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Advanced Practice Professionals specified privileges shall terminate automatically, without hearing or appeal, unless an alternate supervising physician is assigned. If the designated supervising member's privileges are voluntarily or involuntarily reduced, there shall be an automatic corresponding reduction in the Advanced Practice Professional's specified privileges, without hearing or appeal. If the practitioner is a hospital employee, the hospital's existing fair treatment policy will be applied.

Section 6. Categories of the Medical Staff

6.1 Appointment to a Category

1. Initial appointments to the Medical Staff shall be to the Affiliate category. For advancement to Active staff, a candidate must have adequate performance, have passed their initial focused professional practice evaluation (FPPE) and meet all qualifications for Active status. A practitioner may submit a formal request to advance to the Active category to the Medical Staff Services Department.

6.2 The Active Category

6.2.1 Qualifications

1. Members of this category must be involved in twenty-four (24) patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure or referral for inpatient services) to the hospital except as expressly waived for practitioners who document their efforts to support the hospital's patient care mission to the satisfaction of the MEC and the Board.
2. In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

6.2.2. Prerogatives

1. Members of this category may:
    a. Attend medical staff/Service Line/section meetings of which s/he is a member and any medical staff or hospital education programs;
    b. Vote on all matters presented by the medical staff,/Service Line/section, and committee(s) to which the member is assigned; and
    c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

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6.2.3 Responsibilities

1. Members of this category shall:
    a. Contribute to the organizational and administrative affairs of the medical staff;
    b. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and
    c. Fulfill or comply with any applicable medical staff or hospital policies or procedures.

6.3 The Affiliate Category

6.3.1 Qualifications

1. The affiliate category is reserved for medical staff members who do not meet the eligibility requirements for the active category or choose not to pursue active status.

6.3.2 Prerogatives

1. Members of this category may:
    a. Attend medical staff/Service Line/section meetings of which s/he is a member and any medical staff or hospital education programs;
    b. Not vote on matters before the entire medical staff or be an officer of the medical staff; and
    c. Serve on medical staff committees, other than the MEC, and may vote on matters that come before such committees.

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6.3.3 Responsibilities

1. Members of this category shall:
    a. Have the same responsibilities as active category members.

6.4 Telemedicine Category

6.4.1 Qualifications

1. The telemedicine category is reserved for medical staff members providing only remote / distant site telemedicine services at Henry Ford Macomb Hospital.

6.4.2 Prerogatives

1. Members of this category may:
    a. Attend medical staff/Service Line/section meetings of which s/he is a member and any medical staff or hospital education programs;

Not vote on matters before the entire medical staff or be an officer of the medical staff; and

b. Not serve on medical staff committees and may not vote on matters that come before such committees.

6.4.3 Responsibilities

1. Members of this category shall:

    a. Pay medical staff dues as assessed by the Medical Executive Committee.

6.5 Honorary Category

1. The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members or advanced practice providers who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff/Service Line/section meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

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Section 7. Officers of the Medical Staff and MEC at-large members

7.1 Officers of the Medical Staff and MEC at-large members

1. **Chief of Staff**
2. **Vice Chief of Staff**
3. **Immediate Past Chief of Staff**

7.2 Qualifications of Officers and MEC at-large members

1. Officers and MEC at-large members must be members in good standing of the active category and be actively involved in patient care in the hospital, have previously served in a significant leadership position on a medical staff (e.g. Service Line or section chair, committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, support cooperation and collaboration within the medical staff and between the medical staff, senior management and the Board, and have excellent administrative and communication skills.

2. Officers and MEC at-large members may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

7.3 Election of Officers and MEC at-large members

1. The MEC will appoint a Leadership Selection and Development Committee four (4) months in advance of the general medical staff election. The Leadership and Development Committee shall give preference to existing medical staff officers and leaders who are willing to serve when developing a slate for MEC endorsement and the consideration and vote by the general medical staff. The Leadership Selection and Development Committee shall also consider the following criteria when recommending an individual to be included on a slate for MEC endorsement and the consideration and vote by the general medical staff:
    a. The qualifications listed in 7.2.1 and 7.2.2 of these Bylaws for the position to which they wish to be elected. The Leadership Selection and Development Committee will have discretion to determine if these criteria have been met.
    b. The nominee's practice location, clinical specialty and leadership skills and talent needed by the medical staff.
2. The Leadership Selection and Development Committee is made up of the Immediate Past Chief of Staff, who shall serve as the chairperson. The MEC shall appoint five (5) other active members who will serve as voting members. The Leadership and Development Committee will reach unanimous approval of the slate put forward for MEC endorsement and consideration and vote by the general medical staff.
3. The Leadership and Development committee shall offer at least one nominee for each available 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) calendar days prior to the election.
4. A petition signed by at least ten percent (10%) of the members of the active staff may add nominations to the ballot. The medical staff must submit such a petition to the Chief of Staff at least thirty (30) calendar days prior to the election for the nominee(s) to be placed on the ballot. The Leadership and Development committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.
5. Officers and MEC at-large members shall be elected at least one month prior to the expiration of the term of the current officers. Only members of the active category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes will be elected. In the

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event of a tie vote, the medical staff support professional will make arrangements for a repeat vote(s) until one candidate receives a greater number of votes.

7.4 Term of Office

1. All officers and MEC at-large members serve a term of two (2) years. They shall take office in the month of January of even years. Officers may serve no more than 2 consecutive terms.

7.5 Vacancies of Office

1. The MEC shall fill vacancies of office during the medical staff year. If the Chief of Staff is temporarily unable to fulfill the responsibilities of the office, the Vice Chief of Staff shall assume these responsibilities until the Chief of Staff can resume those duties. When a permanent vacancy occurs in the Chief of Staff, the Leadership Selection and Development Committee shall recommend to the MEC the options for permanent replacement for the MECs consideration and decision. If the Immediate Past Chief of Staff resigns or is not eligible to hold this position, the MEC shall appoint another former Chief of Staff to fulfill the remainder of the term, until the current Chief of Staff becomes available to carry out the role.

7.6 Duties of Officers and MEC at-large members

7.6.1 Chief of Staff:

1. The Chief of Staff shall represent the interests of the medical staff to the MEC and the Board. The Chief of Staff will also collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, and coordinate communication within the medical staff. The Chief of Staff will fulfill the duties specified in Part IV of these bylaws (Organization and Functions Manual).

7.6.2 Vice Chief of Staff:

1. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The Vice Chief shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time. The Vice Chief shall act as medical staff treasurer and serve as chair of a bylaws committee when convened. If a Chief of Staff is elected to serve another term, the Leadership Selection and Development Committee will produce a slate of nominees for the Vice Chief of Staff for MEC endorsement and consideration and vote by the general staff.

7.6.3 Immediate Past Chief of Staff:

1. This officer will serve as a consultant to the Chief of Staff and Vice Chief of Staff and provide feedback to the officers regarding their performance of assigned duties on an annual basis. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time. If a Chief of Staff is elected to serve another term, the MEC may invite the existing Immediate Past Chief of Staff to extend their term, or may appoint another former Chief of Staff to fulfill the remainder of the term until the current Chief of Staff

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becomes available to carry out the role.

7.6.4 MEC at-large members:

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

7.7 Removal and Resignation from Office

1. The medical staff may remove any officer or MEC at-large members if at least twenty percent (20%) sign a petition advocating for such action. The petition must be followed by an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes.
2. Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in his/her duties after consulting with the Joint Conference Committee.

7.8 Resignation

1. Any elected officer or MEC at-large members may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

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Section 8. Medical Staff Organization

8.1 Organization of the Medical Staff

1. The medical staff shall be organized as a non-departmentalized staff. The MEC may recognize any group of practitioners who wish to organize themselves into a Service Line. Any Service Line, if organized, shall not be required to hold regularly scheduled meetings, keep routine minutes, or require attendance. A written report is required only when the Service Line is making a formal recommendation to the MEC. The Chief of Staff and the Service Line Chair will decide if the report is placed on the MEC agenda and whether the Service Line Chair (or designee) will attend the MEC meeting to present the report and participate in the vote of the MEC on that specific issue. A Service Line shall identify a Service Line Chair. Service Lines shall be regional. Service Lines are optional and shall exist to perform any of the following activities:
    a. Continuing education and discussion of patient care and input into peer review/quality improvement;
    b. Grand rounds;
    c. Discussion of policies and procedures;

d. Discussion of equipment needs;

e. Development of recommendations for the MEC; and

f. Participation in the development of criteria for clinical privileges when requested by the credentials committee or MEC; or

g. Discussion of a specific issue at the request of a medical staff committee or the MEC.

1. There will also be three (3) divisions (Ambulatory Medicine, Inpatient Medicine, and Surgery) which will interface with the Service Lines. Service Lines functions will be primarily clinically related; Division functions will be primarily operationally related. Roles and responsibilities defined in Part IV, Organizational and Functions Manual. Approval by the Medical Executive Committee is required to modify, add or remove any Divisions on a case-by-case basis.

8.2 Qualifications, Selection, Term, and Removal of Service Line Chair

1. Each Service Line Chair shall serve a term of two (2) years commencing on January 1 of even years and may be elected to serve successive terms. All Service Line Chairs must be members of the active medical staff and have relevant clinical privileges.
2. Service Line Chairs shall be elected by majority vote of the active members of the Service Line, subject to ratification by the MEC. Each Service Line shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC. The Service Line Chair is responsible for communicating with all members within the Service Line at various practice locations.
3. Service Line Chairs may be removed from office by the MEC if two-thirds (2/3) of the voting members of the Service Line recommend such action, or, in the absence of such recommendation, the MEC may remove a Service Line Chair on its own by a two thirds vote if any of the following occurs:
    a. The Service Line Chair suffers an involuntary loss or significant limitation of practice privileges;
    b. The MEC determines that the Service Line Chair has failed to demonstrate to the satisfaction of the MEC and the Board that he or she is effectively carrying out the responsibilities of the position.
    c. Service Line Chairs shall carry out the responsibilities assigned in Part IV of these bylaws the (Organization and Function Manual).
4. Service Line Chairs will be removed from office automatically if the following occurs:
    a. The Service Line Chair ceases to be a member in good standing of the medical staff.

8.3 Assignment to Service Line

1. The MEC will, after consideration of the recommendations of the Service Line Chair, as appropriate, recommend Service Line assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Service Line. Clinical privileges

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are independent of Service Line assignment.

8.4 Appointment of Division Chief

1. Division Chief is a medico-administrative position with the primary responsibility of assisting Service Line Chairs, Chief of Staff, Vice Chief of Staff, Chief Medical Officer and other medical staff leaders with performing credentialing/privileging, peer review, governance and communication functions of the medical staff. The Division Chief is appointed by the CEO and is accountable to the CEO or designee. The MEC will collaborate with the CEO in developing the position description and the performance standards by which the Division Chief will be evaluated. The MEC will have direct involvement with the CEO regarding the selection and the performance evaluation of the Division Chief.

Section 9. Committees

9.1 Designation and Substitution

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

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9.2 MEC

1. **Committee Membership:**
    a. **Composition:**
        1. The MEC shall be a standing committee consisting of the following voting members: the officers of the medical staff, the chair of the credentials committee and the chair of the medical staff quality committee, and six (6) at-large members of the medical staff and one (1) at-large APP member. The chair will be the Chief of Staff. Non-voting attendees will include the CEO, CMO, COO, CNO, the administrative lead for the Medical Staff Services Department and the three (3) Division Chiefs.
2. **Removal from MEC:**
    a. An officer, MEC At-Large Member, who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC. When the chair of either the credentials or medical staff quality committees resigns or is removed from these positions, his/her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. When an at-large member of the MEC resigns or is removed, the Leadership Selection and Development Committee will arrange for an election for a replacement of the at-large member to serve out the

remainder of the vacated term. Such an election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

3. **Duties:**

    a. **The duties of the MEC, as delegated by the medical staff, shall be to:**

        1. Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions;
        2. Coordinate the implementation of policies adopted by the Board;
        3. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Service Line assignments, clinical privileges, and corrective action;
        4. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
        5. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted;
        6. Make recommendations to the Board on medical administrative and hospital management matters;
        7. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
        8. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
        9. Review and act on reports from medical staff committees, Service Lines, and other assigned activity groups;
        10. Formulate and recommend to the Board medical staff rules, policies, and procedures;
        11. Request evaluations of practitioners privileged through the medical staff process when there is question about an applicant or member's ability to perform privileges requested or currently granted;
        12. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
        13. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;
        14. Oversee that portion of the corporate compliance plan that pertains to the medical staff;
        15. Hold medical staff leaders, committees, and Service Lines accountable for fulfilling their duties and responsibilities;

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16. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws; and

4. The MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.
5. Meetings: The MEC shall meet at least 10 times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 10. Medical Staff Meetings

1. **Medical Staff Meetings**
    a. An annual meeting and other general meetings, if any, of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.
    b. Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.
2. **Special Meetings of the Medical Staff**
    a. The Chief of Staff may call a special meeting of the medical staff at any time. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.
    b. Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.
3. **Regular Meetings of Medical Staff Committees and Service Lines**
    a. Committees and Service Lines may, by resolution, provide the time for holding regular meetings without notice other than such resolution.
4. **Special Meetings of Committees and Service Lines**
    a. A special meeting of any committee or Service Line may be called by the chair or Service Line Chair thereof or by the Chief of Staff.
5. **Quorum and Voting**
    a. Medical Staff Meetings: Those present and eligible medical staff members voting on an issue.
    b. MEC, Credentials Committee, and Medical Staff Quality Committee: A quorum will exist when 50% of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will

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consist of at least three members.

c. Service Line meetings or medical staff committees other than those listed in 7.4.2 above: Those present and eligible medical staff members voting on an issue.

d. Except as provided otherwise in these bylaws, whenever a quorum of the MEC, the Credentials Committee, the Medical Staff Quality Committee, Service line meetings or other medical staff committees is present, the vote of the majority of those present and voting shall be the act of the body to whom the matter is submitted to a vote.

6. **Attendance Requirements**

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

      1. MEC, Credentials Committee, and Medical Staff Quality Committee meetings: Members of these committees are expected to attend at least seventy-five percent (75%) of the meetings held. Attendance will be monitored every six (6) months and individuals will be notified if they are in jeopardy of losing their committee positions unless greater attendance occurs.

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

7. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

8. **Participation by the CEO**

   a. The CEO or his/her designee may attend any general, committee or Service Line meetings of the medical staff as an ex-officio member without vote.

9. **Robert's Rules of Order**

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

10. **Notice of Meetings**

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a. Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Service Line or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

11. **Action of Committee or Service Line**
    a. The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Service Line. Such recommendation will then be forwarded to the MEC for action.

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

13. **Minutes**
    a. Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Minutes of Service Lines shall be done only when there are formal recommendations from the Service Line to the Medical Executive Committee (MEC). The presiding chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained in accordance with HFHS Record Retention Policy.

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Section 11. Conflict Resolution

1. In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a joint conference committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.
2. The chair of the Board or the Chief of Staff may call for a joint conference as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.
3. In the event the Medical Executive Committee acts in a manner that is questioned by the medical staff, the medical staff has the ability to call for a meeting of the medical staff pursuant to sections 2.7.3 and 2.7.4.

Section 12. Review, Revision, Adoption, and Amendment

1. **Medical Staff Responsibility**

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

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

2. **Methods of Adoption and Amendment to these Bylaws**

    a. All proposed amendments to these bylaws, whether originated by the MEC, another standing committee, a member of the active category of the staff, or the Board must be reviewed and discussed by the MEC prior to a MEC vote.

    b. When proposed by the MEC or the Board, there will be communication of the proposed amendment to the organized medical staff before a vote is taken by the MEC. When proposed by the organized medical staff, there will be communication of the proposed amendment to the MEC before a vote is taken by the organized medical staff.

    c. The MEC shall vote on proposed amendments at a regular meeting, or at a special MEC meeting called for such purpose. Following a vote by the MEC, each active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. To be rejected, the resolution must receive a return ballot marked "no" by more than thirty-three percent (33%) of those members eligible to vote.

    d. Amendments so adopted shall be effective when approved by the Board.

    e. Any active member may also submit amendments or request repeal of the Bylaws Volumes I, II, III and medical staff policies and procedures directly to the Board. The member must first obtain a petition signed by twenty five percent (25%) of the active medical staff members supporting their position and communicate their intent to the MEC. Proposed amendments submitted by the medical staff member will be forwarded to the Board with the MEC's recommendation if different from that of the medical staff member.a vote is taken by the MEC. When proposed by the organized

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medical staff, there will be communication of the proposed amendment to the MEC before a vote is taken by the organized medical staff.

3. **Methods of Adoption and Amendment to the medical staff rules, regulations and policies.**

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

    b. All proposed amendments to the Rules, Regulations and Policy Manual, whether originated by the MEC, another standing committee, or by a member of the active category of the staff, must be reviewed and discussed by the MEC prior to a MEC vote.

    c. Amendments to the medical staff policies and procedures, rules and regulations and Volume III, Credentials Procedures of these Bylaws shall be effective when approved by a two thirds (2/3) vote of the MEC and is approved by the Board. The MEC shall distribute a copy of the proposed amendments to the active staff within seven (7) days after the MEC vote. Voting members of the active staff may then submit, within twenty-one (21) days after the MEC meeting, comments to the Chief of Staff concerning the MEC's proposed amendments. The Chief of Staff will consider any comments that are received from medical staff members and either:

        1. send the proposed amendments back to the MEC for reconsideration; or
        2. forward the proposed amendments, with comment, to the Board for review and action.

    d. The organized medical staff may challenge any rule or policy as established by the MEC or present a change in policy to the MEC as described in section 2.7.

    e. The MEC and Board may adopt such provisional amendments to these rules and regulations that are in the MEC's and Board's judgments necessary for legal or regulatory compliance. After adoption, these provisional amendments to the rules and regulations will be communicated to the organized medical staff for their review.

        1. If the organized medical staff approves of the provisional amendment, the amendment will stand.
        2. If the organized medical staff does not approve of the provisional amendment, this will be resolved using the conflict resolution mechanism noted in Section 2.7.4. If a substitute amendment is then proposed, it will follow the usual approval process.

    f. The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering,

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punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.

g. Medical staff bylaws and rules and regulations adopted by the medical staff and approved by the Board shall apply to the Hospital's successors and assigns. The procedures specified in these bylaws for the adoption and amendment of medical staff bylaws and rules and regulations shall apply to the adoption of new, superseding bylaws and/or rules as well as to the termination of these bylaws and/or the rules and regulations.

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Henry Ford Macomb Hospitals

Medical Staff Bylaws

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

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

1.1 Criteria for Initiation

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

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

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

Section 2. Investigations

2.1 Initiation

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

2.2 Investigation

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

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

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

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

2.3 MEC Action

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

a. Determining no corrective action is warranted, and if the MEC determines there was

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not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

b. Deferring action for a reasonable time when circumstances warrant;

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee, Service Line, or section chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;

d. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

g. Recommending suspension, revocation, or probation of medical staff membership; or

h. Taking other actions deemed appropriate under the circumstances.

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2.4 Subsequent Action

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

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

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

1. **Licensure**

a. **Revocation and suspension**: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. **Restriction**: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation**: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

2. **Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs**: Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other government programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3. **Controlled substances**

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

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

4. **Medical record completion requirements:** A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

5. **Professional liability insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment the practitioner does not provide evidence of required professional liability

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insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

6. **Medical Staff dues/special assessments:** Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.
7. **Felony/misdemeanor conviction:** A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of immoral action in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.
8. **Failure to satisfy the special appearance requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.
9. **Failure to participate in an evaluation:** A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.
10. **Failure to become board certified or failure to maintain board certification:** A practitioner who fails to become board certified or maintain board certification in compliance with these bylaws or medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges unless an exception is granted by the Board upon recommendation from the MEC.
11. **Failure to Execute Release and/or Provide Documents:** A practitioner who fails to execute a general or specific release and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

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

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3.2 Precautionary Restriction or Suspension

1. **Criteria for Initiation:** A precautionary restriction or suspension of clinical privileges and/or medical staff membership may be imposed when it is determined by the individuals authorized in this Section that immediate action needs to be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution. Under such circumstances any two (2) of the following CEO or designee, Chief of Staff or designee, CMO, Division Chief, Service Line Chair or the MEC may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

2. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.
   Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

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

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

Section 4. Initiation and Notice of Hearing

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4.1 Initiation of Hearing

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

a. Denial of medical staff appointment or reappointment;

b. Revocation of medical staff appointment;

c. Denial or restriction of requested clinical privileges;

d. Involuntary reduction or revocation of clinical privileges;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

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4.2 Hearings Will Not Be Triggered by the Following Actions

a. Issuance of a letter of guidance, warning, or reprimand;

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;

c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;

d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

e. Requirement to appear for a special meeting under the provisions of these bylaws;

f. Automatic relinquishment or voluntary resignation of appointment or privileges;

g. Imposition of a precautionary suspension or administrative suspension that does not exceed 14 calendar days;

h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination that an application is incomplete or untimely;

j. Determination that an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination that an applicant for membership does not meet the requisite qualifications/ criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by hospital;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed for focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned staff category;

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

z. Grant of conditional appointment or appointment for a limited duration; or

aa. Appointment or reappointment for duration of less than 36 months.

4.3 Notice of Recommendation

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

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receipt requested. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);

b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

d. The individual shall receive a copy of Sections 4.4 to 6.6 of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

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

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4.5 Notice of Hearing and Statement of Reasons

The CEO shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

a. The time, place and date of the hearing;

b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence in support of the MEC, (or the Board), at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days or later than ninety (90) days after the notice of the hearing unless specifically agreed to otherwise in writing by both parties.

4.6 Witness List

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

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

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

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5.2 Hearing Panel Chairperson or Presiding Officer

1. In lieu of a hearing panel chair, the CEO, acting for the Board and after considering the recommendations of the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous history with either the hospital or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.
2. If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO to serve as the presiding officer and shall be entitled to one vote.
3. The presiding officer (or hearing panel chair) shall do the following:
    a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
    b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;
    c. Maintain decorum throughout the hearing;
    d. Determine the order of procedure throughout the hearing;
    e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
    f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;
    g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and
    h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

As an alternative to the hearing panel described in Section 5.1 of this manual, the CEO, acting for the Board and in conjunction with the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-

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clinical matters.

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

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

1. There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:
    a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;
    b. Reports of experts relied upon by the MEC;
    c. Copies of redacted relevant committee minutes;
    d. Copies of any other documents relied upon by the MEC or the Board;
    e. No information regarding other practitioners shall be requested, provided or considered; and
    f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
2. Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
3. There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be

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allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

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

6.4 Record of Hearing

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

6.5 Rights of the Practitioner and the Hospital

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1. At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:
    a. To call and examine witnesses to the extent available;
    b. To introduce exhibits;
    c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
    d. To have representation by counsel who may be present at the hearing, the role of counsel determined at the pre-hearing conference. It will be either to:
        1. Advise his or her client;
        2. Participate in resolving procedural matters; or to
        3. Argue the case for his/her client.
    e. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing; and
    f. To submit a written statement at the close of the hearing.
2. Any individuals requesting a hearing who do not testify in their own behalf may be called and examined as if under cross-examination.
3. The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC (or Board of Trustees) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital policies.

6.8 Post-Hearing Memoranda

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

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

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

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CEO.

6.12 Order of Presentation

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

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6.13 Basis of Recommendation

The hearing panel shall recommend in favor of whichever side demonstrates the preponderance of evidence.

6.14 Adjournment and Conclusion

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

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

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

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Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

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

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place and Notice

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

7.4 Nature of Appellate Review

a. The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, a record of this procedure, similar to that done for the hearing panel, will be made.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

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

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the credentials committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing

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or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current member, that individual may not apply within two (2) years for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

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Henry Ford Macomb Hospitals
Medical Staff Bylaws
Part III: Credentials Procedures Manual

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Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the medical staff credentials committee shall consist of at least seven (7) members of the active medical staff (may include Division Chief's), who are experienced leaders and one (1) advanced practice professional staff member. The Chief of Staff will obtain input from the credentials committee regarding their preference for chair and the MEC should endorse the Chief of Staff's appointment of the chair, vice chair and other members. The prerequisite for appointment as chair is having served on the committee for at least two (2) years. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite members such as representatives from hospital administration and the Board. The Chief Medical Officer will be an ex-officio member of the committee. The Chief Nursing Officer will be a standing member of the committee and shall have a vote on credentials when applications for Advanced Practice Professionals are considered.

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1.2 Meetings

The medical staff credentials committee shall meet on call of the chair or Chief of Staff.

1.3 Responsibilities

1. To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category;
2. To review and recommend action on all requests regarding privileges from eligible practitioners;
3. To recommend eligibility criteria for the granting of medical staff membership and privileges;
4. To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;
5. To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders;
6. To review and recommend action to enhance practitioner performance where peer review processes and/or clinical outcome data indicate a need for improvement in the clinical quality of care or conduct.
7. To perform such other functions as requested by the MEC.

1.4 Confidentiality

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

1. The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.
2. Individual practitioners may review their credentials file under the following circumstances:
    - Only upon written request approved by the Chief of Staff, CEO, credentials chair or CMO
    - Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration
    - Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner
    - Nothing may be removed from or copied from the file
    - The practitioner may make notes for inclusion in the file
    - A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

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Section 2. Qualifications for Membership and/or Privileges

2.1 Membership

No practitioner shall be entitled to membership on the medical staff, advanced practice provider staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 Medical Staff

The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges:

1. Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;
2. Have a current unrestricted state license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Michigan;
3. Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;
4. Have a record that is free of felony convictions within the last three (3) years;
5. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within (5) five years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association;
6. Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;
7. Oromaxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;
8. A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;
9. Possess a current, valid, unrestricted drug enforcement administration (DEA) number if applicable;
10. Have appropriate written and verbal communication skills;
11. Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:
    a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
    b. A history of consistently acting in a professional, appropriate and collegial manner with others.

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2.3 Advanced Practice Provider

1. The following qualifications must be met by all applicants for advanced practice provider appointment, reappointment or clinical privileges (in addition to Sections 2.2.2-2.2.4 and 2.2.10-2.2.12 above):

    a. Nurse practitioners must demonstrate that s/he successfully graduated from an accredited Masters' degree program or higher in an advanced practice nursing specialty.

    b. Physician Assistants must demonstrate that s/he successfully completed Accreditation Review Commission on Education for Physician Assistants (ARC-PA) approved program (prior to January 2001, Commission on Accreditation of Allied Health programs).

    c. Certified Registered Nurse Anesthetists must demonstrate that s/he successfully completed an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency.

    d. Clinical Nurse Specialists must demonstrate that s/he successfully completed a master's, post-masters, or doctorate degree from an accredited CNS program.

    e. Advanced practice providers must have current certification, applicable to his/her profession. Required certifications in delineations of privileges, medical staff policies and hospital (system) policies (if applicable) must be maintained and additional certifications may be required. Advanced practice providers are expected to recertify. Any medical staff policies that address extension of membership for failure to recertify or Section 2.6, Part III, CPM, Exceptions, do not apply.

    f. A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA).

2.4 Allied Health Professional

1. The following qualifications must also be met by all allied health professional providers requesting clinical privileges for appointment, reappointment or clinical privileges (in addition to Sections 2.2.2-2.2.4 and 2.2.10-2.2.12 above):

    a. Must possess a license to practice their profession in Michigan and shall apply to and meet criteria for specific delineation of privileges on a form prescribed by the MEC and approved by the board.

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

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

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

e. Demonstrate recent clinical performance within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

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

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

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2.5 Board Recertification

Members are expected to recertify their specialty board certification. The Medical Executive Committee may develop a medical staff policy to address extenuating circumstances related to failure to recertify. Failure of a member to recertify in accordance with the medical staff board recertification policy will result in automatic termination of membership and privileges without right to hearing or appeal.

2.6 Exceptions

A. All practitioners who were continuous staff members for at least five (5) years as of January 1, 2006 and at that time were not board certified, shall be exempt from 2.2.5 – 2.2.9.

B. Only the governing board may create additional exceptions to the above Section 2.2 after recommendation from the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

1. All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the medical staff office. Upon receipt of the request, the medical staff office will notify the centralized verification organization (CVO) to provide the applicant an application package or electronic application portal, which will include a complete

set or overview of the medical staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership or privileges (if such expectations have been adopted by the medical staff).

2. A completed application includes, at a minimum:
    a. A completed, signed, dated application form;
    b. A completed privilege delineation form if requesting privileges;
    c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
    d. All applicable fees;
    e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card or complete practitioner identification form.
    f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;
    g. Relevant practitioner-specific data as compared to aggregate data, when available;
    h. Morbidity and mortality data, when requested and available;
    i. Intended practice plan questionnaire if required by the board-approved medical staff development plan; and
    j. Acceptance and agreement to follow the bylaws and the medical staff expectations.
3. An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action tak
4. The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the credentials verification organization (CVO) and the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. The letter will inform the practitioner of their right to: Review information only as submitted by the

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applicant to support their current credentialing application, correct erroneous information; provide an explanation for reason erroneous information was supplied, receive the status of their credentialing or recredentialing application, upon request and receive notification of these rights. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

5. Upon receipt of a completed application the CEO, CMO, or credentials chair or their designees, in collaboration with the medical staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.
6. Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
7. Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:
    a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past five (5) years;
    b. Documentation of the applicant's recent past clinical work experience;
    c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
    d. Information from the AMA or AOA Physician Profile, Federation of State Medical Board, OIG list of Excluded Individuals/Entities, FACIS (Fraud and Abuse Control Information System) and information from other applicable databases as defined in centralized verification organization policies;
    e. Information from professional training programs including residency and fellowship programs;
    f. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

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g. Other information about adverse credentialing and privileging decisions;

h. Three directed (3) peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;

i. Information from a criminal background check from the past ten (10) years;

j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;

k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and

l. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

8. Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar days will be deemed a withdrawal of the application.
9. When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

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3.2 Applicant's Attestation, Authorization and Acknowledgement

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

1. Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any substantiative inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.
2. Consents to appear for any requested interviews in regard to his/her application.
3. Authorizes the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.
4. Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

5. Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

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

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

8. Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

9. Agrees to provide accurate answers to all relevant questions including the following, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any of the questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved. The Medical Executive Committee shall have the authority to request modification of these

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questions on the application form.

1. Have any adverse actions been initiated or are any pending against you by any of the following?
    a. Any state licensing board?
    b. Any state pharmacy board or the federal DEA?
    c. Any hospital?
    d. Any health care facility?
    e. Any managed care plan or organization e.g. HMO, PPO, PHO, ACO, IPA or similar organization?
    f. Any clinical educational/training program e.g. preceptorship, internship, residency or fellowship?
    g. Any certifying board?
    h. Any state or federal program e.g. Medicare or Medicaid?
    i. Any regulatory agency e.g. CLIA or OSHA?
    j. Any other private, federal, or state health program? Entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?
    k. Any military agency or branch?
    l. Any local, state or national professional association or society?
    m. Have you ever been encouraged or required to be proctored or monitored, or to obtain additional education or training as a result of peer review or quality improvement activities?
    n. Have you been under a Focused Professional Practice Evaluation (FPPE) for reasons other than new applicant or new privilege?
    o. Has information pertaining to you ever been reported to the National Practitioner Databank?
    p. Within the last five (5) years, have you been named in or been the subject of a malpractice claim?
    q. Has a professional liability insurance carrier limited the scope of your coverage, excluded specific procedures, denied coverage, imposed a surcharge or rated you in a higher risk status?
    r. Have you been charged with or indicted for a felony?
    s. Have you been convicted of or pled guilty or no contest to any felony, misdemeanor, or any criminal offense or violation (excluding minor traffic

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violations, but including any substance related offense, e.g. driving while intoxicated or under the influence) regardless of the sentence you received, whether you were given probation, received a deferred adjudication or a pardon or the conviction was sealed?

t. Have you been or are you currently involved in any civil action that is reasonable related to your qualifications, competence, functions or duties as a medical professional or your moral character, including but not limited to alleged fraud, an act of violence, child abuse or sexual misconduct?

u. Do you use any illegal substances?

v. Do you use any legal chemical substances that would in any way impair your ability to practice medicine and/or perform the functions of your job?

w. Are you unable to perform the essential functions of the position for which you are applying, with or without reasonable accommodation?

x. Have you been diagnosed with and/or received treatment for a physical, mental, chemical dependency or emotional condition which could impair your ability to practice medicine?

y. Have you ever been subject to a performance improvement plan, monitoring or rehabilitation agreement for issues associated with alcohol, drug dependence, emotional illness, disruptive behavior or unprofessional conduct?

z. Have you ever been terminated from employment or from a group practice?

aa. If you are currently not board certified please answer the following questions below:

    i. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

    ii. If not certified, have you applied for the certification exam?

    iii. Have you ever been accepted to take the certification exam?

    iv. If yes, what dates are you scheduled to take the certification exam?

ab. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

ac. Has your employment, medical staff membership, or clinical privileges ever been reduced, suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or

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involuntarily?

ad. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's Board made a decision?

ae. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

af. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?

ag. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?

3.3 Application Evaluation

1. **Expedited Credentialing:** An expedited review and approval process may be used for initial appointment and reappointment applications designated as Category 1. Initial appointment and reappointment applications designated as Category 2 may required additional review. All initial applications and reapplications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

    a. **Category 1**: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted medical staff membership and/or privileges after review and action by the following: Service Line Chair, the Division Chief or Designated Physician Leader (DPL) as determined by the Credentials Committee, CMO, credentials chair acting on behalf of the credentials committee, the MEC and the Executive Committee of the Board.

    b. **Category 2**: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Service Line Chair, Division Chief, credentials committee, MEC, and the Board. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

        i. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

        ii. Applicant is, or has been, under investigation by a state medical board or

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has prior disciplinary actions or legal sanctions;

iii. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of $500,000;

iv. Applicant changed medical schools or residency programs or has gaps in training or practice;

v. Applicant has changed practice affiliations more than three times in the past ten (10) years;

vi. Applicant has practiced or been licensed in three (3) or more states post residency/fellowship, unless multiple practices and state licenses are required by specialty (telemedicine);

vii. Applicant has any reference responses that raise concerns or questions;

viii. Discrepancy is found between information received from the applicant and references or verified information;

ix. Applicant has an adverse National Practitioner Data Bank report;

x. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

xi. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

xii. Applicant has potentially relevant physical, mental and/or emotional health problems;

xiii. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

2. **Applicant Interview**

a. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Service Line Chair, the Division Chief, credentials committee, MEC or Board. Applications designated at Category 2 will be subject to interview. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be

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used to communicate medical staff performance expectations.

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

3. **Service Line Chair /Division Chief Action**

    a. All completed applications are presented to the Service Line Chair, the Division Chief or designated physician leader (DPL) for review, and input. The Service Line Chair, Division Chief or DPL reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Service Line Chair, Division Chief or DPL, in consultation with the medical staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Service Line Chair, Division Chief or DPL may obtain input if necessary from an appropriate subject matter expert. If a Service Line Chair, Division Chief or DPL believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.

    b. The Service Line Chair, Division Chief or (DPL) forwards to the medical staff credentials committee the following:

        i. Input as to whether the application should be acted on as Category 1 or Category 2;

        ii. Input whether to approve the applicant's request to membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

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

        iv. Comments supporting the information in 3.3 above.

4. **Medical Staff Credentials Committee Action**

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

    1. A recommendation as to whether the application should be acted on as Category 1

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or Category 2;

2. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
3. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
4. Comments supporting recommendations 3.3.4 above.

6. **MEC Action**

    1. If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. The Chief of Staff has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:
        a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
        b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
        c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
        d. Comments supporting the recommendations in 3.3 above.

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

8. **Board Action:**

    1. If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed thirty-six (36) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

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

    a. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed thirty-six (36) months;

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

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

3. All adverse recommendations are reviewed at the time of governing board action, for potential conflict with nondiscrimination clause as stated in Section 2.3, Governance.

9. **Interval Appointment**

    1. An applicant whose credentials have been approved by the Service Line Chair/ Medical Director, Division Chief, Chief of Staff, Chief Medical Officer and the Credentials Committee and who is available to begin practice at the hospital prior to approval by the board shall be granted an interval appointment with clinical privileges. Interval appointments may not exceed one hundred twenty days (120). Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 3 of this manual.

    2. The granting of interval appointment with clinical privileges does not guarantee approval by the board with regard to appointment, and if such approvals are not obtained, said applicant's interval appointment, privileges, and employment, if applicable, shall automatically terminate immediately. Moreover, should an applicant accept interval clinical privileges, the performance of those privileges will be subject to the supervision of the Service Line Chair/Medical Director or Division Chief until the applicant is formally appointed by the board, his/her application is denied, or the interval privileges are terminated.

    3. For all purposes, including the procedural rights set forth in Part II of these medical staff bylaws, an individual with interval appointment shall be considered in all respects, an applicant. An applicant is not entitled to the procedural rights set forth in Part II of these medical staff bylaws because (a) a request for interval appointment is refused, (b) the granting of interval appointment is made subject to

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conditions (such as proctoring), or (c) all or any portion of the interval privileges are terminated or suspended.

10. **Notice of final decision:** Notice of the Board's final decision shall be given, through the CEO to the MEC and to the chair of each Service Line concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Division to which s/he is assigned, the clinical privileges s/he may exercise, the time frame of the appointment, and any special conditions attached to the appointment.
11. **Time periods for processing:** All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days and a letter is to be issued within 7 days of Governing Board rendering a final decision.
12. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Professional Practice Evaluation

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

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

Section 5. Reappointment

1. **Criteria for Reappointment**

a. It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed thirty-six (36) months. The granting of new clinical privileges to existing medical staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute in the evaluation of current competency of the Service Line Chair or Division Chief, with input from a qualified expert, and recommend appropriate action to the credentials committee.

2. **Information Collection and Verification**

a. From appointee: On or before four (4) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office or centralized verification organization (CVO) notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the CVO or medical staff office:

i. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;

ii. Information concerning continuing training and education internal and external to the hospital during the preceding period; and

iii. By signing the reapplication form the appointee agrees to the same terms as identified in Section 2 and 3 above.

iv. From internal and/or external sources: The medical staff office collects and verifies information regarding each staff appointee's professional and collegial activities to include those items listed in Section 3.

b. The following information is also collected and verified:

i. A summary of clinical activity at this hospital for each appointee due for reappointment;

ii. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

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iii. Documentation of any required hours of continuing medical education activity;

iv. Service on medical staff, Service Line, and hospital committees;

v. Timely and accurate completion of medical records;

vi. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;

vii. Any significant gaps in employment or practice since the previous appointment or reappointment;

viii. Verification of current licensure;

ix. National Practitioner Data Bank query;

x. When sufficient peer review data is not available to evaluate competency, two (2) or more peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges; and

xi. Malpractice history for the past two (2) years, which is primary source verified by the medical staff office with the practitioner's malpractice carrier(s).

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c. Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the staff appointee of any additional information that may be needed to resolve any doubts about performance or material in the credentials file. Privileges are lapsed and application may remain open for an additional 60 days prior to termination of medical staff membership and privileges.

3. **Evaluation of Application for Reappointment of Membership and/or Privileges**

1. Expedited review reappointment applications will be categorized as described in Section 3 above.

2. The reappointment application will be reviewed and acted upon as described in Sections 3 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which

would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment". All adverse recommendations are reviewed at the time of governing board action, for potential conflict with nondiscrimination clause as stated in Section 2.3, Governance.

Section 6. Clinical Privileges

6.1 Exercise of privileges

1. A practitioner providing Service Lines at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advanced Practice Professionals, telemedicine physicians, or allied health professionals, or others deemed appropriate by the MEC and Board.

6.2 Requests

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

6.3 Basis for Privileges Determination

1. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.
2. Privileges for which no criteria have been established:
3. In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:
    a. Review the community, patient and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
    b. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

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c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information and staffing plans; and

d. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee and appropriate Service Line/specialty or subject matter experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

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

    ii. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed through the Medical Staff FPPE/OPPE Policy. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

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

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

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

6.4 Special Conditions for Dental Privileges

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

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

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

6.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the medical staff that will be recorded in the medical record. Podiatric surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric medicine and surgery and demonstrated current competence.

6.7 Special Conditions for Residents or Fellows in Training

1. Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the professional graduate education committee in conjunction with the

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residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

2. The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.8 Telemedicine Privileges

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

    a. The hospital fully privileges and credentials the practitioner; or

    b. The hospital privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization.

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6.9 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges provided the medical staff office is able to verify the practitioner's current licensure and competence. Temporary privileges may be granted only to fulfill an important patient care, treatment or service need.

1. **Important Patient Care, Treatment or Service Need:** Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure, current DEA (if applicable), current professional liability insurance, current competence and results from query to the National Practitioner Databank.

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

3. Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which

raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the medical staff bylaws may effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

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

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

6. **Disaster Privileges:**

    a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected licensed independent practitioners (LIPs). These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

        1. A current picture hospital ID card that clearly identifies professional designation;
        2. A current license to practice;
        3. Primary source verification of the license;
        4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
        5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
        6. Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

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b. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

c. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

d. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

e. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

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7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of two (2) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for modification of appointment status or privileges

A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, or clinical privileges by submitting a written request to the medical staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment,

which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the medical staff office, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

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

7.4 Exhaustion of administrative remedies

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

7.5 Reporting requirements

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

Section 8. Leave of Absence

8.1 Leave Request

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

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8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

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

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Section 9. Practitioners Providing Contracted Services

9.1 Contracts

When the hospital contracts for care services with licensed independent practitioners who provide official readings of images, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

9.2 Exclusivity policy

Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

9.3 Qualifications

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

9.4 Disciplinary action

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

9.5 Effect of contract or employment expiration or termination

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

Section 10. Medical Administrative Officers

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10.1 Medical Administrative Officer

A medical administrative officer (i.e., CMO, Division Chief, Medical Director) is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, after consultation with the MEC. Their activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

10.2 Appointment to staff

Each medical administrative officer must achieve and maintain medical staff appointment and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

1. Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.
2. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the

Board.

3. A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

Henry Ford Macomb Hospitals
Medical Staff Bylaws
Part IV: Organization and Functions Manual

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Section 4. Organization and Functions of the Staff

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Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The medical staff shall be organized as a non-departmentalized staff with the MEC having the ability to formally recognize any group of at least three (3) clinicians as a Service Line consistent with these Bylaws. A Service Line Chair shall head each Service Line with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC. There will also be three (3) divisions (Ambulatory Medicine, Inpatient Medicine, and Surgery) which will interface with the Service Lines.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Service Line Chairs, and hospital and medical staff committee chairs are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate Service Line or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care. Service Lines functions will be primarily clinically related; Division functions will be primarily operationally related.

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1.3 Description of Medical Staff Functions

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

1. **Governance, direction, coordination, and action**
    1. Receive, coordinate and act upon, as necessary, the reports and recommendations from Service Lines, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
    2. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;
    3. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted;
    4. Make recommendations on medical, administrative, and hospital clinical and operational matters;
    5. Inform the medical staff of the accreditation and state licensure status of the hospital;
    6. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

7. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;
8. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
9. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body; and
10. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

2. **Medical Care Evaluation/Performance Improvement/Patient Safety Activities**
    1. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;
    2. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;
    3. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:
    4. Medical assessment and treatment of patients
    5. Use of medications
    6. Use of blood and blood components
    7. Operative and other procedures
    8. Education of patients and families
    9. Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
    10. Appropriateness of clinical practice patterns
    11. Significant departures from established pattern of clinical performance
    12. Use of developed criteria for autopsies
    13. Sentinel event data

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14. Patient safety data
15. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
16. Findings of the assessment process relevant to individual performance; and
17. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

3. **Hospital Performance Improvement and Patient Safety Programs**
    1. Understand the medical staff's and administration's approach to and methods of performance improvement;
    2. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
    3. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
    4. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.
4. **Credentials review (see Part III: Credentials Procedures Manual)**
5. **Information Management**
    1. Review and evaluate medical records to determine that they:
    2. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and
    3. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.
    4. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein; and
    5. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

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6. **Emergency Preparedness**
    1. Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.
7. **Strategic Planning**
    1. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;
    2. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and
    3. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.
8. **Bylaws review**
    1. Conduct periodic review of the medical staff bylaw, rules, regulations and policies; and
    2. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.
9. **Leadership Selection and Development**
    1. Identify nominees for election to the officer and MEC at-large member positions and to other elected positions in the medical staff organizational structure; and
    2. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees. Ensure that the nominee meets the leadership selection criteria in Part I section 4.2.1. Review the position description duties, responsibilities and accountability of the position the nominee will potentially fill.
10. **Infection Control Oversight**
    1. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;
    2. Develop and approve policies describing the type and scope of surveillance activities including:
    3. Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;
    4. Review of prevalence and incidence studies, as appropriate; and

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5. Collection of additional data as needed.
6. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
7. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
8. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;
9. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
10. Report health care acquired infection findings to the attending physician and appropriate clinical or administrative leader; and
11. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

11. **Pharmacy and Therapeutics Functions**

    1. Maintain a formulary of drugs approved for use by the hospital;
    2. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
    3. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);
    4. Perform drug usage evaluation studies on selected topics;
    5. Perform medication usage evaluation studies as required by the Joint Commission;
    6. Perform practitioner analysis related to medication use;
    7. Approve policies and procedures related to the Joint Commission Provision of Care, Treatment, and Services Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;
    8. Develop and measure indicators for the following elements of the patient treatment functions:
    9. Prescribing/ordering of medications;
    10. Preparing and dispensing of medications;
    11. Administrating medications; and
    12. Monitoring of the effects of medication.

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13. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;
14. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;
15. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and
16. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

12. **Practitioner Health**

    1. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;
    2. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;
    3. Notify the impaired practitioner's Service Line Chair, Division Chief and the MEC whenever the impaired practitioner's actions could endanger patients. Even if a Practitioner Health Committee exists, the Service Line Chair / Division Chief still has the primary responsibility for assessment of the clinical performance of the practitioner;
    4. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible; and
    5. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

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1.4 Responsibilities of Division Chiefs

a. To oversee all administratively-related activities of the Service Line, unless otherwise provided by the hospital;
b. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff Service Line or the hospital;
c. To integrate the Service Line into the primary functions of the hospital;

d. To coordinate and integrate interdepartmental and intradepartmental services and communication;

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

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

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

h. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff Service Line to provide patient care services.

1.5 Responsibilities of Service Line Chairs

a. To oversee all clinically-related activities of the Service Line;

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

c. In collaboration with the Division Chiefs, to recommend to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Service Line; and

d. In collaboration with the Division Chiefs, to provide input on the clinical privileges for each member of the Service Line and other licensed independent practitioners practicing with privileges within the scope of the Service Line.

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1.6 Responsibilities of the Chief of Staff

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

    a. Call and preside at all general and special meetings of the medical staff;

    b. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

    c. Vote at meetings only in order to break a tie vote;

    d. Enforce medical staff bylaws, rules, regulations and medical staff/ hospital policies;

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

f. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

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

h. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

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

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

k. Attend Board meetings and Board committee meetings as invited by the Board;

l. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

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

Section 2. Medical Staff Committees

2.1 General language governing committees

The following shall be the standing committees of the medical staff that report to the MEC for performing credentialing and peer review and performance/quality monitoring. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its

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proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief of Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the Chief of Staff when establishing the committee. The Chief of Staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.
Committee members may be removed from the committee by the Chief of Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

2.2 MEC (medical staff committee)

Description of the MEC is in Part I: Governance; Section 6.2. The MEC also performs the functions of bylaws review as described in section 1.3.8 above.

2.3 Credentials Committee (medical staff committee)

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

2.4 Medical Staff Quality Committee (medical staff committee)

Description of the medical staff quality committee is in the Medical Staff Quality Committee Charter.

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

3.1 Confidentiality of Information

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

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

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

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff for acts done in good faith and not done in a willful and wanton manner. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

1. The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:
    a. Applications for appointment/affiliation, clinical privileges, or specified services;
    b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
    c. Corrective or disciplinary actions;
    d. Hearings and appellate reviews;
    e. Quality assessment and performance improvement/peer review activities;
    f. Utilization review and improvement activities;
    g. Claims reviews;
    h. Risk management and liability prevention activities; and
    i. Other hospital, committee, Service Line, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

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3.4 Releases

When requested by the Chief of Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the

issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

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Adoption and Approval

November 30, 2020 Medical Staff Bylaws Revision

ADOPTED by the Medical Executive Committee on **09/15/2020,** the HFMH Medical Staff on **12/15/2020** and the HFHS Board Quality Committee on **05/13/2021**.

APPROVED by the President / CEO on _____.

Chief of Staff

Ali Shakir, MD

_____

Vice Chief of Staff

Prashant Patel, MD

_____

President / CEO

Barbara Rossmann

Review 8/14/2024; amendment updates to allow 3 year reappointment period as passed by medical staff vote on 12/8/2023 . Prashant Patel, MD, Chief of Staff, Natesh Lingam, MD, Vice Chief of Staff, Shanna Johnson, Interim President

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All Revision Dates

7/16/2026, 8/22/2024, 8/27/2021, 6/8/2021

Approval Signatures

Step Description	Approver	Date
Chief of Medical Staff (MEC)	Natesh Lingam: Non Manager-Non Employee [KB]	7/16/2026
Dir-Medical Staff & Medicine Srvcs	Danielle Savant: Dir-MedicalStaff&MedicineSrvcs	7/16/2026
Impact Review (Regulatory, Site Liaison)	Katia Glenn: Quality/ Accreditation Spec II	7/16/2026
Impact Review (Regulatory, Site Liaison)	Rebecca Washburn: Dir-Regional Regulatory&Accred	7/14/2026

System Policy Management Office	System Policy Management Offic	7/13/2026
Document Owner	Katie Berg: Mgr- Medical Staff Svcs	7/13/2026

Applicability

HF Macomb Hospital

Standards

No standards are associated with this document

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