Carson Tahoe Health

Medical Staff Bylaws

DEFINITIONS

The following definitions apply to the provisions of these Medical Staff Bylaws and its Related Manuals.

1. **ADVERSE RECOMMENDATION OR ADVERSE ACTION** - means a recommendation of the Medical Executive Committee or action of the Board of Trustees which denies, limits, or otherwise restricts a Medical Staff appointment or requested or existing Clinical Privileges.

2. **ALLIED HEALTH PRACTITIONER, ALLIED HEALTH PROFESSIONAL or AHP -** An individual other than a licensed Physician, Podiatrist or Dentist who is qualified by training, experience, and current competence in a discipline which the Board has determined by policy to allow to practice in the Hospital and either (a) is licensed by the State of Nevada and permitted by the Hospital to provide services in the Hospital without the direction or immediate supervision of a Practitioner; or (b) functions in a medical support role to and under the direction and supervision of a Practitioner.

3. **APPLICANT** -- means any practitioner who seeks either appointment to the Medical Staff or Clinical Privileges in the Hospital or an increase in the category of appointment or an increase in clinical privileges.

4. **APPOINTMENT** -- means approval for membership granted by the Board of Trustees.

5. **BOARD or BOARD OF HOSPITAL TRUSTEES** - means the Governing Body of the Hospital, or, as appropriate to the context, any committee or individual authorized by the Board to act on its behalf on certain matters..

6. **BOARD CERTIFIED** - means the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual's area of clinical practice.

7. **BOARD ADMISSIBLE** - means that a Practitioner has completed a training program required by an organization formed for the purpose of specialty certification recognized for such purpose which utilized standards and criteria or training, experience, and professional proficiency that is commensurate and comparable with delineation of training as set forth by the American Board of Medical Specialties.

8. **CLINICAL PRIVILEGES OR PRIVILEGES** - means the permission granted by the Board to a Practitioner to render specific diagnostic, therapeutic, medical, dental, surgical or psychological services in the Hospital–based upon the individual's professional license and the individual's experience, competence, ability and judgment. This includes access to hospital resources (equipment, facilities, personnel) which are necessary to effectively exercise those privileges.

9. **CONSTRUCTION, TERMS and HEADINGS** - words used in these Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws and related manuals are for convenience only and are not intended to limit or define the scope or effect or any provision of these Bylaws and related manuals.

10. **DENTIST** - means an individual with a doctor of dental surgery degree or its equivalent who is fully licensed to practice dentistry.

11. **EX OFFICIO** - means service as a member of a body by virtue of office or position held, and unless otherwise expressly provided, means without voting rights.

12. **GENERAL OFFICER OF THE MEDICAL STAFF** - means Chief of Staff, Vice Chief of Staff, Secretary / Treasurer.

13. **GEOGRAPHIC SERVICE AREA** - means the area serviced by Carson Tahoe Regional Medical Center and as determined by the Board of Hospital Trustees which includes primary and secondary geographically defined areas. Service will however, be provided to all patients regardless of their residence address.

14. **HOSPITAL** - means Carson Tahoe Regional Healthcare / Carson Tahoe Regional Medical Center (CTRMC).

15. **HOSPITAL REPRESENTATIVE** - shall include: the Board of Trustees, its individual trustees and committees; the Hospital administrator or his designee; the Medical Staff organization and all Medical Staff appointees, service/clinical units and committees which have responsibility for providing information about or collecting and evaluating the Applicant=s credentials or acting upon the application; and any authorized representative of any of the foregoing.

16. **LICENSED INDEPENDENT PRACTITIONER** - refers to any individual permitted by law and by the organization to provide care and services without direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

17. **MAJORITY VOTE** - means a vote by more than fifty percent (50%) of the voting appointees present at any meeting where a quorum is present.

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

19. **MEDICAL STAFF** - means that component of the Hospital chart of organization comprised of physicians, dentists, oral surgeons and podiatrists who are appointed to the Medical Staff and who are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

20. **MEDICAL STAFF APPOINTEE IN GOOD STANDING OR APPOINTEE IN GOOD STANDING** - means a Practitioner who has been appointed to the Medical Staff or to a particular category of the Staff, as the context requires, and who: (1) is not under either a full appointment suspension or a full or partial suspension of any section of these Bylaws or Related Manuals or any other policies of the Medical Staff or Hospital; (2) has no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges; or (3) is not subject to a Performance Improvement Plan overseen by the Quality Management Committee or the Medical Executive Committee.

21. **MEDICAL STAFF SERVICES or MSS** - refers to the office and personnel that supports the practitioners on staff at Carson Tahoe Regional Healthcare / Carson Tahoe Regional Medical Center.

22. **MEDICAL STAFF YEAR** - means the 12-month period commencing on the first day of July of each year and ending on the last day of June of the following year.

23. **NOTICE** - means the distribution of information by mail, by use of physician Hospital mail boxes or by personal delivery.

24. **OFFICER -** refers to the Chief and Vice Chief of Staff.

25. **ORAL SURGEON OR ORAL and MAXILLOFACIAL SURGEON** - an individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the US Department of Education. As determined by the Medical Staff, the individual is also currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

26. **PATIENT CONTACT** - a patient contact equates to a consultation, admission, emergency room treatment, radiologic and/or pathologic interpretation, and/or surgical/invasive procedure performed on a patient at a Carson-Tahoe affiliated facility.

27. **PEER** - A practitioner who is similarly trained and practicing within the same professional discipline.

28. **PHYSICIAN** - means an individual who holds the degree of Doctor of Medicine or Doctor of Osteopathic Medicine or surgery who is fully licensed to practice medicine in all phases.

29. **PODIATRIST** - means an individual who holds the degree of Doctor or Podiatric Medicine who is fully licensed to practice podiatry in Nevada.

30. **PRACTITIONER** - means, unless otherwise expressly provided, any individual who:
    a. is applying for appointment to the Medical Staff and Clinical Privileges; or
    b. currently holds appointment to the Medical Staff and exercises specific delineated Clinical Privileges;
    c. is applying for or is exercising temporary Privileges; or
    d. is applying for appointment or is currently a member of the Allied Health Professionals Staff.

31. **PRESIDENT & CEO -** means the individual appointed by the Board to act on the Board's behalf in the overall executive and administrative management of the Hospital. The President & CEO may, consistent with his or her responsibilities under the bylaws of the Hospital, designate a representative to perform his or her responsibilities under these Bylaws.

32. **PROFESSIONAL LIABILITY INSURANCE** - means medical malpractice insurance coverage by an insurance company licensed in the State of Nevada.

33. **PROVISIONAL PERIOD** - means that period in which a new appointee is required to undergo proctorship which at a minimum shall be one year.

34. **PSYCHOLOGIST** - means an individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the State of Nevada Board of Psychological Examiners, who is fully licensed to practice psychology. This practitioner is eligible for appointment to the staff of Allied Health Professionals.

35. **PREROGATIVE** - means a participatory right granted, by virtue of Staff category or otherwise to a Staff appointee or Allied Health Professional, and exercisable subject to the ultimate authority of the Board and to the conditions and limitations imposed in these Bylaws and Related Manuals and in other Hospital and Medical Staff policies.

36. **QUORUM** – means those members present at any meeting who are eligible to vote.

37. **RELATED MANUALS** - refers to documents that exist to clarify or supplement these Bylaws such as policies and manuals which may be established from time to time by the Medical Staff.

38. **RULES AND REGULATIONS** - The document which provides general procedural information with respect to the day-to-day practice of medicine at the Hospital.

39. **SPECIAL NOTICE** - means written notification posted in the mail via the United States Postal Service, certified or registered mail, return receipt requested or by personal delivery service to the address of the Medical Staff member or applicant as shown on their application on file at the Hospital or with signed acknowledgment of receipt.

SECTION ONE: THE ORGANIZED MEDICAL STAFF

1.1 Name

The name of the Medical Staff shall be the "Medical Staff of Carson Tahoe Regional Medical Center".

1.2 Preamble and Statement of Purpose

The purpose of the Medical Staff shall be to provide oversight for the quality of care, treatment and services provided by practitioners approved to be members of the Medical Staff and who are granted clinical privileges by recommendation of the Medical Executive Committee and approved by the Board of Trustees.

The Medical Staff shall be self governed in accordance with the Bylaws, Rules and Regulations and Policies and Procedures that have been developed by the Medical Staff and approved by the Hospital Board of Trustees.

1.3 Roles and Responsibilities

As defined in the framework outlined within the Bylaws, Rules and Regulation, and Policies and Procedures the Medical Staff will at a minimum:

A. Oversee the care, treatment and services provided by practitioners granted clinical privileges;

B. Provide a uniform standard of quality patient care, treatment and services;

C. Be accountable to the Board of Trustees;

D. Develop, approve, initiate, monitor, implement and maintain a set of Bylaws , Rules and Regulations and Policies and Procedures and implement as approved by the Board of Trustees;

E. Approve or disapprove amendments to the Medical Staff Bylaws and Rules and Regulations prior to submitting to the Board for approval.

Neither the Medical Staff, nor the Board of Trustees, may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. (MS.01.01.03)

F. Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;

G. Determine the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges;

H. Engage in performance improvement activities.

I. Determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership.

SECTION TWO: MEDICAL STAFF GOVERNANCE

2.1 Amendments to Medical Staff Bylaws

a. This section describes the process for amending these Medical Staff Bylaws, excluding Section 9 and Section 10 entitled Medical Staff Rules and Regulations and the Allied Health Professionals Policy. These two sections, as well as the Medical Staff Policies and Procedures have a separate amendment process which is described below (Section 2.2).

b. Amendments to these Bylaws may be proposed by a petition signed by 25% of the voting members of the Medical Staff, by the Bylaws and Credentials Committee, or by the MEC.

c. All proposed amendments to these Bylaws must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall provide notice of all proposed amendments, including amendments proposed by the voting members of the Medical Staff as set forth above, to the voting staff. The MEC may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

d. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

e. In unusual circumstances, the MEC may present proposed amendments to the voting Medical Staff by written or electronic ballot. The unusual circumstances necessitating the written or electronic ballot will be explained in the distribution. The ballot will be returned to the Medical Staff Office by the date indicated (at least 14 days) by the MEC. To be adopted, an amendment must receive a majority of the votes cast.

f. All amendments to the Bylaws shall be effective only after approval by the Board.

g. The MEC and the Board shall have the power to provisionally adopt urgent amendments to the Bylaws when there is a documented need in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have at least 14 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts set forth below shall be implemented.

2.2 Conflict resolution between the medical staff and the MEC

Each staff member in the active or senior active category may challenge any rule, regulation, policy, or procedure established by the MEC through the following process:

a. The staff member submits to the Chief of Staff his or her challenge to the rule or policy in writing, including any recommended changes to the rule or policy.

b. At the MEC meeting that follows such notification, the MEC shall discuss the challenge and determine if it will change the rule or policy.

c. If changes are adopted, they will be communicated to the medical staff. At such time, each medical staff member in the active category may submit written notification of any further challenge(s) to the rule or policy to the Chief of Staff.

d. In response to a written challenge to a rule or policy, the MEC may, but is not required to, appoint an ad hoc committee to review the challenge and recommend potential changes to address concerns raised by the challenge.

e. If an ad hoc committee is appointed, the MEC will take final action on the rule or policy based on the recommendations of the ad hoc committee.

f. Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by [25%] of the members of the active category requesting review and possible change of a rule, regulation, policy or procedure. After receiving a petition, the MEC will follow the adoption procedure outlined in 2.1.

If the medical staff votes to recommend directly to the board an amendment to the bylaws, rules or regulations, or policies that is different from what the MEC has recommended, the following conflict resolution process shall be followed:

a. The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC and the medical staff, and recommend language to the bylaws, rules and regulations, or policies that is agreeable to both the medical staff and the MEC.

b. Regardless of whether MEC adopts modified language, the medical staff shall have the opportunity to recommend alternative language directly to the board. If the board receives differing recommendations for bylaws, rules and regulations, or policies from the MEC and the medical staff, the board shall have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate board action.

c. Regardless of whether the board appoints such a task force, the board shall have final authority to resolve the differences between the medical staff and the MEC. At any point in the process of addressing a disagreement between the medical staff and MEC regarding the bylaws, rules and regulations, or policies, the medical staff, MEC, or governing board shall each have the right to recommend using an outside facilitator to assist in addressing the disagreement. The final decision regarding whether to use an outside resource and the process that will be followed in so doing is the responsibility of the Board.

2.3 Rules and Regulations, Policies and Procedures and the Allied Health Professionals Manual

a. The Medical Staff Rules and Regulations (Section 9 of the Bylaws), the Medical Staff Policies and Procedures and the Policy Regarding Allied Health Professionals, and amendments thereto, require the affirmative vote of a majority of the Medical Executive Committee at a regular or special Medical Executive Committee meeting, provided that a copy of the proposed documents or amendments was given or made available to each member entitled to vote thereon with or at the time of notice of the meeting. .

b. Adoption of and changes to Medical Staff Rules and Regulations, Medical Staff policies and the Policy regarding Allied Health Professionals will become effective only when approved by the Board.

2.4 Approval and Implementation

Amendments or new documents will become effective upon the affirmative vote of a majority of the Board. Any changes to the Medical Executive Committee recommendations proposed by the Board shall first be submitted back to the Medical Executive Committee for its response. The MEC will have 30 days in which to return such response to the Board.

Whenever the Board is:

a. Taking action which is contrary to the recommendations of the MEC; or

b. Taking action without having received a recommendation on the matter from the MEC, the Board shall, by written notice to the Chief of Staff, inform the MEC or its concerns, of the reasons therefore, and of the date by which the MEC's response is requested which shall be not less than seven (7) nor more than fourteen (14) days after receipt of the notice.

c. Action Following Staff Response: If the MEC's response satisfies the Board's concern, the Board shall act upon the matter as defined above. If the MEC's response fails to satisfy the Board's concerns or if no MEC response is received within the specified time frame, the matter shall be referred to a special combined committee for review. This special combined committee shall be composed of two (2) representatives each from the Medical Staff and Board appointed respectively by the Chief of Staff and chair of the Board. The Hospital CEO shall sit with this committee as an ex-officio member, without vote.

d. Action Following Special Combined Committee Review: Within seven (7) working days after receiving a matter referred to it pursuant to paragraph (c) above, the special combined committee shall convene to review, discuss, and prepare its written report on the matter. This shall be communicated to the MEC for consideration and response to the Board within a specified time period. Board action after receiving the MEC's response or after expiration of the response period without an MEC response shall be effective as the final decision. The documents or amendments the Board approves are effective as of the date the Board specifies.

2.5 Joint Conference

If the Board has determined not to accept a recommendation submitted to it by the MEC, the MEC is entitled to a Joint Conference between the officers of the Board and the officers of the Medical Staff. Such Joint Conference shall be for purposes of further communicating the Board's rationale for its contemplated action and to permit the officers of the Medical Staff to fully articulate the rationale for the MEC's recommendation. Such a Joint Conference will be scheduled by the CEO within two weeks after receipt of a request of the same submitted by the Chief of Staff.

2.6 Effect of Bylaws

These Medical Staff Bylaws and their related manuals and policies and procedures, and the privileges of individual members of the Medical Staff accorded under these Bylaws are intended to bind the Medical Staff member and Carson Tahoe Regional Healthcare / Carson Tahoe Regional Medical Center and the Board of Trustees / Directors of any successor in interests in this Hospital, except where the hospital Medical Staffs are being combined.

In the event that the Medical Staffs are being combined, they shall work together to develop new Medical Staff Bylaws which will govern the combined Medical Staffs, subject to the approval of the hospital's Board of Trustees / Directors or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution shall remain in effect.

The most current approved version of the Bylaws supersedes any and all previous versions.

2.7 Technical and Editorial Amendments

The MEC shall have the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within ninety (90) days of adoption by the MEC. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the MEC.

2.8 Notification

After approval, such amendments and/or revised texts shall be communicated in writing or other reasonable mechanism to the Medical Staff and the Board.

2.9 Reserved

2.10 Medical Executive Committee

Composition - The MEC is composed of the Chief of Staff, Vice Chief of Staff, Immediate past Chief of Staff, Chair of the Bylaws and Credentials Committee, Chair of the Quality Management Committee, the Chair of each department; one elected representative from each the Department of Surgery and the Department of Medicine and one appointed representative from each the Department of Surgery and Medicine - all with vote.

Ex Officio members shall include the President/CEO (or his designee), the Chief Medical Officer, the Director of Quality Improvement, the Vice President Patient Care Services and the Coordinator, Medical Staff Services, all without vote.

Qualification for MEC membership - Physician members must be fully licensed members in good standing of the Active Medical Staff.

Meetings - The Committee shall meet as often as necessary to fulfill its responsibilities. A permanent record of the proceedings and actions shall be maintained. Special meetings may be called whenever the need exists.

Duties - Represent and act on behalf of the Medical Staff between meetings of the organized Medical Staff subject to any stated limitations as defined in the Bylaws and other related Medical Staff documents;

a. Represent and act on behalf of the Bylaws and Credentials Committee between meetings;

b. Coordinate the activities and general policies of the Medical Staff;

c. To receive, review and act upon reports from Medical Staff Department and Committee(s) and other assigned activity groups;

d. To implement policies of the Medical Staff not otherwise the responsibility of the departments;

e. To provide a liaison between the Medical Staff and the CEO;

f. To recommend action on medico-administrative matters to the CEO;

g. To make recommendations on Hospital management matters (e.g., long-range planning) to the Board;

h. To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital;

i. To fulfill the Medical Staff organization's accountability to the Board for the medical care of patients in the Hospital;

j. To request and review reports and evaluations from the Bylaws and Credentials Committee and/or Departments all applicants in regards to Medical Staff membership, departmental assignments, and the delineation of clinical privileges and or termination of those if appropriate and to formulate recommendations to the Board of Trustees;

k. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;

l. To conduct such other functions as are necessary for the effective operation of the Medical Staff including participation in performance improvement activities;

m. To report at each meeting of the General Staff;

n. To receive reports regarding the Medical Students and oversee the activities related to such Medical Student rotations;

o. To review and act upon recommendations or situations necessitating corrective action; and

p. To make recommendations to the Board on:

1. The Medical Staff Structure;

2. The process used to review credentials and delineate privileges;

3. The delineation of privileges for each practitioner privileged through the Medical Staff Process;

4. Medical Staff membership;

5. Medical Staff membership termination if appropriate.

2.11 Medical Staff Officers - Officers of the Medical Staff shall include:

1. Chief of Staff
2. Vice Chief of Staff
3. Secretary – Treasurer

A. Qualifications

Officers must be members in good standing of the Active Medical Staff at the time of nomination and election and must remain as such throughout their term in office. Officers may not simultaneously hold leadership positions on another hospital's Medical Staff.

B. Term of Office

All officers shall take office on July 1st for a term of two (2) years. Consecutive terms may be served.

C. Election

To promote quality leadership, succession planning for Medical Staff leaders is adopted. To that end, only the Vice Chief of Staff will be determined by election.

A nominating committee shall be appointed by the MEC and my include members of the MEC. This committee shall offer one or more nominees for each office. Nominations will be presented at the May Medical Staff Departmental meetings. The Medical Executive Committee will verify the nominees' qualifications. Official vote will be taken at the May General Medical Staff meeting. A simple majority vote of those members present who are eligible to vote is required. Final appointment is subject to approval of the Board.

Only members of the Active Medical Staff shall be eligible to vote. All officers shall be confirmed by the Board.

D. Vacancies

In the event of a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term. In the event of a vacancy of the Vice Chief of Staff, the position will be filled by special election.

E. Duties

1. Chief of Staff – service as the chief administrative office of the Medical Staff, fulfilling the duties specified throughout the Medical Staff Bylaws and related manuals and policies. (see policy MS0031)

2. Vice Chief of Staff – in the absence of the Chief of Staff, shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such other duties to assist the Chief of Staff as may be requested. (see policy MS0032)

3. Secretary-Treasurer – will be responsible for:

    a. Providing for notices as specified in these Bylaws;

    b. Assuring that attendance and minutes are recorded for all meeting of the Medical Staff and the Medical Executive Committee;

    c. Serve as a voting member of the MEC;

    d. Be responsible for the collection of, accounting for, and disbursements of any funds collected, donated, or otherwise assessed and present in the Medical Staff Fund and report on such funds to the Medical Staff.

F. Removal of a Medical Executive Committee Member

The removal of a Medical Staff Officer or other MEC members, other than Department representatives (see G below), may be may be initiated for failure to carry out the duties and responsibilities as set forth in these Bylaws.

Removal may be effected either by (1) the Board after a joint conference with representatives of the MEC; or (2) by a petition signed by not less than twenty-five (25) percent of the Active Medical Staff members, followed by a two-thirds (2/3) majority vote of the Active Medical Staff members present and voting at a General Medical Staff meeting or a Special meeting of the Medical Staff called for that purpose and ratified by the MEC and the Board.

The officer who is subject of the removal action shall be given ten (10) days prior written notice of the meeting at which time the vote on removal shall be taken. The chair or officer shall be afforded the opportunity to speak in his or her own behalf before the MEC or Board, as applicable, prior to the taking of any vote on removal.

Removal from any position is an automatic termination of MEC membership.

G. Removal of Department Chair, Elected or Appointment Representative to the MEC

The removal of a Department representative to the MEC may be may be initiated for failure to carry out the duties and responsibilities as set forth in these Bylaws. Removal may be effected either by (1) the Board after a joint conference with representatives of the MEC; or (2) by a petition signed by not less than twenty-five (25) percent of the Active Medical Staff members, followed by a two-thirds (2/3) majority vote of the Active Medical Staff members present and voting at a General Medical Staff meeting or a Special meeting of the Medical Staff called for that purpose and ratified by the MEC and the Board.

H. Permissible grounds for removal

a. Failure to perform the duties of the position in a timely and appropriate manner, including attendance;

b. Failure to continuously satisfy the qualifications for the position;

c. Imposition of an automatic or summary suspension imposed by the operation of the Medical Staff Bylaws or a corrective action matter pursuant to the Medical Staff Bylaws resulting in a final decision other than to take no action;

d. Conduct or statements inimical or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs or public image, or;

e. A condition or situation that renders the officer incapable of fulfilling the essential functions of the office

f. The voluntary compliance with a Performance Improvement Plan initiated and monitored by the Quality Committee.

SECTION THREE: MEMBERSHIP OF THE MEDICAL STAFF

3.1 **Appointment** to the Medical Staff is a privilege that shall be extended only to competent professionals who continuously meet the qualifications, standards and requirements set forth in these Bylaws and related manuals and the Policies and Procedures of the Medical Staff. The process for initial appointment and privileging and reappointment is delineated in Section 7 of this manual.

3.2 **Nondiscrimination**

No practitioner will be discriminated against in the granting of Medical Staff membership or clinical privileges on the basis of age, sex, race, creed, color, religion, national origin, handicap or on the basis of any other criterion unrelated to the practitioner=s qualifications to perform the essential functions of his/her profession and the ability to deliver quality patient care in the Hospital.

3.3 **Hospital and Community Need and the Ability to Accommodate**

In acting on new applications for Staff appointment and Clinical Privileges, and on applications for changes in Clinical Privileges, in Staff appointment status, or in principal department affiliations, the MEC in making its recommendation and the Board in rendering its decision, may determine that Applicants are ineligible for appointment or the requested privileges based on:

1. policies or plans adopted by the Board concerning:

    a. the Hospital's current and projected patient care needs;

    b. the Hospital's ability to provide the physical and financial resources and personnel that will be required if the application is acted upon favorably;

    c. the Hospital's strategic plan of development, including the mix of patient care services to be provided as currently implemented;

    d. Evidence based volume criteria established to facilitate continued competence and patient safety; or

2. the Hospital’s entry into an exclusive contract to provide the patient care services in question.

When an Applicant is deemed to be ineligible based on this Section, the Applicant shall be offered the opportunity to meet with the MEC and the Board to address whether evidence exists to support the basis for the finding of ineligibility. Such meetings shall not be held for the purpose of questioning the Hospital's use of resources, policy decisions, or strategic planning.

3.4 **Eligibility Criteria for Membership**

Only those practitioners who meet the following criteria shall be eligible for appointment to the Medical Staff:

1. Hold a degree as a Doctor of Medicine, Osteopathy, Podiatry, Oral Surgery, or Dentistry from an accredited teaching facility;

2. Hold a current, unrestricted license to practice their profession in the State of Nevada, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

3. Have a current, unrestricted DEA registration, if applicable to practice;

4. Have professional liability insurance in the amount of $1 million / $3 million;

5. Have never been convicted of Medicare, Medicaid or other federal or state governmental fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

6. Have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

7. Have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

8. Have never had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct~~,~~;

9. Have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;

10. Be a graduate of an approved medical school or school of osteopathy, podiatry school, dental school, a school certified by the Educational Council for Foreign Medical Graduates, or have a Fifth Pathway certificate and have passed the Foreign Medical Graduate Examination in the Medical Sciences.

    For purposes of this section, an approved school is one fully accredited during the time of the Practitioner's attendance by the Liaison Committee on Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, American Podiatry Board or by a successor agency to any of the foregoing or by an equivalent professionally recognized accrediting body;

11. Have successfully completed an approved postgraduate training program in the specialty in which the Applicant seeks clinical privileges. An approved postgraduate training program is one fully accredited throughout the time of the Practitioner's training by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Commission on Dental Accreditation of the American Dental Association ("ADA"), the Council on Podiatric Medical Education of the American Podiatric Medical Association, or by an equivalent professionally recognized national accrediting body; and

12. Be board certified or admissible (or in the last three months of an accredited residency program) and actively pursuing Board Certification within the specialty clinical privileges will be requested. Upon appointment to the Medical Staff, the physician must comply as follows:

    a. Board Certification must be obtained within requisite number of years as identified by the applicant's requisite specialty Board.

    b. Subspecialty certification is required for those individuals practicing within ABMS / AOA subspecialty certification areas - (this will extend to "Certificates of Added Qualifications" in those areas where no subspecialty certificate exists)

    c. Physicians will be required to maintain certification / recertification, if required by their specialty board. Physicians who have achieved Senior Active status will be exempt from this requirement, if so requested, so long as they have been recertified by their specialty board at least once during their tenure at CTRMC.

    d. Physicians on staff prior to January 1998 shall be "grandfathered" which is defined as exempt from fulfilling these board certification requirements.

Failure to meet the above criteria renders an applicant ineligible for membership and their application will not be processed. Applicants who are not eligible or members who become ineligible and thereby loose membership are not qualified to be members of the Medical Staff are therefore not eligible for procedural rights under the Medical Staff Fair Hearing Plan.

3.5 Waiver of Eligibility Criteria

Any individual who does not satisfy one or more of the eligibility criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

The Board may grant waivers in exceptional cases after considering the findings of the Bylaws and Credentials Committee, the Medical Executive Committee, or other committees designated by the Board, the specific qualifications of the individual in question, and the best interests of CTRH and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. Failure to grant a request for a waiver is not a denial of an application for Medical Staff membership, and shall not entitle an Applicant to procedural rights under the Medical Staff Fair Hearing Plan.

3.6 Other Requirements for Medical Staff Membership

1. In addition to the eligibility criteria set forth above, practitioners must satisfy the following requirements to be considered qualified for appointment to the Medical Staff:

    a. Can document their background, training, judgment, individual character;

    b. Have demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession;

    c. Have demonstrated the ability to work with others;

    d. Can demonstrate with sufficient adequacy to assure the Medical Staff and Board of Trustees that any patient treated by them in the Hospital will be given a high quality of patient care;

2. Practitioners must provide evidence of education, training and experience commensurate with their request for Clinical Privileges.

3. No Practitioner is entitled to membership on the Medical Staff or to the exercise of Clinical Privileges in the Hospital merely by virtue of licensure to practice in this or any other state, or by membership in any professional organization or by holding privileges at another hospital.

4. **Clinical Performance:** Current experience, clinical results and utilization practice pattern documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of healing arts and consistent with available resources. It is recognized that residents and Practitioners who have recently completed training may not at the time of application and initial appointment to the Staff have had the same extent of experience and so be able to document satisfaction of this qualification to the degree generally expected by the Medical Staff and Hospital. However, such individuals are expected to satisfy the overall intent of this provision and as their practices develop, to demonstrate by actual independent performance their compliance with it.

5. **Cooperativeness:** Have demonstrated the ability to work with and relate to other Staff appointees, members of other health disciplines, Hospital management and employees, the Board, visitors and the community in general in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care.

6. **Professional Ethics and Conduct:** Members are expected to be of high moral character, to adhere to generally recognized standards of medical and professional ethics, and maintain the Principles of Medical Ethics (Appendix A of the Medical Staff Bylaws). Specifically, but without limitation, this includes refraining from:

    a. Paying or accepting commissions or referral fees for professional services;

    b. Delegating the responsibility for diagnosis or care of patients to a Practitioner or Allied Health Professional not qualified to undertake that responsibility;

    c. Failing to reveal to the patient the identity of Practitioners involved in providing services to the patient;

    d. Failing to seek appropriate consultation when medically indicated;

    e. Failing to provide or arrange for appropriate and timely medical coverage and care to patients for whom the Practitioner is responsible; and

    f. Failing to obtain informed patient consent for treatments.

7. **Ability to Perform:** To be free of, or have under adequate control, any significant physical or mental health condition or impairment which would preclude the Practitioner from being able to perform the essential functions of his or her practice, from creating an unsafe patient environment, or from fully and competently carrying out the clinical privileges requested, and to be free of any type of substance or chemical use that affects cognitive, motor or communication ability in a manner, that interferes with, or presents a reasonable probability of interfering with the qualifications required by the Bylaws and Credentials manuals.

    The Credentials Committee may, based upon information obtained through the verification process, ask the applicant to obtain a mental and/or physical evaluation if the applicant has otherwise been determined to be qualified for Medical Staff membership.

8. **Verbal and Written Communication Skills:** Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligent manner, and to prepare medical record entries and other required documentation in a legible manner.

3.7 Medical Staff Categories

A. The Provisional Staff

All initial appointments for practitioners requesting membership in the Active and Courtesy categories will be to the Provisional Staff for a minimum of one year. All Provisional Staff members must successfully complete the Provisional Period to remain eligible for reappointment to the Medical Staff.

Provisional Staff members are expected to fulfill all obligations for Medical Staff membership.

Provisional Staff members are not eligible to vote, hold office or chair any standing committee of the Medical Staff.

Provisional Staff members shall pay annual medical staff dues.

B. The Active Staff

Qualifications for Active Staff:

The Active Staff shall consist of those qualified practitioners who:

1. Reside close enough to the Hospital to provide continuing care to his/her patients and to respond when requested, within the time frame(s) as defined by the department in which clinical privileges are granted;

2. Maintain an office within the geographic service area of the Hospital, as defined by the Board, where patients are seen at least one day per week;

3. To the extent that the Practitioner has privileges at more than one hospital, the Practitioner must have a **minimum** of 25 patient contacts within any calendar year except as waived by action of the MEC and approval by the Board;

4. Actively participate in Medical Staff functions;

5. Have completed at least one (1) year of satisfactory performance on the Provisional Staff.

6. Continually meet the obligations of Medical Staff membership;

7. Pay annual Medical Staff dues;

8. Participate in On Call assignments as defined in the policy regarding On-Call;

9. Contribute to the organizational, administrative and medico-administrative (including quality review, risk management, utilization management and proctoring) activities of the Medical Staff including service in Medical Staff and departmental offices and on Hospital and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed.

10. Abide by the Medical Staff Bylaws and Related Manuals, Rules and Regulations and all policies and procedures as may be in effect from time to time by the Medical Staff and the Hospital.

Failure to maintain the minimum number of patient contacts annually shall result in the automatic transfer to the appropriate Medical Staff membership category for the next reappointment period. Such a transfer shall not be considered a reduction in Privileges or an adverse action for purposes of the Practitioner's procedural rights under the Medical Staff Fair Hearing Plan.

A transfer pursuant to the above may be waived by the MEC upon recommendation of the department chair and the Credentials Committee but only if the Practitioner makes a satisfactory showing of unusual circumstances unlikely to occur again in his/her practice.

Prerogatives of Active Status

An Active Staff appointee **may**:

1. Have unrestricted use of the Hospital, including admissions, and exercise Clinical privileges as are granted to him/her;

2. Be eligible to hold office;

3. Vote on matters of the Medical Staff, committees, and clinical department(s) of which he/she is a member;

4. Chair and/or be a member of medical staff committees, including the Bylaws and Credentials, Quality and Medical Executive Committees.

C. The Courtesy Staff

A Courtesy Staff appointee must:

Agree to provide copies of any and all quality assessment and improvement information from other institutions relative to the Practitioner's clinical performance or in such other form as may be required the a department chair, the Bylaws and Credentials Committee or other Staff or Board authorities) in order to allow an appropriate judgment to be made with respect to his/her ability to exercise the clinical privileges being requested. Certified copies may be required.

Pay annual dues of the Medical Staff;

Abide by the Bylaws, Rules and Regulations and Policies and Procedures of the Medical Staff and Hospital;

Continually meet the basic obligations of Medical Staff membership;

Participate in the On-Call schedule as defined in the Policies and Procedures (MS0005);

Have a minimum of one and not more than 24 patient contacts in a calendar year. Practitioners who exceed 24 patient contacts in a calendar year will automatically be elevated to Active Status at the next reappointment cycle;

A Courtesy Staff appointee may:

Exercise such clinical privileges as are granted to him/her;

Attend meetings of the Department in which clinical privileges are granted as well as attend General Medical Staff meetings, all WITHOUT vote;

Have full use of the Hospital facilities;

Not be elected to any office;

Not Chair any standing committee;

Not vote on matters of the Medical Staff.

Failure to maintain the minimum number of patient contacts annually shall result in the automatic transfer to Affiliate Staff status for the next reappointment period. Such a transfer shall not be considered a reduction in Privileges or an adverse action for purposes of the Practitioner's procedural rights under the Medical Staff Fair Hearing Plan.

D. The Consulting Staff

A Consulting Staff appointee must:

Document sufficient formal training and experience to allow an appropriate judgment to be made with respect to his/her ability to exercise the clinical privileges requested.

Attend Departmental and MEC meetings for discussion of quality issues when so directed.

Continually meet the basic obligations of Medical Staff membership;

Abide by the Bylaws, Rules and Regulations and Policies and Procedures of the Medical Staff and Hospital;

Pay annual dues of the Medical Staff.

A Consulting Staff appointee may:

Exercise such clinical privileges as are granted to him/her, but may never be solely responsible for managing a patient;

Not independently admit patients, however may co-manage a patient's care with the attending practitioner;

Not hold office or vote on matters of the Medical Staff.

E. Affiliate Staff

Practitioners requesting appointment to this category do not meet the requirements for the above categories; however, they wish to maintain a professional relationship with the Hospital and the Medical Staff for referral purposes in the event their patients require admission to the Hospital.

Affiliate Staff **are not** eligible to admit patients, perform procedures, and **are not** eligible for clinical privileges.

Affiliate Staff members are not eligible to vote or hold office.

Affiliate Staff members may visit their patients when hospitalized and review the chart but may not write in the chart or otherwise direct patient care.

Affiliate Staff members must pay dues.

F. Senior Active Category

Practitioners who meet the following criteria may request a change to this category if the following criteria are met:

1. The practitioner has held appointment to the Active Staff of Carson Tahoe Regional Medical Center for a period of at least ten (10) consecutive years; and

2. The practitioner is at least fifty-five (55) years of age.

Practitioners in this category must continually fulfill the obligations of an Active Staff appointment with the exception that they are not required to participate in the on call emergency room coverage schedule(s). All other rights and responsibilities remain identical to that of Active Staff status.

However, if at any time it is determined that there is an inadequate number of practitioners in any given specialty available to provide adequate on call coverage, the Board of Trustees may mandate practitioner(s) in this category to return to participation in the on call coverage schedule(s).

G. Honorary Staff

Appointment to Honorary Staff shall be at the recommendation from the MEC and the approval of the Board. Appointees in this category of membership shall consist of former Active Staff practitioners who no longer participate in an active Hospital practice and/or have had a long-standing service to the Hospital or other noteworthy contributions to the Hospital and/or Medical Staff.

Honorary appointees may attend meetings of the Medical Staff but shall have no vote.

Honorary appointees must maintain a current Nevada medical license.

Honorary appointees shall not pay dues.

H. Telemedicine Staff

Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications for the purpose of improving patient care, treatment and services.

Qualifications:
The Telemedicine Staff will consist of physicians who qualify for Medical Staff membership and privileging within their specialty and include:

a. Current Licensure by the appropriate State of Nevada licensing board;
b. Current State and Federal controlled substances registration(s);
c. Current professional liability insurance ;
d. Successful completion of an ACGME / AOA accredited residency training program within the specialty privileges are being requested;
e. Current Medical Staff Appointment in good standing with unrestricted clinical privileges at a JCAHO accredited hospital.
f. Community Need as determined by the Bylaws and Credentials Committee.

Prerogatives and Responsibilities

Telemedicine Staff members:

a. May perform medical evaluations, provide orders, and assist in monitoring and managing patients from a remote monitoring site; and
b. At reappointment, shall provide evidence of clinical practice activities in such form as may be required by the Medical Staff to allow for appropriate assessment of continued qualifications for Staff appointment and clinical privileges; and,
c. Must comply with all Medical Staff and Hospital policies and procedures.

I. Outpatient Staff

Qualifications:
1. Maintain an office practice within the CTRH Service Area;
2. Provide ambulatory, non surgical services to patients;
3. Have a desire to participate in hospital professional Medical Staff activities;
4. Meet the membership requirements for Active Staff membership with the exception of volume;

Members of the Outpatient Staff may:
1. Vote and hold office;
2. Chair Committees;
3. Participate in all Medical Staff activities, CME's, etc.

Members of the Outpatient Staff may not:
1. Admit or provide care to patients in the hospital;
2. Perform procedures or surgery at any CTRMC affiliate facility, i.e. SSH, CDASC.

Members of the Outpatient Staff must:

1. Have an arrangement with a CTRMC affiliated practitioner or group for care of their patients if hospitalized;
2. Pay annual Medical Staff dues.

3.8 Conditions and Duration of Appointment

A. Initial appointments and reappointments to the Medical Staff shall be official only after action by the Board of Hospital Trustees.

The Board shall act on appointments and reappointments only after there has been a recommendation forwarded from the Medical Executive Committee.

B. Initial appointments shall be Provisional Status for a minimum of 12 months. Provisional status may be extended based upon review of performance and recommendations from the department, Bylaws and Credentials Committee and/or the Medical Executive Committee.

C. Reappointments to the Medical Staff will recur biannually and the approved reappointment shall be for a period of no more than 24 calendar months.

3.9 Responsibilities of Medical Staff Membership

Each Staff member shall:

A. Direct the care of his or her patients and supervise the work of any allied health professional(s) under his/her direction;

B. Assist the Hospital in fulfilling its responsibilities for providing emergency and charitable care;

C. Assist other practitioner(s) in the care of their patients when asked;

D. Act in an ethical and professional manner;

E. Treat patients, their families, hospital staff and colleagues in a respectful and professional manner at all times (reference policy MS0017);

F. Maintain Professional liability insurance in the amount of $1 million / $3 million;

G. Maintain current, unrestricted Nevada State Medical license, DEA, and Nevada State Controlled Substance Certificate.

H. As a condition of medical staff membership, every applicant and member specifically agrees to immediately submit to a blood, hair or urine test, or to complete a physical or mental evaluation, if concern about his or her ability to safely and competently care for patients is reported. The health care professional(s) to perform the testing or evaluations will be determined by the medical staff leaders.

3.10 Compliance

Satisfactory compliance with the basic obligations accompanying appointment to the Medical Staff is an on-going responsibility of membership. This includes, but is not limited to, participation in on call coverage as determined by the Medical Staff and Board authorities and discharge of obligations specific to the Staff category and clinical privileges granted.

3.11 Practitioners Providing Professional Services by Contract or Employment

A Practitioner who is, or will be providing specified professional services pursuant to a contract / employment with the Hospital must meet the same Medical Staff appointment qualifications, must

be evaluated for appointment, reappointment and clinical privileges in the same manner, and must fulfill all the obligations of his or her Medical Staff category as any other applicant or Medical Staff appointee.

3.12 Effect of Contract / Employment Expiration or Termination

The effect of expiration or other termination of a contract / employment upon a Practitioner's Staff appointment and clinical privileges shall be governed solely by the terms of the Practitioner's contract / employment with the Hospital, if the same addresses the issue.

If the contract / employment arrangement is silent on the matter, then the expiration or termination of the contract / employment arrangement will result in the practitioner(s) voluntary relinquishment of clinical privileges and termination of Medical Staff membership.

Termination of Medical Staff appointment and clinical privileges or a limitation on clinical privileges pursuant to contract / employment termination shall not give rise to the procedural rights afforded by the Fair Hearing Plan.

The only exception to this rule shall be if the basis of such termination or limitation is such that the Hospital would be obligated to report the Practitioner's actions to the Medical Board or NPDB. In such circumstances, the Practitioner shall be entitled to the procedural rights afforded by the Fair Hearing Plan solely with respect to those issues which formed the basis of the reporting requirement.

SECTION FOUR: Medical Staff Structure

4.1 Departments and Sections

The Medical Staff shall be divided into two clinical departments; Medicine and Surgery.

Each department shall be organized as a component of the Medical Staff and have a chairperson elected to fulfill the duties and responsibilities as defined within the Bylaws, Rules and Regulations, Policies and Procedures and to act with authority in matters related to those responsibilities.

Within the departments will be sections that may meet as often as needed to discuss matters specific to their specialty(s). Reports, including any peer review activity, from these sections will be forwarded to the appropriate department(s). Any group of physicians providing specialty care may meet to discuss issues relative to their specialty of practice. However, all requests and/or recommendations must be presented to the Department who will determine if these need to be presented to the Medical Executive Committee for action.

Department of Medicine – Medicine based sections, including but not limited to:

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Cardiology
- Nephrology
- Gastroenterology
- Pulmonology
- Dermatology
- Physical Medicine and Rehab
- Pediatrics
- Diagnostic Radiology

Department of Surgery – Surgical based specialties, including but not limited to:

- Anesthesiology
- General / Vascular Surgery
- Orthopedics
- OB/GYN
- Pathology
- Interventional Radiology
- Urology

The primary function of each department shall be to develop and conduct a peer review / quality management program to promote and assure a high quality of patient care by means of continuous review of the work of the department. Appropriate presentation of an educational nature should be made to the entire department as problems or deficiencies are identified by the quality management program.

Each department shall review the application and reappointment information submitted from practitioners applying for initial and/or reappointment to the Medical Staff and formulate a recommendation to submit to the Bylaws and Credentials Committee. New applicants will be requested to attend the departmental meeting at the time of initial review and recommendation.

4.2 Assignments

Each physician appointed to the Medical Staff will be assigned to one primary department as recommended by the Bylaws and Credentials Committee and approved by the Medical Executive Committee. He/She may also be involved in a section that will meet in addition to the departmental meeting. Clinical privileges will be granted based upon education, training and documented competence and may cross specialties.

4.3 Duties of the Departments

Each department shall participate in development and implementation of a peer/quality review program to promote high quality patient care through continuous review and shall assist the Quality Department in identifying meaningful metrics to be monitored in Ongoing Professional Practice Evaluations. When appropriate, findings shall be utilized in an appropriate educational forum.

4.4 Department Chairperson

Each department shall have a chair charged with the overall supervision of the clinical and administrative work of the department. A Vice Chair shall also be appointed and be available to act in the absence of the Chair. In the absence of the chair, the Vice Chair or a chair designee, shall function with all the powers, duties, and privileges bestowed upon the Chair.

a. Qualifications

Each chair and vice chair shall be a member in good standing of the Active Medical Staff and demonstrate the ability to fulfill the requirements of the position.

b. Selection

Biannually, the department shall elect a Chair and Vice Chair. Nominations will be accepted from the floor. A simple majority vote of those members present who are eligible to vote is required. Final appointment is subject to approval of the Medical Executive Committee.

c. Term of Office

The term of office shall be two years. Unlimited terms may be served subject to the supporting recommendation by the department and subsequent approval by the Medical Executive Committee.

d. Roles and Responsibilities

Each chairperson shall oversee access and/or recommend:

A. Clinically related activities of the department;

B. Administratively related activities of the department, unless otherwise provided by the hospital;

C. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

D. To the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

E. Clinical privileges for each member of the department;

F. The integration of the department or service into the primary functions of the organization;

G. The coordination and integration of interdepartmental and intra-departmental services;

H. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

I. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;

J. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient

care, treatment, and services;

K. The continuous assessment and improvement of the quality of care quality of care, treatment, and services;

L. The maintenance of quality control programs, as appropriate;

M. The orientation and continuing education of all persons in the department or service;

N. Recommending space and other resources needed by the department or service;

O. Assessing and recommending to the relevant hospital authority, off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

e. Vacancies

Unless otherwise specified, vacancies shall be filled in the same manner as the initial selection process. In the absence of the Chair, the Vice Chair, or a Chair designee, shall function with all the powers, duties and privileges bestowed upon the Chair.

f. Removal from Office

See Section 2.10 (G)

4.5 Regular Meetings

Departments shall meet as often as needed or upon a schedule as determined by the membership. A record of the proceedings, including recommendations, conclusions and actions taken will be maintained and submitted to the MEC.

4.6 Duties of the Sections

Sections shall meet as often as necessary and at the request of the Department Chair. Sections meetings shall serve as a forum to discuss clinical aspects of care related to those practitioners in the Section. A representative chair shall be selected by the members. Any Peer Review activity that occurs during a Section meeting shall be reported to the Department through reports to the Quality department or directly to the Department Chair.

4.7 Committees of the Medical Staff

The Medical Staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of the departments and sections, and meeting of committees established in this document, as well as special and/or ad hoc committee when appointed.

The committees described herein shall be known as the standing committees of the Medical Staff.

Unless otherwise specified, the chairs of these committees shall be appointed by the Chief of Staff, subject to approval by the Medical Executive Committee.

Chairs for Ad Hoc or other special committees may be appointed by the department chair or Chief of Staff or Vice Chief of Staff. Each Chair must be a member in good standing of the Active Medical Staff.

All reports from the Ad Hoc committee meetings shall be returned to the department whereby the committee was originated. It will be the responsibility of the department chair to forward reports to the Medical Executive Committee as appropriate.

4.8 Purpose of Committees

The purpose of all committees of the Medical Staff is to review, monitor, evaluate and formulate recommendations that may improve the quality of care provided to patients and fulfill the functions required by the State and accrediting agencies.

4.9 Committee Appointments

The Chief of Staff shall make recommendation for Medical Staff member appointments to serve on the Standing Committees. The Medical Executive Committee will review and act to finalize the appointments.

When necessary to accomplish a function or task assigned to a committee, the Chair may, after consultation with the Chief of Staff or CEO, call upon outside consultants or special advisors from clinical specialties or administrative or patient care units who possess expertise in the subject matter involved.

Each Chair, or other authorized person chairing a meeting, has the right to participate in discussion of and to vote on issues presented to the committee. Each chair should have served for at least one (1) year on the committee or otherwise have experience in the functions assigned to the committee prior to serving as the chair.

4.10 Voting Membership

Only those committee members whose Medical Staff membership category includes the right to vote may do so. Those categories include Active, Senior Active and and Outpatient members only.

The Chief of Staff shall be an ex-officio member of all departments, sections and committees, without vote.

4.11 Standing Committees

The standing committees of the Medical Staff are as follows:

a. Medical Executive Committee
b. Bylaws and Credentials Committee
c. Quality Management Committee
d. Continuing Medical Education Committee
e. Pharmacy and Blood Utilization Committee
f. Cancer Committee
g. Ethics Committee
h. Infection Control Committee

1. Bylaws and Credentials Committee

Composition - The membership shall consist of up to six practitioners who are members in good standing of the Active and Outpatient Staff - all with vote.

Ex Officio members shall include the Coordinator, Medical Staff Services and the Chief Medical Officer - all without vote.

The committee will meet as often as necessary to provide timely recommendations in the conduction of business. The MEC shall have the authority to act on behalf of this group between meetings.

Duties of the Committee shall include:

a. Review and formulate recommendations for changes as needed in the Bylaws and Related Manuals of the Medical Staff;

b. Review and formulate recommendations regarding policies of the Medical Staff;

c Review and formulate recommendations regarding policies affecting the Medical Staff;

d. Formulate recommendations to the MEC regarding standards for Medical Staff membership and Clinical privileges;

e. Recommend to the MEC the standards for credentialing Allied Health Professionals;

f. Apply standards in evaluating applications for clinical privileges for Allied Health Professionals;

g. Review recommendations from the departments in evaluating and formulating recommendations to the MEC regarding new applicants, reappointments; requests for clinical privileges and/or changes to currently held clinical privileges, requests for change of status, requests for Leaves of Absence, and review information relative to conclusion of provisional status.

2. Quality Management Committee

The QMC shall be composed of a chair and up to six physician members representative of the clinical services provided by the Medical Staff, appointed by the Medical Executive Committee; all with vote.

Ex Officio members include the Chief of the Medical Staff, the President/CEO or his designee, the Chief Medical Officer and the Vice President of Patient Care Services (CNO), the Director of Quality, Risk Management and Regulatory Affairs; all without vote.

The QMC assists the MEC by overseeing, coordinating, recommending, and/or approving the performance of the following:

a. The measurement and assessment of performance improvement activities;

b. Establishment of measurement/screening criteria and focus review methodologies, where appropriate;

c. Reviews information and/or cases from the utilization management services for the quality of the services provided, the length of stay, the initiation of appropriate corrective action(s) focus on opportunities to improve;

d. Reviews minutes from Medical Staff departmental peer review meetings regarding the quality and appropriateness of services/care rendered by members;

e. Receives and reviews reports and/or other information from hospital-wide Performance Improvement activities;

f. Receives and reviews reports from the Medical Records Department including monitors and pertinence criteria and delinquencies/deficiencies;

g. Monitors actions initiated by Hospital departments/services to assure resolution of identified and/or potential problem areas of clinical care;

h. Reviews all Sentinel Events or potential events and evaluates the actions taken to reduce potential or prevent future related events;

i. Act as a Professional Practice Evaluation Committee and evaluate and initiat interventions outlined in Medical Staff policy MS0010 – Complaints Involving

Physicians Regarding Quality Issues and MS0035 – Medical Staff Code of Conduct and MS0037 – Professional Practice Evaluation.

j. Investigate any perceived breach of ethics and/or otherwise review behavior and clinical competence.

3. Continuing Medical Education Committee

Meets quarterly with Medical Staff members as appointed by the Chief of Staff.

Duties: Oversee continuing education opportunities related to quality activities, new developments and other perceived needs. Provide assistance to CTRMC staff in maintaining Continuing Medical Education Accreditation (ACCME) allowing the granting of CME hours for local activities.

4. Pharmacy and Blood Utilization Committee

The Committee shall be composed of up to six physician representatives - all with vote. Ex officio members shall include the Hospital Pharmacist, the Director of Quality, Risk Management and Regulatory Affairs, the Quality Coordinator, and representatives from Administration and Nursing - all without vote. The Committee shall meet at least quarterly.

Duties: Drug Usage Evaluation

Monitors and evaluates the use of drugs through an ongoing, planned, systematic and criteria based process to help assure that they are provided appropriately, safely, and effectively. The process is performed in cooperation with the Pharmacy Department, the Nursing Department Management and Administrative Staff, and other individuals as necessary. The ongoing monitoring process shall include:

The routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use;

The use of objective criteria that reflect current knowledge, clinical experience, and relevant literature;

Screening mechanisms to identify, for more intensive evaluation, problems in or opportunities to improve the use of a specific drug or drug category.

Duties: Pharmacy and Therapeutics

The monitoring function includes at least the following:

The development or approval of policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

The development and maintenance of a drug formulary or drug list;

The evaluation and approval of protocols concerned with the use of investigational or experimental drugs;

The definition and review of all significant untoward drug reactions;

The promotion of educational programs on drugs and drug therapy for the medical and nursing staffs;

To review and make recommendations on drug usage reports, medication error or notification reports, storage, distribution and administration of drugs.

Duties: Blood Utilization Review

On at least a quarterly basis, evaluates the appropriateness of all cases in which patients were administered transfusions.

Review confirmed transfusion reactions;

Development and/or approval of policies and procedures relating to the distribution, handling, use and administration of blood and blood components;

Review the adequacy of transfusion services to meet the needs of patients;

Review ordering practices for blood and blood products;

Screening mechanisms to identify problems in blood usage for more intensive evaluation;

5. Cancer Committee

The membership requirments for the cancer committee is established by the American College of Surgeons Commission on Cancer Standards. Required physician members include diagnostic radiologist, pathologist, general surgeon, medical oncologist, radiation oncologist, pain specialist, and the Cancer Liaison Physician. Non-physician representatives from each of the administrative, clinical and supportive services available at the facility are also required to be members.

The committee shall meet at least quarterly and shall report to the Quality Management and Medical Executive Committees.

The Chief of the Medical Staff shall appoint the chair of the Cancer Committee. All other members of cancer committee shall be voted upon by the committee.

Responsibilities:

1. Develop and evaluate the annual goals and objectives for the clinical, educational and programmatic activities related to cancer.

2. Promotes a coordinated, multi-disciplinary approach to patient management.

3. Ensures that educational and consultative cancer conferences cover all major sites and related issues

4. Ensures than an active supportive care system is in place for patients, families and staff

5. Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes

6. Promotes clinical research

7. Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting

8. Performs quality control of registry data

9. Encourages data usage and regular reporting

10. Monitors attendance and appoints new members as needed when attendance of any specialty is not consistent.

11. Monitors meetings for quorum requirement of one physician present at each meeting.

12. Upholds medical ethical standards

6. Ethics Committee

The Ethics Committee will have representation from Administration, Nursing, Risk Management, Clergy, the community, Legal Counsel, Social Services, Board of Trustees, and Medical Staff.

The Committee shall meet no less than semi-annually but as often as required to address needs and on call as needed.

The general functions of the Ethics Committee shall include staff and community education, policy and guideline recommendations and consultative services regarding ethically related issues.

7. Infection Control Committee

The Infection Control Committee shall be composed of at least one member of the Active Medical Staff. The Infection Control Coordinator shall serve as a voting member of the committee. Representatives from Nursing and Administration shall attend, without vote. Meetings shall be held as often as necessary but at a minimum, biannually. Communications of findings, conclusions, recommendations and actions shall be reported to the Quality Management Committee. Surgical Surveillance statistics shall be provided to the Department of Surgery.

The duties and responsibilities of this committee shall be to:

1. Evaluate the quality of patient care provided to patients related to the infection control function;

2. Develop, implement and assess quality control and performance improvement measures for the Infection Control program;

3. Review and recommend to the Medical Executive Committee, relevant policies, procedures and protocols that my be necessary for the operations of the Infection Control program

4. Develop and monitor a hospital-wide Infection Control Surveillance program

4.12 Special Committees

The Chief of Staff, in coordination with the Medical Executive, may appoint such other committees as may be required for the effective and efficient operating of the Hospital and for the proper discharge of the Medical Staff's responsibility of assuring the optimum patient care in the Hospital, and may provide for Medical Staff representation thereon. The MEC may also assign new functions to existing committees or make certain committee functions the responsibility of the Staff as a whole.

4.13 General Provisions

1. Terms of Members - Unless otherwise specified, Medical Staff standing committee members shall be appointed for a term of two (2) years corresponding with the terms of the Medical Staff Officers. Multiple two year terms may be served if members desire to continue membership on committees.

2. Removal of Member - If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of clinical privileges, or if other cause exists, that member may be removed by a majority vote of the Medical Executive Committee.

3. Vacancies - Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

4. Executive Session - The chairperson of any standing, special or ad hoc committee of the Medical Staff, including departments and sections, may call an executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity.

5. Addition, Deletion or Modifications of Standing Committee(s) - The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff as described in these Bylaws with the exception of the Medical Executive Committee. Modification of the Medical Executive Committee requires a vote of the General Medical Staff pursuant to the Bylaws modification requirement.

6. Representation on Hospital Committees: Active members of the Medical Staff shall be appointed by the Chief of Staff to serve on Hospital committees as necessary and/or required by state, federal and/or the Accrediting Organization regulations, including but not limited to the Safety Committee, the Radiation Safety Committee, and/or the Institutional Review Board.

4.14 Reporting

Reports shall be submitted as defined in the description and/or to the Department(s) and committees to which the members report.

4.15 Attendance

All members of the Medical Staff, as well as specifically appointed ex officio members are encouraged to attend al meetings of the Medical Staff departments, sections and committees to which they are appointed. Meeting attendance will not, however, be used as a criteria for reappointment evaluation.

Any Medical Staff member may attend meetings of other departments, sections or committee of which they are not assigned members by giving prior notice to and receiving approval from, the respective Chair of that department, section or committee.

Whenever special or ad hoc committees are appointed, only those physicians and other individuals appointed to serve are permitted to attend. However, if a request is made for a physician to attend for the purpose of addressing a specific issue(s), that physician is expected to attend.

At no time, unless a request is made and approved by the respective chairperson prior to the meeting date, will non members be permitted to attend Medical Staff meetings.

4.16 Special Attendance Requirements

Whenever a staff or departmental educational program is prompted by the findings of quality assessment / improvement activities, the practitioner whose performance prompted the program will be notified by Special Notice of the time, date and place of the program, the subject matter to be covered, and its special applicability to the practitioner's practice. Except in unusual circumstances, the practitioner shall be required to be present. Failing to appear without good cause may result in corrective action.

If the Practitioner fails to attend and has not requested an extension based upon justifiable cause, the Practitioner's clinical performance will be presented, discussed and acted upon as scheduled. In no case shall postponement be granted beyond the next regular meeting.

4.17 Minutes

Minutes of Medical Staff meetings shall be prepared and retained. They shall include, at a minimum, a record of attendance, issues discussed and summary of recommendations and actions taken.

4.18 Special Meetings

A special meeting of any department, section or committee may be called by the chairperson, by the Chief of the Medical Staff or by one-third (1/3) of the group=’s voting members, however but not less than two (2) members.

4.19 Notice of Meetings: Written 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 committee or department not less than three 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.

4.20 Manner of Action

The action of a majority of the voting members present at a meeting shall be the action of the department, section or committee. Additionally, any action may also be taken without a meeting by:

a. Written resolution stating the proposed action and signed by a majority of the members entitled to vote.

b. documentation of a verbal vote of each member obtained via phone poll

4.21 Robert’s Rules of Order

Robert’s Rules of Order shall not be binding at Medical Staff meetings or elections, but may be used for reference at the discretion of the presiding officer for the meeting. Rahter, specific provisions of these Bylaws, anad Medial Staff, department, or committee custom shall prevail at all meetings and the department chair or committee chair shall have the authority to rule definitvely on all matters of procedure.

4.22 Rights of Ad Hoc Committee Members

Persons serving as ad hoc members of a committee shall have all the rights and privileges of regular committee members except they shall not be counted in determining the exercise of a quorum and shall not vote unless voting rights are otherwise granted by the committee chairperson.

4.23 Rights of Ex Officio Members

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

4.24 Participation by the CEO

The CEO, and any representative assigned by the CEO, may attend any committee, department or section meeting of the Medical Staff as an ex officio member, without vote

4.25 Reserved

4.26 Reserved

4.27 Activities and Information Covered

The confidentiality, state evidence code protections and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility’s or organization’s activities concerning, but not limited to:

a. Applications for appointment, reappointment or clinical privileges;
b. Responsive action;

c. Hearings and appellate reviews;
d. Utilization reviews;
e. Department, section, committee or Medical Staff activities related to monitoring and maintaining quality patient are and appropriate professional conduct; and
f. The actions of peer review organizations, medical boards and other entities which engage in the monitoring or evaluation of processional competence or conduct.

SECTION FIVE: MEMBER RIGHTS, CORRECTIVE ACTION AND FAIR HEARINGS

5.1 Practitioner Rights

a. Each practitioner on the Medical Staff has the right to an audience with the MEC. In the event a practitioner is unable to resolve a difficulty in working with his/her respective department chair, that practitioner may, upon presentation of a written notice, meet with the MEC to discuss the issue.

b. Any practitioner has the right to initiate a recall election of a Medical Staff Officer and/or department chair. A petition for such recall must be presented, signed by at least 25% of the members of the Active Staff. Upon presentation of such valid petition, the MEC will schedule a special general staff meeting for the purposes of discussing the issue and (if appropriate) entertain a no-confidence vote.

c. Any practitioner may initiate the scheduling of a general staff meeting. Upon presentation of a petition signed by 25% of the members of the Active Staff, the MEC will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

d. Any practitioner may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate, any practitioner may submit a petition signed by 25% of the members of the Active Staff. When such petition has been received by the MEC, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

e. Any section/sub-specialty group may request a department meeting when a majority of the members/sub-specialists believe that the department has not acted appropriately.

f. This section is common to Sections 8.1 through 8.5 above. These sections do not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual "credentialing" actions. The Medical Staff Fair Hearing Plan provide recourse in these matters.

g. Any practitioner has a right to a hearing/appeal pursuant to the institution's Medical Staff Fair Hearing Plan.

5.2 Corrective Action

Informal corrective action should be used when appropriate in accordance with CTRMC Policy #MS0035. Proper documentation is necessary in the provider’s credentials folder to facilitate identification of behavior or activity trends.

5.3 Criteria for Initiating a Formal Investigation for Possible Corrective Action Other than Summary or Automatic Relinquishment

Basis for Correction Action

A. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards of the Medical Staff or are considered to be disruptive to the operations of the Hospital, to the extent that formal corrective action against such practitioner may be warranted. Such corrective action may be requested by any officer of the Medical Staff, by the Chair of any Department, by the Chair of any standing Committee of the Medical Staff, by the CEO or his/her designee or by the Board of Trustees.

All requests for corrective action shall be in writing, shall be forwarded to the MEC, and shall be supported by reference to the specific activities or conduct which constitutes the

grounds for the request. A verbal request reduced to writing in committee minutes shall constitute such writing.

B. Whenever the corrective action could be deemed adverse, the MEC shall forward such request to the Chair of the Department in which the Practitioner holds such privileges. Upon receipt of such request, the Chair of the Department shall immediately appoint an Ad Hoc Committee to investigate the matter.

C. The department shall complete its investigation and make a report to the MEC within thirty (30) days after the department's receipt of the request for corrective action; provided, however, that an extension of time may be granted by the MEC for good cause. Prior to the making of such report, the Practitioner against whom corrective action had been requested shall have the opportunity for an interview with the Department Ad Hoc investigating committee. At such interview, he/she shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and with respect to hearings, shall apply thereto. A record of such interview shall be made by the department and included with the report to the MEC.

D. The MEC shall make every effort to act upon the request within sixty (60) days after receiving the report from the department or receiving the request for corrective action, whichever is later. If the corrective action involving a potential adverse recommendation, or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the MEC prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such appearance shall be made by the MEC.

E. The action of the MEC on a request for corrective action may be to reject or modify the request for correction action; to issue a warning, a letter of admonition, or a letter of reprimand; to impose terms of probation but without special requirements of prior or concurrent consultation or direct supervision; to impose a requirement of prior or concurrent consultation or direct supervision, but which does not require the consultant or supervisor to approve a course of action; to develop other conditions on the physician's practice which do not constitute a restriction of privileges; to recommend the imposition of a prior or concurrent consultation requirement (a "mandatory concurring consultation requirement") by which the consultant must approve a course of action; to recommend reduction, suspension, revocation or other form of limitation of Clinical Privileges; to recommend that an already imposed summary suspension of Clinical Privileges be terminated, modified, or sustained; or to recommend that the Practitioner's Medical Staff membership be suspended or revoked.

F. Any recommendation by the MEC for reduction, suspension, or revocation of clinical privileges, including a mandatory concurring consultation requirement, or for suspension or expulsion from the Medical Staff, shall entitle the affected practitioner to the procedural rights provided in Section 4.9 of these Bylaws.

G. The Chair of the MEC shall promptly notify the Administrator in writing of all requests for corrective action received by the MEC and shall continue to keep the Administrator fully informed of all action taken in connection therewith. After the MEC has made its recommendations in the matter, the procedure to be followed shall be as provided in the Medical Staff Fair Hearing Manual.

5.4 Summary Suspension

A. Any one of the following: The Chief of Staff, the Chair of the appropriate Department, the CEO or his/her designee, the MEC, the Chair of the Board of Trustees and or its representative, shall each have the authority, whenever immediate action must be taken in

the best interest of patient care within the Hospital, to summarily suspend any portion or all of a practitioner's clinical privileges. Such action toward summary suspension shall become effective immediately upon imposition.

B. Unless the summary suspension was imposed by action of the MEC (in which case no further action on the part of the MEC shall be required), within three (3) business days after a summary suspension, the MEC shall convene to review and consider the action. The MEC may modify, continue, or terminate the terms of the summary suspension, provided that the summary suspension was not imposed by the Board or the chair of the Board. In the latter case, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, sustained or terminated.

An MEC recommendation to lift the suspension or to modify it to a lesser sanction not triggering procedural rights shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board.

Lifting of a summary suspension within fourteen (14) days of its imposition on the grounds that corrective action was not required shall not be deemed to have been adverse, and a statement to such effect shall be placed in the Practitioner's file. A summary suspension which remains in effect for fifteen (15) days or longer shall be deemed adverse.

C. Immediately upon the imposition of a summary suspension, the Chair of the MEC, or the responsible Chair of the Department, shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternative practitioner.

5.5 Automatic Relinquishment - Failure to Complete Medical Records

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations and Policies. Failure to complete the medical records that caused the relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff.

5.6 Action by Government Agency or Insurer

Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Medical Staff Office.

An individual's clinical privileges shall be automatically relinquished (or restricted as stated) if any of the following occur:

a. Licensure - Revocation, suspension or the placement of conditions or restrictions on an individual's license.

b. Controlled Substance Authorization - Revocation, suspension or the placement of conditions or restrictions on an individual's federal or state controlled substance certificate

c. Insurance Coverage - Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

d. Medicare and Medicaid Participation - Involuntary termination, exclusion or preclusion from participation in the Medicare or Medicaid programs. Bases for exclusion include

convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Loans.

e. Criminal Activity - Conviction, or a plea of guilty or a plea of no contest, pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance fraud or abuse or (iv) violence.

5.7 Failure to Provide Requested Information

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

5.8 Failure to Attend Special Conference

a. Whenever there is an apparent or suspected deviation from standard clinical practice or behavior involving any individual, the department chief or Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

b. The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

c. Failure of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the matter is resolved.

5.9 Rules, Regulations and Policies

Failure to abide by the Rules and Regulations of the Medical Staff, the rules of the department in which the practitioner has clinical privileges, or the Hospital's policies and procedures shall result in the imposition of an automatic suspension to the extent such rules and/or regulations authorize the imposition of an automatic suspension for such action. Such temporary suspension shall be lifted at such time as the conditions causing its imposition is corrected.

5.10 Practitioner Effectiveness Committee

Failure to meet the time requirements of the Medical Staff Practitioner Effectiveness Committee with respect to blood and/or urine testing if such testing has been made a condition of the Practitioner's appointment, shall result in a temporary suspension of the Practitioner's Staff appointment and clinical privileges pursuant to the terms of the Practitioner's agreement with said committee. (MS0030)

5.11 Reports to Federal and State Authorities

The CEO shall be responsible for submission of all reports required by federal or state law based upon professional review actions as that term is defined in the Health Care Quality Improvement Act of 1986, as amended, and formal disciplinary procedures. Prior to submission to the National Practitioner Data Bank or the Nevada State Board of Medical Examiners, the report shall be approved by the committee which reviewed the matter and/or by the Hospital's Board of Trustees.

The filing or non-filing of such reports, or any investigation or disciplinary action taken by the Nevada State Board of Medical Examiners, or lack thereof, shall not preclude any action to suspend, restrict, or revoke the Privileges of an appointee of the Medical Staff pursuant to these Bylaws.

Nothing herein shall be construed to be a waiver of the privileged and confidential status of the proceedings or records of the Hospital's Executive or other review committees.

5.12 Procedural Rights

a. Necessity for Adverse Action
When a Practitioner receives Special Notice of an adverse action by the MEC or the Board, the Practitioner is entitled, upon timely and proper request, to a hearing in accordance with the procedures set forth in the Medical Staff Fair Hearing Plan.

b. Process for Hearings and Appellate Reviews
All hearing and appellate reviews will be conducted in accordance with the procedures and safeguards set forth in the Medical Staff Fair Hearing Plan.

5.13 Confidentiality, Immunity and Releases

Special Definitions
For purposes of this Article only, the following definitions shall apply:

a. Information means record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communication whether in written or oral form relating to any of the subject matter.

b. Practitioner means a Staff appointee or Applicant.

c. Representative means the Board of Trustees of the Hospital and any trustee or committee thereof, the CEO or the CEO's designee; registered nurses and other employees of the Hospital; the Medical Staff organization and any appointee, officer, clinical unit or committee thereof; any individual authorized by any of the foregoing to perform specific information gathering analysis, use or disseminating functions.

d. Third Parties means any individual or organization providing information to any representative.

5.14 Authorizations and Conditions
By submitting an application for Staff appointment or reappointment or by applying for or exercising clinical privileges or providing specified patient care services at the Hospital, a Practitioner:

a. Authorizes representative to solicit, provide an act upon information bearing on his or her professional ability and other qualifications; and

b. Agrees to be bound by the provisions of the Article and to waive all legal claims against any representative who acts in accordance with the provisions of the Article; and

c. Acknowledges that the provisions of the Article are express conditions to his or her application for, or acceptance of, Staff appointment and the continuation of such appointment and to his or her exercise of clinical privileges or provisions or specified patient care services at the Hospital.

5.15 Confidentiality of Information
Information with respect to any Practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating monitoring or improving the quality, appropriateness and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in

compliance with the applicable standards of care or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each Practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Staff appointment and clinical privileges or specified services.

5.16 Immunity from Liability

a. For Action Taken

No representative of the Hospital or Medical Staff shall be liable to a Practitioner for damages or other relief for any decisions, opinion, action, statement or recommendation made within the scope of his or her duties as a representative, after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

b. For Providing Such Information

No representative of the Hospital or Medical Staff and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Practitioner who is or has been an Applicant to or appointee of the Staff or who did or does exercise Clinical privileges or provide specified services at this Hospital, provided that information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

c. Activities

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility's or organizations activities concerning, but not limited to:

a. Applications for appointment, Clinical privileges or specific services;

b. Periodic reappraisals for reappointment, Clinical privileges or specific services;

c. Corrective or disciplinary actions, recommended or taken;

d. Hearing and appellate reviews;

e. Quality assurance review program activities;

f. Utilization review and management activities;

g. Claims review;

h. Profiles and profile analysis;

I. Risk management activities; and

j. Other Hospital, committee, department, or Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

The immunity and confidentiality provisions of this Article are applicable:

(1) whether or not appointment or Clinical Privileges are granted;
(2) throughout the term of any appointment or reappointment period and thereafter;
(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.

d. Information

The information referred to in this Article may relate to a Practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency or appropriateness of patient care provided in the Hospital.

5.17 Releases

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and intent of this Article, subject to such requirements as may be applicable under the State and federal law. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases in connection with a disciplinary or corrective action shall be grounds for automatic suspension of Clinical privileges.

Failure to execute such releases in connection with conclusion of the provisional period shall be deemed a voluntary resignation of Staff appointment or particular Clinical privileges as appropriate to the context. Failure to execute such releases in connection with a disciplinary or corrective action shall result in the facts or circumstances that are the subject matter of the particular releases being construed in the most negative manner possible in relation to the Practitioner involved.

5.18 Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability are in addition to other protection provided by State and federal law and not in limitation thereof.

5.19 Conflict of Interest

In any instance where a member of any committee has, or reasonably could be perceived to be biased, or have a conflict of interest in any matter involving another Medical Staff member that comes before such committee, or in any instance where a member of a committee has requested an investigation of another member, or in any instance where a committee member is the subject of action by a committee, that committee member shall not participate in the discussion or voting on the matter.

However, the committee member may be asked and may answer any questions concerning the matter. The committee chair may routinely inquire prior to committee discussions on the matter, as to whether any member has any bias or conflict of interest. The existence of a bias or potential conflict of interest on the part of any committee member may be called to the attention of the chair by any committee member with knowledge of the matter.

The department chairs shall have the duty to delegate review of applications for appointment, reappointment, or Clinical Privileges or questions that may arise to the vice chair or other member of the department if the chair has a conflict of interest with the individual under review which could be reasonable perceived to be biased.

SECTION SIX: THE MEDICAL STAFF FAIR HEARING

6.1 Request For Hearing:

The hearing and appeals procedure is the administrative and judicatory process for resolution of actions taken against Medical Staff members. An aggrieved Medical Staff member must follow the applicable procedures set forth in Section 6.3 and Section 6.12.

6.2 Definitions:

The following definitions, in addition to those stated in other provisions of the Medical Staff Bylaws, shall apply to the provisions of this Fair Hearing Plan:

APPELLATE REVIEW BODY means the group designated pursuant to Section 6.16 of this Plan to hear a request for appellate review properly filed and pursued by a practitioner.

HEARING COMMITTEE means the committee appointed pursuant to Section 6.10 of this Plan to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

PARTIES means the practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review request is predicted.

PRACTITIONER means unless otherwise expressly limited, any appropriately licensed physician and allied health professional applying for, or exercising clinical privileges in this hospital.

SPECIAL NOTICE means notification via registered mail, properly addressed and postage prepaid with return receipt requested.

6.3 Initiation of Hearing

The following recommendations or actions shall, if deemed adverse pursuant to Section 6.4, entitle the practitioner affected thereby to a hearing:

a. Denial of initial staff appointment

b. Denial of reappointment

c. Suspension of staff appointment

d. Revocation of staff appointment

e. Limitation of admitting privileges

f. Denial of requested clinical privileges

g. Reduction in clinical privileges

h. Suspension of clinical privileges

i. Revocation of clinical privileges

j. Mandatory concurring consultation requirement

k. Any other action reportable to The National Practitioner Data Bank and/or State Medical Board.

In particular, without limitation, the following actions do not give rise to hearing rights: issuance of a warning, letter of admonition or reprimand; imposition of supervision or consultation requirements other than a mandatory concurring consultation; reduction, suspension or revocation of temporary privileges.

6.4 When Deemed Adverse

A recommendation or action listed in Section 6.3 shall be deemed an adverse action only when it has been:

a. Recommended by the Medical Executive Committee; or

b. A suspension continued in effect after review by the Medical Executive Committee and/or Board; or

c. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no prior right to a hearing existed; or

d. Taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee; or

6.5 Notice of Adverse Recommendation or Action

A practitioner against whom adverse action has been taken pursuant to Section 6.4 shall promptly be given special notice of such action by the CEO or his/her designee. The notice shall indicate that the practitioner has 30 days in which to request a hearing in accordance with the Medical Staff Bylaws and the Fair Hearing Plan. The physician will be provided a copy of the Fair Hearing Plan, the nature of the adverse recommendation, and a general description of the reasons for the adverse recommendation, delivered in person or sent certified registered mail, return receipt requested. The notice shall also include a statement that the adverse recommendation, if adopted, would be reported to their respective Medical Board of Nevada and/or National Practitioner Data Bank, if required by law.

6.6 Request for Hearing

A practitioner shall have thirty (30) days following his receipt of a notice to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the CEO or his/her designee in person or when sent by registered mail to the CEO or his/her designee, properly addressed and postage prepaid.

6.7 Waiver by Failure to Request a Hearing

A practitioner who fails to request a hearing within the time and in the manner specified in Section 6.6 waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled. Such waiver in connection with:

An adverse action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board.

An adverse recommendation by the Medical Executive Committee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the committee's recommendations at its next regular meeting following waiver. In its deliberations the Board shall review all the information and material considered by the committee. If the Board is in possession of information that would mitigate in favor of a different decision, the Board should send the matter back to the committee for a further hearing and recommendation.

The CEO or his/her designee shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Section 6.7 and shall notify the Chief of Staff of such action.

6.8 Hearing Prerequisites

a. Notice of Time and Place of Hearing

Upon receipt of a timely request for hearing, the CEO or his/her designee shall deliver such request to the Chief of Staff and/or to the Board, depending on whose recommendation led to the hearing.

b. The CEO will schedule the hearing and provide, by special notice, the following:

1. the time, place, and date of the hearing;

2. a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

3. the names of the Hearing Committee members, if known; and

4. a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

c. The date of commencement of the hearing shall not be less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for a hearing. An exception would be if the practitioner who requested the hearing voluntarily waives the minimum time limit and requests a shorter waiting period in writing and the Hearing Committee concurs or if the parties agree to a longer time period.

d. If a practitioner is under a summary suspension, the hearing will be scheduled to commence on a date not more than forty-five (45) days from the date of receipt of the request.

e. The Hearing Committee reserves the right to extend the above time frames.

f. If Legal Counsel are representing either party during hearing proceedings, they may be asked to leave at any time at the discretion of the hearing committee. Counsel is not permitted in closed sessions of meetings of the hearing committee.

6.9 Reserved

6.10 Appointment of Hearing Committee

a. By Staff - A hearing occasioned by a Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chief of Staff and composed of no fewer than three (3) members of the Active Staff. An outside neutral individual will be appointed as the presiding officer. The role of the presiding officer is to rule on matters of law, admissibility of evidence, rule on matters of the procedure and to facilitate the procedure. The presiding officer is not a voting member of the Hearing Committee.

b. By Board - A hearing occasioned by an adverse action of the Board pursuant to Section 6.4 or upon a request pursuant to Section 5.12 of the Medical Staff Bylaws, shall be conducted by a hearing committee appointed by the Chairman of The Board and composed of at least (3) persons. At least one (1) Active Staff member chosen with the advice of the Chief of the Staff shall be included on this committee when the issues concern professional competence or performance. An outside neutral individual will be appointed as the presiding officer. The role of the presiding officer is to rule on matters of law, admissibility of evidence, rule on matters of the procedure and to facilitate the procedure. The presiding officer is not a voting member of the Hearing Committee

6.11 Service on Hearing Committee

A staff or board member shall not be disqualified from serving on a hearing committee solely because he/she has heard of the case nor has knowledge of the facts involved or what he/she supposes the facts to be. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

Individuals involved in peer review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest[1] with the subject of the peer review activity.

[1] A conflict of interest exists when the individual has a blood relationship, employer/employee relationship, or other potential conflict that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of peer review.

Any objections to any member of the Hearing Panel shall be made in writing, within ten days of receipt of notice, to the CEO. The written objections must include the basis for the objection, and may include requested questions to be asked of the Hearing Panel member by the CEO. A copy of such written objections must be provided to the Chief of Staff. The Chief of Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objections and give notice to the parties.

6.12 Hearing Procedure

a. Personal Presence - The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 6.7.

b. The Presiding Officer of the Hearing Committee - The presiding officer shall act to maintain decorum and to ensure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all ruling on matters of law, procedure and the admissibility of evidence. The presiding officer is not a voting member.

c. Representation - The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the staff in good standing or by a member of his/her local professional society. The Medical Executive Committee or the Board, depending upon whose recommendation has prompted the hearing, shall appoint one of its members, or in the case of the Medical Executive Committee, any staff member to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provision of Section 6.28.

d. Rights of Parties - During a hearing, each of the parties shall have the right to:

1. Call and examine witnesses

2. Introduce exhibits

3. Cross-examine any witness on any matter relevant to the issues

4. Impeach any witness

5. Rebut any evidence, and/or

6. Submit a written statement at the close of the hearing

If the practitioner who requested the hearing does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

6.13 Procedure and Evidence

a. Pre Hearing Conduct - While neither side in a hearing shall have any right to discovery of documents or other evidence in advance of hearing, both parties shall exchange all documents that they intend to offer at least fifteen (15) days prior to the commencement of the hearing. Failure to disclose the identity of witnesses or to produce evidence at least fifteen (15) days prior to commencement of the hearing shall constitute good cause for a continuance. No documentary evidence shall be admitted or witnesses allowed to testify at the hearing unless the documents or names of witnesses were exchanged prior to the hearing as set forth herein.

The presiding officer of the Hearing Committee, in his/her, discretion, may allow evidence or testimony if it could not have been reasonably discovered and made available to the other party prior to the hearing.

The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memorandum concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The hearing committee may require one or both parties to prepare and submit to the committee, written statements of their position on the issues, prior to, during, or after, the hearing. The hearing committee may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and exhibits. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents.

b. Evidentiary Notice - In reaching a decision, a hearing committee may take note, for evidentiary purposes, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Nevada. Parties at the hearing shall be informed of the matters to be noticed and those matters shall be recited in the hearing record. Any party shall be given opportunity, in a timely manner, to request that a matter be evidentially noticed and to refute the evidentially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material contained on file in the hospital, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the staff and for clinical privileges.

“Taking notice” means the rule in the law of evidence that allows a fact to be introduced into evidence as if it is the truth (for example, a scientific fact that is well known or accepted in the medical community as standard of care). This would be an “evidentiary notice” determined by the committee.

c. Burden of Proof - The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence that is reasonable and warranted in support thereof, but the practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn there from are either arbitrary, unreasonable, or capricious.

d. Record of Hearing - The proceedings will be recorded by a court reporter. The cost of the court reporter will be shared between both parties unless waived by the committee.

e. Postponement - Request for postponement of a hearing shall be granted by the hearing committee only upon a showing of good cause.

f. Recesses and Adjournment - The hearing committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purposes of obtaining new or additional evidence or consultation. Upon conclusions of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of its deliberations, the hearing shall be closed.

6.14 Hearing Committee Report And Further Action

a. Hearing Committee Report - Within ten (10) days after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendation in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing. Practitioner will be given notice of final committee recommendations.

b. Action on Hearing Committee Report - Within thirty (30) days after receipt of the report of the hearing committee, the Medical Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered, to the CEO or his/her designee and Chief of Staff.

6.15 Notice and Effect of Result

a. Notice - The CEO or his/her designee shall promptly send a copy of the result to the practitioner by special notice, to the Chief of Staff and to the Board.

b. Effect of Favorable Result - Adopted by the Board - If the Board's result pursuant to Section 6.14 is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered closed.

c. Adopted by the Medical Executive Committee - If the Medical Executive Committee's result pursuant to Section 6.14 is favorable to the practitioner, the Chief of Staff shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's result in whole or in part, or by referring the matter back to the Medical Executive Committee for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO or his/her designee shall promptly send the practitioner special notice informing him of each action taken. Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse in any of the respects listed in Section 6.3, the special notice shall inform the practitioner of his/her right to request an appellate review by the Board as provided in Section 6.16 of this Plan.

d. Effect of Adverse Result - If the result of the Medical Executive Committee or of the Board pursuant to Section 6.14(b) continues to be adverse to the practitioner in any of the respects listed in Section 6.14. The special notice required by Section 6.3 shall inform the

practitioner of his/her right to request an appellate review by the Board as provided in Section 6.16 of this Fair Hearing Plan.

6.16 Initiation and Prerequisites of Appellate Review

a. Request for Appellate Review - A practitioner shall have ten (10) days following his/her receipt of a notice pursuant to Section 6.15 to file a written request for an appellate review. Such request shall be deemed to have been delivered to the CEO or his/her designee when received in person or when sent by registered mail to the CEO or his/her designee, properly addressed and postage prepaid, and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

b. Waiver by Failure to Request Appellate Review - A practitioner who fails to request an appellate review within the time and in the manner specified in Section 6.16 waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 6.7.

c. Notice of Time and Place for Appellate Review - Upon receipt of a timely request for appellate review, the CEO or his/her designee shall deliver such request to the Board. The Board shall promptly schedule and arrange for an appellate review which shall be not less than thirty (30) days from the receipt of the request for appellate review. However, if the practitioner is already under suspension then review shall be held as soon as arrangements for it can reasonably be made. Requests for postponement of a hearing should be granted liberally when requested by the practitioner, if it is reasonable to do so.

d. Appellate Review Body - The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of at least three (3) members of the Board, the Chief of Staff or his/her designee should be included in panel and at least one other active Medical Staff member, appointed by the Chairman of the Board of Trustees. When a committee is appointed, one of its members shall be designated as Chairman.

6.17 Appellate Review Procedure

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (1) substantial non-compliance with the procedures required by Medical Staff Bylaws; (2) the decision was not supported by substantial evidence based upon the hearing record; (3) the decision is not sustainable in light of new evidence as may be permitted pursuant to Section 6.21.

6.18 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, the committee's report, and all subsequent results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 6.18 and such other materials as may be presented and accepted under Sections 6.20 and 6.21.

6.19 Written Statement

The practitioner seeking the review shall submit a written statement detailing the findings of the fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the CEO or his/her designee at least seven (7) days prior to their review date. A written statement in reply may be submitted by the Medical Executive Committee or by the Board prior to the scheduled date of the appellate review.

6.20 Chairman of Appellate Review Body

The chairman of the appellate review body shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.21 Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body. Representation of either party by an attorney at law shall be governed by the provision of Section 6.28.

6.22 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

6.23 Powers

The appellate review body shall have all power granted to a hearing committee, and such additional powers as are reasonable appropriate to the discharge of its responsibilities.

The appellate review body may refer back to the original Hearing Committee if new evidence is reviewed and accepted.

6.24 Recesses and Adjournment

The appellate review body may recess the review proceedings and reconvene the same without additional notice. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations the appellate review shall be declared finally adjourned

6.25 Action Taken

The appellate review body may recommend that the Board affirm, modify or reverse the adverse result or action taken the Medical Executive Committee or by the Board pursuant to Section 6.14 or, in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within twenty-one (21) days. Within seven (7) days after receipt of such recommendation after referral, the appellate review body shall make its own recommendation to the Board as provided in this Section 6.25.

6.26 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in Section 6 have been completed or waived.

6.27 Final Decision of the Board

Board Action - Within fifteen (15) days after the conclusion of the appellate review, the Board shall render its final decision in the matter in writing and the CEO or his/her designee shall send notice thereof to the practitioner by special notice, and to the Medical Executive Committee.

6.28 General Provisions

a. Attorneys - If the affected practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance pursuant to Section 6.21, his/her request for such hearing or appellate review must so state. If the practitioner is not represented by an attorney, neither shall the Medical Executive Committee or the Board be allowed representation at the hearing or appellate review session. The foregoing shall not be deemed to limit the practitioner, the Medical Executive Committee or the Board in the use of legal counsel in connection with preparation for a hearing or an appellate review.

b. Waiver - If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

c. Number of Reviews - Notwithstanding any other provisions of the Medical Staff Bylaws or of this Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

d. Extensions - No applicant or medical staff member shall be entitled as a matter of right to more than one hearing or appellate review on any single matter that may be the subject of an appeal.

e. Release - By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of Section 5 of the Medical Staff Bylaws in all matters relating thereto.

6.29 Report to Authorities

Reports of disciplinary actions will be reported to the appropriate authorities upon completion or waiver of Fair Hearing procedures.

SECTION SEVEN: CREDENTIALING AND PRIVILEGING PROCEDURES

7.1 Initial Appointment Process

Requests for Medical Staff applications will be forwarded to the Medical Staff Office. Upon receipt, a Medical Staff application packet, including the appropriate Clinical Privilege Request Forms, will be forwarded to the requesting Practitioner.

The Applicant will be given the opportunity to go through the qualifications and requirements for Medical Staff membership and clinical privileging with a Hospital representative, either in person, by telephone or in writing.

If the Practitioner determines through completion of the pre-application questionnaire that he/she meets the eligibility requirements for Medical Staff appointment, the practitioner may complete and return the application and supporting documentation to the Medical Staff Office.

If an application is returned and it is later determined that the applicant does not meet the eligibility criteria for Medical Staff appointment, the application processing will be halted and the practitioner notified in writing. Termination of application processing for lack of meeting the eligibility criteria does not afford the practitioner rights to the Fair Hearing process.

7.2 Northern Nevada Standardized Application

Submission of the standardized Northern Nevada Application for Medical Staff membership from a practitioner applying at multiple facilities will not be considered complete for processing until the CTRMC facility specific documents are completed by the applicant and returned.

Attestation statements with signatures older than six months must be resigned prior to the beginning of the verification process.

7.3 Application Fee

A one time, non-refundable application filing fee in the amount of $500.00 must be submitted with the completed application. Applications returned without the fee are ineligible to be processed until the fee is submitted. If the fee has not been submitted within 30 days after notice, the application will be considered withdrawn.

7.4 Access to Medical Staff Bylaws

Copies of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures and other documents relating to clinical practice in the Hospital will be made available for review.

7.5 Application Content

Each Applicant must furnish complete information, accounting for all gaps in time, concerning at least the following:

a. Education

Undergraduate, medical school and postgraduate training, including the name of each institution, degrees granted, program completed, dates attended, and the names of Practitioners responsible for monitoring the Applicant's performance.

The board certification requirement shall be waived for any Practitioner who was an appointee of the Medical Staff prior to January 1, 1998.

b. Licensure

Applicants must provide evidence of all currently valid medical, dental, or other professional licensure or certifications, Drug Enforcement Administration registration, and any other controlled substances registration, with the date and number of each, unless specifically excused by the MEC in circumstances where a DEA is not needed to practice the privileges requested (e.g. Pathologists, Tele-radiologists). Except as otherwise provided, each

Member of the Medical Staff is strongly encouraged to maintain a DEA certificate that includes all drug schedules (2, 2N, 3, 3N, 4 and 5). Any exceptions to the full schedule DEA will be addressed on a case-by-case basis by the Credentials Committee and MEC. A copy of the Practitioner's current Nevada medical license, DEA, and Nevada Pharmacy certificate must accompany the application.

c. Professional Liability Insurance

Evidence of Professional Liability Insurance coverage in the amount of $1 million / $3 million and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names of present and past insurance carriers must be provided with the application.

d. Professional Sanctions

The nature and specifics of any pending or completed action involving denial, revocation, suspension, reduction, limitation, probationary requirements, non-renewal, voluntary or involuntary relinquishment (by resignation or expiration) of:

a. License or certificate to practice any profession in any state or country;
b. Drug Enforcement Administration or other controlled substances registration;
c. Appointment or fellowship in local, state or national professional organizations;
d. Specialty or sub-specialty board classifications or eligibility;
e. Faculty appointment at any medical or other professional school;
f. Staff appointment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution;
g. Adverse interactions with the Professional Review Organization; and/or
h. Medicare or Medicaid sanction.

e. Background

Location of offices; names and addresses of other practitioners with whom the Applicant is or was associated and inclusive dates of such association; names and locations of all other hospitals, clinics or health care institutions where the Applicant provides or provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges.

f. Legal Actions

An explanation of any medical related lawsuits in which the Applicant has been a party, including the status or resolution of each such lawsuit, and an explanation of any criminal charges of which the Applicant was found guilty or to which the Applicant plead guilty or no contest.

g. References

The Applicant must provide the names of at least three (3) peers for references of which at least:

1. one (1) is not a new or prospective partner to the Applicant and at least one

2. one (1) who is a similarly trained or clinically privileged peer, preferably of the same specialty,

3. all references should have personal knowledge of the Applicant's:

    a. current clinical ability;
    b. ethical character;
    c. health status;
    d. ability to work cooperatively with others, and
    e. who will provide specific written comments on these matters upon request from the Hospital or Medical Staff authorities.

The named individuals must have acquired the requisite knowledge through recent observation of the Applicant's professional performance over a period of time, and at least one (1) must have had organizational responsibility for supervision of the Applicant's performance (e.g., department chair, service chief, chief of residency training program, etc.)

7.6 Effect of Application

By signing the application, the Applicant:

a. Attests to the correctness and completeness of all information furnished. If it is discovered that there is a misstatement or omission, the Hospital may stop processing the application. If an appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. There is no right to a hearing or an appeal in this situation~~.~~;

b. Signifies his or her willingness to appear for interviews in connection with the application;

c. Authorizes and consents to Hospital Representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;

d. As set forth in these Bylaws, releases from any liability all those who review, act on or provide information regarding the Applicant's background, experience, clinical competence, professional ethics, utilization practice patterns, character, health status and other qualifications for Staff appointment and Clinical Privileges;

e. Agrees to continually throughout his/her Medical Staff appointment, abide by the Medical Staff Bylaws, related manuals, and any policies of the Hospital and Medical Staff which are in effect during the appointment; and

f. Pledges to provide for the continuous care of all patients under his/her care.

7.7 Processing the Application

a. Applicant's Burden

The Applicant has the burden of producing adequate information, within the allotted time frame, for a proper evaluation of his or her experience, training, current competence, utilization practice pattern, ability to work cooperatively with others, and health status. If at any time an individual does not supply information necessary to complete an application within the time frame indicated with the request, the application shall be deemed to be withdrawn.

An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Incomplete applications for appointment and reappointment will not be processed. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

The Applicant is also responsible for any resolution of doubts about the information provided and/or any questions regarding Staff appointment, staff category requested, Clinical Privileges and to satisfy any reasonable requests for information or clarifications, including health examinations, made by the appropriate Staff or Board authorities.

If the Medical Staff Application is not returned by the requesting Applicant within thirty (30) days, the application will be deemed to have been withdrawn.

b. Verification of Information

Primary source verification and processing of applications, both initial and reappointment, shall be conducted via a central verification service who will organize and coordinate the collection and verification, from primary sources whenever feasible, the information submitted by the applicant.

If problems are encountered in obtaining the required information, the Applicant will be informed of the nature of the problem(s) and what additional information the Applicant must provide. Upon receipt of such request, the Applicant has thirty (30) days in which to secure the appropriate information needed to complete the application. Failure without good cause by the practitioner to respond to the notification in a satisfactory manner shall be deemed a voluntary withdrawal of the application.

Verification requests shall include a recent photograph and a copy of the listing of Clinical Privileges requested by the Applicant to at least the Applicant's most recent affiliations with request for specific information regarding his or her competence in exercising those Privileges.

When collection and verification is accomplished and the application is deemed complete, the Medical Staff Manager shall notify the appropriate department chair.

c. Medical Staff Input

A listing of Medical Staff Applicants will be available in the Medical Staff Office and posted in a location convenient for Medical Staff review. Any Medical Staff appointee may submit, in writing or verbally to the Credentials Committee, any relevant information regarding an Applicant's qualifications for appointment or the Privileges requested. Any Practitioner may request or may be requested to confer with the department chair or Credentials Committee to discuss his or her statement.

d. Department Evaluation

The chair of each department in which the Applicant seeks Privileges shall review the application and its supporting documentation, solicit the opinion of his or her department members as indicated, and forward to the Credentials Committee a recommendation. All information sought or acquired by the chair as part of this evaluation must be considered in the recommendation.

A department chair may conduct an interview with the Applicant or request the Applicant be present at the next scheduled department meeting for such interview. If a department chair requires further information, the chair may defer transmitting his or her report but overall, the combined time should generally not exceed thirty (30) days.

In the case of a deferral, the applicable department chair must, through the office of the Medical Staff, notify the Applicant, the chair of the Credentials Committee, the CEO and the Chief of Staff in writing, of the deferral and the grounds for such. If the Applicant is to provide additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to the Applicant must so state, must be by Special Notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response.

Failure, without good cause, to respond with requested information within thirty (30) days of receipt of notice shall be deemed a voluntary withdrawal of the application.

e. Credentials Committee Evaluation

The Credentials Committee shall review the application, the supporting documentation, the reports from the department chair and any other relevant information available. If the Credentials Committee requires further information, it may defer transmitting its report, but

generally not for more than thirty (30) days, and it must, through the office of the Medical Staff, notify the Applicant, the Chief of Staff and the CEO in writing of the deferral and the grounds. If the Applicant is to provide additional information or a specific release/authorization to allow Hospital Representatives to obtain information, the notice to the Applicant must so state, must be by Special Notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. In the event the Credentials Committee is not scheduled to meet, the MEC will act on behalf of the Credentials Committee.

Failure, without good cause, of the Applicant to respond with requested information within thirty (30) days of receipt of notice shall be deemed a voluntary withdrawal of the application.

f. Action by the Medical Executive Committee

The MEC, at its next regular meeting, shall review the report of the Credentials Committee, as well as the reports and evaluations from the department chair(s), and any other relevant information made available to or requested by, the MEC. The MEC shall either defer action on the application, act favorably on the recommendation or act unfavorably on the recommendation and prepare a written report with recommendations as required by Section 6.5-9.

g. Effect of Medical Executive Committee Action

Deferral: Action by the MEC to defer the application for further consideration must, except for good cause, be followed up within thirty (30) days with its report and recommendation. The CEO shall advise the Applicant by Special Notice, through the office of the Medical Staff, of any action to defer, including a request for the specific data/explanation or release/authorization, if any, required form the Applicant and the time frame for response.

Failure, without good cause, of the Applicant to respond with requested information within thirty (30) days of receipt of notice shall be deemed a voluntary withdrawal of the application.

Favorable Recommendation: A MEC recommendation that is favorable to the Applicant in all respects shall be forwarded to the Board for final action.

Adverse Recommendation: An adverse MEC recommendation shall be forwarded to the office of the CEO who, through the office of the Medical Staff, shall promptly advise the Applicant by Special Notice of the recommendation and of the Applicant's procedural rights, if any, as provided in the Fair Hearing Plan.

h. Board of Trustees Action

If, as part of its deliberations pursuant to this Section, the Board determines that it requires further information, it may defer action and shall notify the Applicant and the Chief of Staff, in writing, of the deferral and the grounds. If the Applicant is to provide the additional information, the CEO, through the office of the Medical Staff Manager, shall advise the Applicant by Special Notice, including a request for the specific data/explanation or release/authorization, if any, required from the Applicant and time frame for response.

Failure, without good cause, to respond with requested information within thirty (30) days of receipt of notice shall be deemed a voluntary withdrawal of the application.

1. On Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, a favorable MEC recommendation or refer the MEC recommendation back 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 back to the Board.

2. Procedural Rights: In the case of an adverse MEC recommendation, the Board shall take final action in the matter as provided in the Fair Hearing Plan.

i. Content or Report and Basis for Recommendation and Actions

The report of each individual or group required to act on an application must include evaluations or recommendations as to approval or denial of, and any special limitations on Staff Appointment, Category of Staff Appointment and prerogative, department affiliation and scope of Clinical Privileges.

All documentation and information received by any individual or group, during or as part of the evaluation process, must be included with the application as part of the individual's central credentials file and, as appropriate or requested, transmitted with reports, evaluations, and recommendations. The reasons for each evaluation, recommendation, or action to deny, restrict, or otherwise limit must be stated, with reference to the completed application and all other documentation considered.

Any dissenting views from the majority position at any point in the process must also be documented in a minority report which shall state the reason for the differing view, and the information on which it is based, and the alternative evaluation or recommendation, if any. This minority report must be transmitted with the majority report.

j. Conflict Resolution

Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, the matter will be submitted to an Ad hoc committee composed of three (3) members each from the Medical Staff and the Board, appointed respectively by the Chief of Staff and the chair of the Board, for review and recommendation before the Board makes its decision.

k. Notice of Final Decision

Notice of the final decision shall be given through the office of the CEO and shall be delivered to the Applicant by Special Notice and to the Chief of Staff, the MEC and the applicable department chair.

A decision and notice to appoint shall include: (1) the Staff category to which the Applicant is appointed; (2) the department to which he or she is assigned; (3) the Clinical Privileges he or she may exercise; and (4) any special conditions attached to the appointment.

l. Time Periods for Processing

All individuals and groups required to act on an application for Staff appointment must do so in a timely and good faith manner and, except for obtaining required additional information or other than for good cause, each application should be processed within 120 days.

7.8 Re-application After Adverse Credentials Decision

Except as otherwise provided in this Manual or as determined by the Credentials Committee in light of exceptional circumstances, an Applicant or Staff appointee who has received a final adverse decision, or who has voluntarily resigned or withdrawn an application for appointment, Staff category, department assignment, or Clinical Privileges, shall not be eligible to reapply to the Medical Staff or for the denied/resigned/withdrawn category, department, or Privileges for a period of one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal.

Any such reapplication shall be processed in accordance with the procedures set forth above, and the Applicant or Staff appointee must submit such additional information as the applicable authorities of the Staff and the Board may reasonably require in demonstrating that the basis of any

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 further processed.

7.9 Provisional Status / Proctoring / Observation

New appointees of the Staff shall be subject to an initial provisional period of a minimum of one year under the Chair, or the Chair=s designee, i.e., a practitioner of the same or related specialty, of the respective department in which clinical privileges are requested. This observation/proctoring period is to determine the new appointee=s eligibility for exercising the clinical privileges requested. The observation period shall remain in effect until the following documentation is submitted to the Medical Executive Committee:

1. A signed statement from the Chair of the Department (or his designee) attesting that the practitioner meets all qualifications for, has discharged all responsibilities of, and has not exceeded or abused the prerogatives of his/her requested clinical privileges;

2. A signed statement from the Chair of the Department (or his designee) attesting that the practitioner has satisfactorily demonstrated competence to exercise his/her requested clinical privileges.

3. The protocol as defined in the policy AProctoring Provisional Staff@ shall be followed and proctor reports shall be completed in the approved format. Completed reports are to be submitted to the Quality Management Department.

7.10 Temporary Privileges

Temporary privileges may be granted under the following circumstances:

b. To meet an important patient care need. Important patient care needs include, but are not limited to, the care of a specific patient, when necessary to prevent a lack of services in a needed specialty area, or for proctoring.

b. To a new applicant whose application is complete and without derogatory substance, and is awaiting the review and approval process.

c. To an individual who will be serving as locum tenens for a member of the Medical Staff.

Any practitioner granted temporary privileges shall be under the supervision of the chair of the respective department who may revoke the temporary privileges at any time for any reason.

Temporary privileges shall not be used to circumvent the requirements of Medical Staff appointment.

Request must be submitted using the facility specific form with copies of the documents required. At a minimum, an AMA profile and NPDB will be obtained, State license(s) verified, OIG queried, proof of malpractice documented and a positive professional reference obtained.

a. Patient Need

When temporary privileges are requested to meet an important patient care, treatment or service need, the practitioner will complete an application for temporary privileges and provide copies of their medical license, DEA, state pharmacy certificate and malpractice certificate. In addition, the Hospital will verify information related to the practitioner's relevant training, experience, and current competence.

Temporary privileges may be granted for this circumstance for an initial period of thirty (30) days and must be renewed in 30 day increments as necessary for the care of a particular patient. Such privileges shall be restricted to provide care to the specific patient(s) for which they are granted.

Temporary privileges of this nature may not be granted for more than three (3) patients in any twelve (12) month period. If the Practitioner would have the need to care for additional patients, he/she must apply for Medical Staff membership.

b. Pendency of Completed Application

Temporary privileges may be granted after the application verification process has been completed for at least the following criteria and where no concerns have been identified:

1. Completed application
2. Current unrestricted licensure
3. Relevant training or experience (AMA profile is acceptable)
4. Current competence
5. Ability to perform the privileges requested
6. Query and evaluation of the NPDB information
7. No current or previously successful challenge to licensure or registration(s)
8. No subjection to involuntary termination of medical staff membership at another organization
9. No subjection to involuntary limitation, reduction, denial or loss of clinical privileges
10. Other criteria required by the Medical Staff Bylaws and related manuals

All temporary privileges are granted based upon the recommendation of the Chief of Staff or authorized designee with the approval of the CEO or authorized designee.

Temporary privileges for new applicants are granted for no more than 120 days.

c. Locum Tenens Privileges

Practitioners requesting locum tenens privileges must request and submit a completed Medical Staff application with supporting documentation. Temporary privileges may be granted, based upon need, as determined by the Hospital.

Practitioners requesting locum tenens privileges must meet all the requirements for Medical Staff membership and granting of clinical privileges and are subject to the same processing rules as defined in the Credentials Section.

Privileges in this category shall not exceed 120 days.

In the event a Practitioner in this category seeks to exercises privileges as a locum tenens more than once during a two year period, the practitioner will be required to update the information provided in the initial application.

7.11 Reserved

7.12 Termination

The Chief of Staff, the CEO or the Chair of the applicable department ~~must~~, on the discovery of any information or the occurrence of any event of a nature which raised a question about the Practitioner='s professional qualifications or ability to exercise any or all of the Temporary Privileges granted, may at any time, after consultation with the Department Chair responsible for supervision, terminate any or all of a Practitioner='s Temporary Privileges.

In the event of any such termination, the Practitioner='s patients then in the Hospital shall be assigned to another Practitioner by the Chair responsible for supervision. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

7.13 Rights of the Practitioner

A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws and the Fair Hearing Plan because his or her request for Temporary Privileges is refused in whole or in part or

because all or any portion of his or her Temporary Privileges are terminated, not renewed, restricted, suspended, or limited in any way.

7.14 Emergency Privileges

During times of an emergency, any Medical Staff member with clinical privileges is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff Status or clinical privileges provided that the care, treatment and services provided are within the scope of the individual's license.

7.14a Disaster Privileges

Disaster privileges may be granted when the hospital Emergency Response Plan has been activated and the hospital is unable to handle the immediate patient needs.

During disaster(s) in which the Hospital's Emergency Response Plan has been activated, the CEO, the CMO, the Chief of Staff or their designee(s) have the option to grant disaster privileges and is expected to make such decisions on a case-by-case basis at his or her discretion.

The determination to grant such privileges will be made on a case by case basis dependent upon the patient population and needs of the facility during such time of disaster. (Refer to policy MS0026)

7.15 Change of Classification or Privileges

Application for change of Medical Staff classification or for change in clinical privileges shall be submitted in writing to the appropriate clinical department, through the office of the Medical Staff. The credentials of the Medical Staff member shall be checked through the National Practitioner Data Bank prior to approval of additions to the Clinical Privileges presently held. The department=s recommendation will be forwarded to the Credentials Committee who will forward their recommendation to the Medical Executive Committee who will forward a final recommendation to the Board of Trustees for action.

All Practitioners requesting a change of departments and/or clinical privileges shall be required to undergo a provisional and proctoring period and must comply with any other defined provisions of provisional status.

7.16 Reappointment Process

Reappointments shall occur at the end of the initial one year Provisional period and every two years thereafter.

a. Information Collection

On or before ninety (90) days prior to the expiration of a Medical Staff appointee's appointment, a reappointment application packet will be forwarded to the practitioner. It is the practitioner=s responsibility to complete the request for reappointment and renewal of clinical privileges and return to the CVO at least sixty (60) days prior to the expiration date.

If any changes/additions are requested to Clinical Privileges as currently defined, this request must be made on the approved form with supporting documentation accompanying such request.

The requirement for accuracy and completeness as defined in the initial application process applies equally to the Reappointment application. Without limiting the foregoing, applications that are incomplete, or that become incomplete because of the need for additional information, shall not be processed.

The Appointee shall furnish, in writing, on the application provided, all information required to bring the Appointee's file current including, but not limited to, licensure, DEA, Nevada Pharmacy Certificate, Professional Liability Insurance, any pending, potential or settled suits, affiliations at other institutions and status thereat, Board Certification status,

disciplinary actions pending or completed, any changes in health status, attestation to maintenance of required Continuing Medical Education, specific requests for additions or deletions from Clinical Privileges presently held, with information regarding the basis for requesting said changes and specific requests for changes in Staff category or department assignments.

Failure, without good cause, to return the Reappointment application shall result in automatic expiration of that member's Medical Staff appointment and clinical privileges at the end of the appointment cycle.

A Practitioner whose appointment is so terminated is entitled to procedural rights provided in these Bylaws, solely for the purpose of determining the issue of whether "good cause" existed for failure to return the application.

b. Verification

Information provided on the Reappointment Application shall be verified, and the applicant will be notified of any information inadequacies, discrepancies, or verification problems. The Staff appointee shall then have the burden of producing adequate information and resolving any issues or doubts.

The Manager of Medical Staff Services shall transmit the reappointment application and all supporting information and to the chair of each department in which the appointee exercised Privileges during the last period of appointment.

c. Information Considered for Reappointment

All relevant information regarding the individual's professional and collegial activities, performance, and conduct from internal and/or external sources (as applicable) will be reviewed. Such information shall include, without limitation:

1. Patterns of care and utilization and overall professional performance and/or judgment as demonstrated in the findings of quality review and utilization management activities;

2. Participation in relevant continuing education activities

3. Level/amount of clinical activity (patient care contacts) at the Hospital, to ensure sufficient information is available to assess the individual’s competence;

4. Clinical judgment;

5. Sanctions imposed or pending and other problems;

6. Evidence of ability to perform;

7. Attendance at required Medical Staff, department and committee meetings;

8. Participation as a Staff officer or member;

9. Timely and accurate completion and preparation of medical records;

10. Cooperativeness in working with other Practitioners and Hospital personnel;

11. Compliance with all applicable Bylaws, Related Manuals, Rules and Regulations, policies, procedures of the Hospital and Medical Staff; and

12. Information on file with the National Practitioner Data Bank.

Every practitioner, by virtue of Medical Staff appointment or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him or her by the Board of Trustees.

7.17 Department Evaluation

Each chair of a department in which the Staff appointee requests or has exercised Privileges shall review the reappointment application, its supporting information, and pertinent aspects of the appointee's file and shall evaluate the information for continuing satisfaction of the qualifications for Staff appointment, the category of assignment, and the Privileges requested. The applicable chair(s) shall forward to the MEC a report which shall include the following:

a. A statement as to whether or not the chair has observed or been informed of any conduct which indicates significant present or potential physical, alcohol or drug dependence, or behavioral problems affecting the Practitioner's ability to perform professional and Medical Staff duties appropriately;

b. Any actions or information contained in the department's files that were not previously transmitted for inclusion in the Practitioner's credentials file to the Medical Staff Office concerning the Appointee's clinical performance, fulfillment of Medical Staff appointment category obligations, or satisfaction of any other qualifications for appointment or the Clinical Privileges granted; and

c. An evaluation regarding, and for any special limitations on, reappointment or non-reappointment and Staff category, department assignment and Clinical Privileges.

7.18 Credentials Committee Evaluation

The Credentials Committee shall review and evaluate the reappointment application and its supporting information, other pertinent aspects of the appointee's file, the chair(s) report, and all other relevant information available to it and prepare a written report with suggestions for, and any special limitations on, reappointment or non-reappointment and Staff category, department assignment, and Clinical Privileges. The Credentials Committee report shall be transmitted with all the chair(s) reports and supporting documentation as required, to the MEC.

In the absence of a meeting of the Credentials Committee, the Medical Executive Committee shall fulfill the functions of the Credentials Committee.

7.19 Completion, Final Processing and Board Action

Once a reapplication has been deemed complete and has been reviewed by the appropriate department(s), a recommendation will be forwarded to the Credentials Committee for further review and input. The Credentials Committee will make recommendation to the Medical Executive Committee who shall forward a final recommendation to the Board of Trustees for final action.

7.20 Basis for Recommendations and Action

The report of each individual or group required to act on a reappointment shall state the reasons for each adverse evaluation or recommendation made or action taken, with specific reference to the Staff appointee's credentials file and all other documentation considered. Any individual or group required to act on a reappointment may consider no or very minimal involvement at the Hospital by a Staff appointee over the last period of appointment such as lack of activity may prevent the Hospital from obtaining sufficient information to fulfill its duty to assess the competence of the practitioner at reappointment and on an ongoing basis. Any dissenting views at any point in the process must be documented by minority report which shall state the reason for the differing view, the information on which it is based, and the alternative recommendation, if any. This minority report must be transmitted with the majority report.

7.21 Time Periods for Processing

Transmittals of notices to Staff appointees and to appointees providing updated information shall be carried out in accordance with Sections 2.11-4 through 2.11-8 of this Manual. Thereafter, and

except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendation are acted on by the Board prior to the expiration date of Staff appointment of the Practitioner whose reappointment is being processed.

The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment processing has not been completed by an appointment expiration date through no fault of the Medical Staff member and where a lapse as a result of a delay in the reappointment process and a failure to grant such Privileges may result in patient harm due to the inability of any other Practitioner on the Medical Staff to provide the required medical care, temporary privileges may be granted to the Medical Staff member consistent with Section 2.14 of this Manual. If delay without apparent cause occurs at any step in the processing and is attributable to a Medical Staff or Hospital authority, the next higher may be directed by the Chief of Staff on behalf of the MEC or by the CEO on behalf of the Board to so proceed.

If the delay is attributable to the Practitioner=s failure to provide information required, the Practitioner shall not be eligible for temporary Privileges.

7.22 Systems & Procedures for Delineating Clinical Privileges

a. Department Responsibility

Each department must define, in writing:

1. The operative, invasive and other special procedures that fall within its clinical area;

2. Those skills and/or procedures that fall within the generally accepted core competencies of a well trained specialist in each field;

3. The formal training required to exercise privileges;

4. The required previous experience to exercise privileges.

5. The reappointment requirements to assure continued competency in the procedures;

6. Those additional privileges that are not part of the core competencies and that may require proof of addition training and/or experience.

These definitions are to be coordinated by the Credentials Committee and approved by the MEC and the Board. They must be periodically reviewed and revised, and shall form the basis for delineating Privileges within the Department. Specialty specific privilege request forms will be available from the Medical Staff Office.

b. Consultation and Other Conditions

There may be attached to any grant of Privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws and Related Manuals, Rules and Regulations and Policies of the Medical Staff, any of its clinical units or the Hospital, special requirements for consultation as a condition to the exercise of particular Privileges.

As a part of a request for Clinical Privileges, each Practitioner must:

1. Pledge that in dealing with cases outside of his or her training and usual area of practice, he or she will seek appropriate consultation or refer to a Practitioner who has expertise in such cases; and

2. Acknowledge that his or her request is circumscribed by Hospital and Medical Staff policies as may from time to time be in force.

c. Procedure for Delineating Privileges

1. Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for Core and any Special Request Clinical Privileges desired by the Applicant or Staff appointee.

Specific requests must also be submitted for temporary Privileges and for modification of Privileges in the interim between reappraisals.

2. Processing Requests

All requests for Clinical Privileges, except for those for temporary Privileges, shall be processed according to the procedures outlined herein.

3. Proctoring

Requests for new clinical privileges will be subject to requirements as defined in the Proctoring Policy MS0037.

d. Resigning Individual Privileges

A request to resign individual clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request. Resignation of specific core privileges will not be accepted if, in view of the Bylaws and Credentials Committee and the MEC, the request for resignation of such privileges is in attempt to avoid on call responsibilities.

7.23 Requirements for Successful Conclusion of Provisional Period

a. Review and Observation Required

The requirements for, applicability and duration of, and status of a Practitioner in the provisional period are set forth in the Proctoring policy. The department chair will prepare as part of the process for reviewing the provisional appointee, a summary of appointee's file with the same type of information as is collected under Section 2.18-3 of this Manual in connection with reappointments. This summary will be reviewed by the Credentials Committee and forwarded with recommendation to the MEC.

b. Statements Required

A provisional Medical Staff appointee's request and the request of a non-provisional Medical Staff appointee for increased Privileges must be accompanied by one or more of the following signed statements as applicable:

1. From the chair of the department in which the appointment was made attesting that performance was observed by the chair in accordance with Section 6.4-1 above, that the Practitioner has demonstrated the qualifications for the requested Staff appointment and Staff category, that the Practitioner has not abused his or her Prerogatives, and that the Practitioner has discharged his or her appointment obligations; and

2. From the chair of each department in which the Practitioner was granted initial or increased Clinical Privileges attesting that the Practitioner has satisfactorily demonstrated the ability to exercise those Privileges.

c. <u>Complaints</u>

In addition to the requirements for clinical performance, it is expected that the practitioner be free of significant complaints from staff, management and fellow physicians.

7.24 Extension of Provisional Period

If a practitioner is unable to meet volume criteria, if defined, with respect to a particular Clinical Privilege because the Practitioner's case load at the Hospital was inadequate to demonstrate ability to exercise that Privilege, the Practitioner may submit to the Credentials Committee, a statement to this effect describing his or her case load.

If recommended by the Chair of the applicable department, the Credentials Committee may extend the provisional period for exercising the Privilege or privileges involved for a defined period of time not to exceed one (1) additional year. Such action to extend the period shall be recommended to the MEC for action. Only one (1) such extension shall be permissible. Such an extension shall not be deemed adverse for purposes of the Fair Hearing Plan.

7.25 Leave Of Absence

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the COS or MEC. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

Members of the Medical Staff must report to the Medical Staff Office any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for the absence.

(2) The Medical Executive Committee/ Chief of Staff will determine whether a request for a leave of absence will be sent to the Board for action. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(3) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Staff.

Requests for reinstatement shall then be reviewed by the relevant department chairman, the Credentials Committee Chair, and the Chief of the Medical Staff. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical privileges at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the Credentials Committee, for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(4) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(5) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(6) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual 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.

(7) A Practitioner relinquishes all clinical privileges during the period a leave of absence and Medical Staff responsibilities are suspended. Medical staff dues must be paid, except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

(8) A Practitioner returning from a Leave of Absence based upon health reasons may be required to submit a Practitioner's report on the Practitioners' health and capability to resume practice and other documentation as the Practitioner Effectiveness Committee may require.

7.26 Resignations of Medical Staff Appointment

a. Resignations

A request for resignation from the Medical Staff, and the reason for such, shall be submitted in writing to the Board through the Chief of Staff. A request to resign must (a) specify the desired date of resignation, which must be at least 30 days from the date of the request unless an exception is granted by the Board, and (b) confirm that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. Notice of an approved resignation shall be provided to the Department, Credentials Committee, MEC and general Medical Staff.

b. Automatic Resignation

In those cases where a Staff appointee moves away from the area without submitting a forwarding address or the appointee's written intentions with regard to Medical Staff appointment, the appointee shall be deemed to have automatically resigned from the Medical Staff after approval by the MEC and the Board.

In those cases where a Medical Staff appointee moves away from the area and a forwarding address is known, the Practitioner will be asked his or her intentions with regard to Medical Staff appointment. If the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the Credentials Committee, MEC and Board for approval of automatic resignation. The Chief of Staff will inform the Medical Staff appointee by Special Notice of the approved resignation.

A resignation pursuant to this Section shall not give rise to any procedural due process rights under the Fair Hearing Plan.

SECTION EIGHT: MEDICAL STAFF OPERATIONAL ISSUES

8.1 Attendance

All members of the Medical Staff, as well as specifically appointed ex officio members are encouraged to attend al meetings of the Medical Staff departments, sections and committees to which they are appointed. Meeting attendance will not, however, be used as a criteria for reappointment evaluation.

Any Medical Staff member may attend meetings of other departments, sections or committee of which they are not assigned members by giving prior notice to and receiving approval from, the respective Chair of that department, section or committee.

Whenever special or ad hoc committees are appointed, only those physicians and other individuals appointed to serve are permitted to attend. However, if a request is made for a physician to attend for the purpose of addressing a specific issue(s), that physician is expected to attend.

At no time, unless a request is made and approved by the respective chairperson prior to the meeting date, will non members be permitted to attend Medical Staff meetings.

8.2 Quorum

Except as may otherwise be defined, a quorum for any department, section or other committee shall be defined to consist of those voting members present whenever a vote is taken. The action of the majority of the committee members present and voting shall be considered the act of the committee as a whole.

8.3 Dues

Annual Medical Staff dues shall be governed by the most recent action recommended by the MEC and adopted at a regular or special meeting of the General Staff as defined in Policy MS0027.

All members, regardless of staff category type except Honorary, who are appointed to the Medical Staff must pay dues as a condition of continued Medical Staff membership.

Dues shall be payable January 1st of each calendar year. Notices will be mailed from the Medical Staff Office. Non payment shall be construed as a voluntary resignation from the Medical Staff. After thirty (30) days from the date the second notices were mailed to practitioners, a listing of those practitioners who have still not paid dues will be presented to the Medical Executive Committee for action to accept a voluntary resignation from the Medical Staff for such non payment of dues. The practitioners affected by this action will be notified in writing.

SECTION NINE: MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff of Carson Tahoe Regional Medical Center has developed the following rules and regulations for all practitioners privileged to work at this facility.

9.1 EMERGENCY DEPARTMENT

There shall be a Practitioner with clinical privileges in Emergency Medicine responsible for the Emergency Room (ER) at all times.

Every patient presenting to the Hospital Emergency Room for care must receive a screening examination by the Emergency Practitioner or the patient's personal practitioner. All patients will be evaluated regardless of age, gender, race, creed and/or ability to pay.

Practitioners providing Emergency Medicine services shall be appropriately credentialed with clinical privileges and staff appointment as recommended by the Emergency Medicine Section of the Department of Medicine

The Emergency Room practitioner shall have the overall responsibility for emergency care in the Emergency Room. The term "emergent" shall be determined at the discretion of the Emergency Room practitioner.

If a patient requires admission to the Hospital and or surgical procedure(s), the on-call Practitioner for that specialty will be contacted to accept the patient. Assignment of the accepting Practitioner shall be at which time the Emergency Room physician requested the consultation.

Although the ER physicians do not have privileges to admit a patient to his or her own care, the ER physician may initiate the admitting process by writing orders in consultation with the patient's admitting physician. Once the patient leaves the Emergency Department, the patient is under the care of the admitting physician, and as such the admitting physician should be contacted for any further information regarding the patient's care.

Any physician evaluating a patient in the Emergency Room must have membership on the Medical Staff and be appropriately credentialed with clinical privileges at CTRMC.

It is the prime responsibility of Members of the Emergency Department to provide medical care to patients in the ER. However, instances will arise when it is appropriate for the ED physician to provide emergency care in the Hospital (e.g. codes, etc.).

9.2 COVERAGE OBLIGATIONS FOR MEMBERS OF THE MEDICAL STAFF

It is the duty of all Active and Courtesy Medical Staff Members to provide coverage to the Emergency Department ("ED"). While on ED Call, Members are required to respond to requests for in-house consultative services.

On Call time will be allocated equally on an individual basis. However, no physician shall be required to be on call for his/her specialty more than one in four days. Additional time may be allocated to a physician upon his or her request.

In cases of extreme emergency, the Emergency Department physician is authorized to obtain the services of any physician, regardless of Medical Staff category, who is immediately available to cope with the situation. In such a situation, any physician has the authority to provide whatever medication or treatment is deemed necessary by that physician, given the urgency of the situation.

A. OBLIGATIONS OF ON-CALL PHYSICIANS

1. While on call to the ED, physicians are required to:

a. Respond without discrimination on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance or economic status, or ability to pay for medical care.

b. Assist in the diagnosis and treatment of the patient, and when the patient's condition so warrants, accept continuing primary responsibility for the patient's care, including admission to the hospital and/or subsequent outpatient care.

c. Assist in the decision and arrangement for transfer in concurrence with the Emergency Department physician when the patient's condition so warrants and in accordance with applicable federal and state laws, Hospital transfer policies and procedures, and these Bylaws, Policies & Procedures, and Rules & Regulations.

d. Respond to the Emergency Department in a timely manner. The physician is expected to assume responsibility for the patient in a time frame appropriate for the patient's medical condition. If unable to do so, he/she must inform the ED of his /her back up physician. When no back up is available, or the critical patient's stay in the E.D. is prolonged because of physician issues, the E.D. will notify the Chair of that specific Department. The Chair will then arrange for appropriate care for the patient.

e. Respond to the ED when on call for the specialty in which core privileges are held.

2. Members of the Medical Staff who are, for any reason unavailable to care for their own inpatient admissions, are responsible for making appropriate formal arrangements for coverage by another appropriately credentialed member of the Medical Staff. The Practitioner is also responsible for communicating this information to the ED staff, his/her answering service, the Unit(s) in which any patients may already be hospitalized and documenting of the transfer of care within the patient(s) chart.

3. If the patient has previously been discharged from the on-call Practitioner's private practice, the Practitioner is still responsible for seeing the patient and/or arranging for alternate care/disposition of the patient.

4. Multiple Specialties Available - When two or more specialties maintain core privileges in a required specialty, including, but not limited to, hand call or facial fracture call, and an ED patient requires the services provided by those specialties, then the Emergency Department Physician ("EDP") may contact a Member on call in either specialty to cover the patient. The Member called must see the patient or obtain coverage from a Member in the other on call specialty.

B. FAILURE TO FULFILL ON -CALL OBLIGATIONS

If, after multiple contact attempts by the Emergency Department Physician, the on call physician has not responded, then the ED Physician will immediately place a call to the Member's specialty chairperson or, if unavailable, to the Chief of Staff. The specialty chairperson will notify the Chief of Staff after receiving such notification. Upon receiving such notice, the following sequence of corrective actions will be followed:

1. First Instance. For the first instance of a Member failing to fulfill his or her on call obligations, the Department Chair will send a written warning to the Member.

2. Second Instance. If the Member fails to fulfill his or her on call obligations for a second time within 12 months, the Chief of Staff will send to the Member a written request for a plan of corrective action to eliminate further instances of failing to fulfill his or her on call obligations. If appropriate, the Member also will be referred to the Practitioner Effectiveness Committee of the Nevada State Medical Association for intervention or assistance.

3. Third Instance. If the Member fails to fulfill his or her on call obligations for a third time within 12 months of the second instance, the physician will be suspended for a term to be recommended by the Bylaws and Credentials Committee and approved by MEC and the Board.

C. ASSIGNMENT OF PATIENTS WITHOUT ESTABLISHED PRIMARY CARE PROVIDERS

Patients presenting to the ER who do not have an established physician and who require admission will be assigned to the appropriate on call practitioner or Hospitalist. It is the responsibility of this practitioner to provide care throughout the period of hospitalization and for a minimum of three (3) weeks for follow-up if necessary for patients acquired when on call for unassigned patients.

D. EMERGENCY ROOM PATIENT MEDICAL RECORD

An appropriate Medical Record shall be incorporated into the patient's Hospital record if such exists. The record shall include:

a. Adequate patient identification;
b. Information concerning the time and means of the patient's arrival
c. Pertinent history of the injury or illness including details relative to first aid or emergency care prior to arrival;
d. Description of significant clinical laboratory and roentgen logic findings;
e. Diagnosis;
f. Treatment provided;
g. Condition of the patient on discharge or transfer;
h. Final disposition, including instruction(s) given to the patient and/or family.

E. TRANSFER OF PATIENTS

If the patient's condition requires services beyond those available at CTRMC, the patient shall be transferred to an appropriate referral institution consistent with the Hospital=s transfer policy and federal law (EMTALA) governing the appropriateness of transfer. (See Hospital Transfer Policy.)

a. Patients who request or require transfer to another Hospital will be readied for transfer so as to minimize the risk of transfer.

b. A transfer form will be completed on each patient transferred from the Hospital Emergency Room and the form will become a part of the Medical Record.

c. Patients refusing recommended transfer or requesting transfer against medical advise will sign the release on the release form after the patient has received proper information.

d. Prior to transfer, the patient must be accepted by a practitioner at the receiving hospital. and

e. A copy of the ER medical record must be sent with the patient.

F. DISCHARGE INSTRUCTIONS

Patients who are discharged from the Emergency Room, excluding those transferred will be provided written instructions for follow-up care.

The patient or responsible party will sign the instruction sheet and receive a copy. The staff person instructing the patient will witness, sign and date the form. This form becomes a part of the medical record.

G. LEAVING AGAINST MEDICAL ADVICE

Patients requesting to leave against the advice of the Emergency Room Practitioner shall sign the release on the medical record, and the incident shall be documented appropriately in the medical record.

Prior to departure of the patient, the Emergency Room Practitioner should attempt to assess the patient regarding mental competence. If mentally competent, the suspected diagnosis, the treatment and procedure(s) and the possible complications should be explained.

9.3 Requests for Consultations

The attending practitioner is responsible for requesting consultation(s) when indicated based upon the patient's condition and the attending's level of expertise:

All requests for consultations shall be recorded in the patient's medical record however, physician to physician communication is expected to take place.

The following are examples of when consultations may be appropriate:

1. To assess a patient's risk prior to surgical intervention;
2. When a diagnosis is obscure upon completion of diagnostic testing;
3. When there is doubt regarding the appropriate therapeutic measures;
4. When co-morbidities indicate additional skill sets may be needed;
5. When the patient exhibits severe psychiatric symptoms; etc.

9.4 ORDERS

No patient will be admitted to the Hospital without orders.

All orders must be legible, clear, complete, authenticated, and dated promptly by the person who is responsible for ordering or providing the service.

All orders, according to NRS 453.385 and NRS 454.223, Nurse Practice Act and standards for safety, must include the following:

- Patient Name
- Drug Name, Strength and route of administration
- Directions for use
- Date and Time Written
- Prescriber's name, signature and scope of practice, i.e. MD, DO, PA, NP

9.5 VERBAL ORDERS

Telephone or other verbal orders shall be valid if dictated to a person authorized to receive these.

A registered respiratory therapist, certified respiratory therapy technician, medical technician (ASCP, HEW), x-ray, nuclear and ultrasound technician and physical therapists may take verbal orders for medication and/or procedures within his/her area of competence and treatment and/or procedures within their area of competence and which they will deliver or perform.

Registered/Licensed dieticians are authorized to receive verbal orders pertaining to patients' diet and/or other nutritional needs.

All verbal orders shall be read back to the practitioner for clarification before placing the order.

All verbal orders shall be transcribed in the proper place in the medical record and shall include the date, time, name and the signature of the person transcribing the order. Verbal orders must be dated, timed and authenticated by the ordering practitioner within 30 days.

9.6 AUTHENTICATION OF ORDERS

A physician may sign (authenticate) another physician's verbal or telephone order if the signing physician is on the case or is in an on-call relationship with the physician giving the order, and the order seems logical and appropriate for the patient.

Authentication may include the signature of the person writing the order or a computer entry electronic signature by that person.

9.7 ORDERS BY PRACTITIONER DIRECTED ALLIED HEALTH PROFESSIONALS

An order by an AHP must be within the clinical privileges or the scope of practice approved by the supervising practitioner and granted through the credentialing process.

9.8 STANDING ORDERS

Standing orders for each Service, Practitioner or other clinical unit may be formulated. All such orders shall be subject to approval by the appropriate Department. All Standing Orders shall be available on the appropriate Hospital form and shall be signed by the Attending Practitioner. Standing orders shall be followed in absence of other specific orders. All standing orders must be reviewed at least annually and revised as necessary and dated with the date of the last review and/or revision.

9.9 OFF SERVICE NOTES

When an attending physician signs off a case, a written order shall clearly identify the new attending. Whenever appropriate due to the complexity of the case or prolonged length of stay, an off-service note is encouraged.

9.10 FORMULARY AND INVESTIGATIONAL MEDICATIONS

a. The Hospital Formulary/Drug List lists drugs available for ordering from stock, and each appointee of the Medical Staff agrees to the use of the Formulary as approved by the Medical Executive Committee. .

b. Use of investigational / experimental drugs must be approved by the IRB. Upon approval, these drugs must be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and within all regulations of the Federal Drug Administration and the Hospital policy regarding the same.

c. Each Adverse Drug Reaction is to be reported immediately by or to the prescribing practitioner and an Adverse Drug Reaction Report completed by the health care practitioner, RN or LPN detecting the reaction. Adverse drug reactions and physician notification shall be documented in the medical record.

9.11 FREQUENCY OF ROUNDS

Daily visits are required for all patients admitted to the hospital. The rounding physician may be the attending or other covering practitioner or designee. Daily progress reports, that are factual and appropriate at the time of observation, that are sufficient to permit continuity of care and transferability, shall be recorded.

9.12 ICU / CCU ADMISSIONS

Practitioners must evaluate patients admitted to the ICU/CCU within 4 hours of admission (changed from 12 hours) and at least daily thereafter.

Orders need to be reassessed upon transfer of the patient from the ICU/CCU or Telemetry to the floor, or from the floor to Telemetry or the ICU/CCU.

9.13 CONSCIENTIOUS OBJECTION

CTRMC as an institution has no conscientious objection and will honor all patients' advance directives, regardless of range of medical conditions or procedures. However, there may be individual physicians on the Medical Staff who, due to religion, ethical or moral conscientious objections, may be unwilling or unable to honor a patient's advanced directive.

9.14 PROVISIONAL DIAGNOSIS

The admitting practitioner shall provide the Hospital with a provisional diagnosis and give such other information as would be required to enable the Hospital to take action as is necessary to protect patients already in the hospital, or the patient being admitted to the hospital, from any source of danger.

9.15 MEDICAL RECORDS

A. REQUIRED CONTENT

The attending practitioner shall be responsible for the preparation of a complete, legible, and timely medical record for each patient for whom he/she is responsible. The record shall include:

1. Patient identification data. When not obtainable, the reason is entered in the record;
2. Patient medical history;
3. As appropriate to the age of the patient, a summary of psycho social needs;
4. Description and history of present complaints and/or illnesses;
5. Report of physical examination;
6. Diagnostic and therapeutic orders;
7. Evidence of appropriate informed consent. When consent is not obtainable, the reason is entered in the record;
8. Clinical observations, including results of therapy;
9. Reports of procedures, tests, and the results;
10. Patient condition upon discharge, including instructions, if any, to the Patient or significant other, on post-Hospital care;
11. Conclusion at termination of Hospitalization or evaluation/treatment.

B. AUTHENTICATION

All clinical entries in the patient's record must be accurately dated and timed and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials or computer key.

9.16 HISTORIES AND PHYSICAL EXAMINATIONS

An H & P must be completed for all patients who require admission, surgery and/or procedures which utilize anesthesia services.

The H&P shall be present on the chart prior to the start of any surgery and/or high risk procedure(s) requiring Anesthesia services.

Except for emergency cases, procedures will be delayed until the H&P is present in the medical record. H&P's must be completed as soon as possible following any emergency procedure(s).

The H&P shall be completed no more than 30 days prior to registration or admission or 24 hours after admission or registration. For a medical H&P's completed within 30 days, prior to registration or inpatient admission, an update documenting any changes in the patient's condition must be completed within 24 hours after registration or inpatient admission, but prior to surgery or procedure(s) requiring anesthesia services.

History and physicals completed greater than 30 days prior to registration or admission are unacceptable and a new H&P is required.

A qualified licensed independent practitioner (LIP), or other qualified practitioner, who is a member of the Medical Staff or Allied Health Professionals staff, must perform the H&P.

An H&P may be accepted from a LIP who is not a member of the Medical Staff, provided the H&P is reviewed, updated and authenticated by date, time and signature of a physician on staff at CTRMC.

Dentists, podiatrists and psychologists are responsible for that portion of the H&P relative to the service and/or care they will be providing. A medical practitioner is responsible for the medical portion of the H&P and for the medical care beyond the capabilities of the dentist, podiatrist or psychologist.

Oral and maxillofacial surgeons with a medical license may complete H&P's for their patients undergoing oral and maxillofacial surgery if that privilege has been granted. (Chart page 71)

9.17 CONSULTATION DOCUMENTATION

Consultation notes containing the findings through interviewing the patient, review of the patient's medical record, examination, diagnosis and recommendations shall be written or otherwise recorded within 48 hours. Physicians consulting on patients shall include the date of request of consultation, as well as the date of consultation, within the report recorded.

Whenever operative procedures are involved, the consultation note (including the Anesthesia note), except in emergency situations as so verified in the record, must be recorded prior to the operative procedure's occurrence.

Carson Tahoe Regional Healthcare / Carson Tahoe Regional Medical Center

Required Elements	**Complete H&P For all inpatients** Must be complete and on the chart within 24 hours of an admission or prior to an operative procedure (except in emergencies)	**Short Form H&P For outpatients**	
		Receiving General, Spinal & Epidural Anesthesia	Receiving Conscious Sedation and/or Regional Block
Chief Complaint and/or Provisional Diagnosis	X	X	X
Details of Present Illness	X	X	X
Allergies	X	X	X
Current Medications	X	X	X
Medical & Surgical History	X	X	Relevant to Procedure
Social & Family History Appropriate to Pt. Age	X	X	Relevant to Procedure
Inventory of Body Systems	X	X	Relevant to Procedure
Complete Physician Exam	X	X	Relevant to Procedure (must include cardiopulmonary exam)
Pre-op Diagnosis (Surgical / Procedural Patients)	X	X	X
Conclusions or Impressions	X	X	X
Plan of care	X	X	X

Physical examinations of the breast, genitalia, pelvis and rectum are only required if medically indicated.

9.18 SURGICAL CASES

Practitioners must be in the Procedure Room and ready to commence the procedure at the time scheduled.

Any problems in determining priority order of procedures will be referred to the Chair of the respective department for final decision.

Timing of admission of patients for scheduled procedures shall be at the discretion of the Attending and/or Anesthesia practitioner(s).

If a Practitioner feels a procedure or test is needed on an emergent / urgent basis, a physician to physician discussion shall be take place.

All tissue removed by biopsy shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.

The pathologist shall sign the Pathology Report of Findings.

9.19 POST-OPERATIVE MEDICAL CARE

The surgeon of record is responsible for:

1. Personally performing the post-operative medical care, or

2. Delegating post-operative care to another qualified practitioner, providing the surgeon of record remains primarily responsible for the patient's overall care unless the patient and the surgeon have agreed in advance to shift that responsibility to another practitioner; or

9.20 SURGICAL ASSISTANT

The use of a surgical assistant shall be at the discretion of the surgeon. Any appropriately credentialed and privileged physician, RNFA or certified surgical assist may be utilized.

Any questions regarding a required surgical assistant shall be presented to the Chair of the Surgery Department. If the Chair is not available, the Chief of Staff will be called for a decision in the matter.

9.21 OPERATIVE REPORTS

Operative reports must be dictated immediately upon completion of the operation or procedure. The post operative report must at a minimum contain:

a. the names of the primary surgeon and any assistants;
b. a description of the findings;
c. the technical procedures used;
d. any specimens removed (if appropriate);
e. the pre and post op diagnosis;
f. any estimated blood loss.

The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.

Prior to the patient being transferred to the next level of care, to allow for delays in transcription, and to ensure that pertinent information is available to the next caregiver, a comprehensive **post operative note** must be written in the medical record immediately after surgery. This applies to outpatient as well as inpatient surgical procedures.

9.22 OBSTETRICAL REPORTS

The current obstetrical record shall include a complete prenatal record. A legible copy of the attending practitioner's prenatal office record may be submitted for the Hospital record. An interval admission note must be written which documents any pertinent additions or changes to the patient's history and/or other physical findings.

9.23 SPECIAL PROCEDURES, TEST REPORTS AND PATHOLOGY

Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records and any other diagnostic or therapeutic procedures are to be completed promptly and filed in the record within 24 hours of completion, if possible.

All diagnostic and therapeutic procedures must be recorded and authenticated in the medical record.

Any reports from organizations outside the Hospital may also be included, in which case, the source organization must be identified in the report.

Only laboratory reports from State licensed and JCAHO or CAP approved facilities, or organizations meeting the applicable federal standards for clinical laboratories, may be placed on the Hospital record.

All tissue or cytology specimens removed from a patient in CTRMC facilities must be submitted to the CTRMC Pathology Department for examination unless exempted by the surgical specimen exemption list.

9.24 PROGRESS NOTES

Daily Progress Notes are required.

9.25 DISCHARGE SUMMARY

A discharge summary shall be written or dictated within 30 days of discharge for all hospitalized patients

A. The discharge summary shall include:

1. the reason for hospitalization;
2. the significant findings;
3. the procedures performed and treatment rendered;
4. the condition of the patient upon discharge;
5. any specific instructions given to the patient and/or family.

A final progress note which completely summarizes the events during an admission for an uncomplicated stay of 48 hours or less may be substituted for a formal dictated Discharge Summary.

The Discharge Summary is the responsibility of the attending physician of record at the time of discharge.

Discharge summary(s) is not required for (1) healthy newborns who remain in the hospital beyond 48 hours due to medical conditions the mothers; or for (2) healthy mothers who remain in the hospital beyond 48 hours due to medical conditions of the newborn.

B. Discharge Diagnosis

The discharge diagnosis must be recorded and clearly labeled in the:

a. Discharge Summary; or
b. Final Progress Note; or
c. Diagnosis / Procedure Sheet; or

For short stay patients or those patients in house less than 48 hours, when the final diagnosis is included in the H&P and/or Operative Note.

C. Continuity of Care

To facilitate transfer of a patient from the Hospital to another facility, the practitioner must complete the Consent of Transfer/Physician Referral and/or Convalescent Center Admission Orders.

D. In the Event of Death

A summation statement is added to the record either as a final progress note or as a separate summary. The final statement includes:

1. The reason for admission;
2. The findings and course in during hospitalization; and
3. The events leading to death

When an autopsy is performed (MS0014), provisional anatomic diagnoses are to be recorded in the medical record within three days and the complete protocol made part of the record within 60 days unless exceptions for special studies are established by the Medical Staff.

9.26 ABBREVIATIONS

The use of abbreviations will be in accordance with the Hospital policy.

Repeated use of prohibited abbreviations is considered a patient safety which may be considered grounds for disciplinary action.

9.27 MEDICAL RECORDS

All portions of the medical records, both inpatient and outpatient, should be completed at the time of discharge. The Medical Record must be completed and signed by the responsible practitioner within 30 days after the patient's discharge. Records not complete by the 30th day from the date of discharge will be considered delinquent.

No medical record shall be deemed complete until it is properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the practitioner responsible to complete the record, the Quality Management Committee shall consider the circumstances and may enter such reasons in the record and deem the chart completed.

Due to the current state of the technology systems, all documents in an active chart are considered attested to by the provider. These active records will have up to 30 days from the date of discharge to be electronically authenticated.

The exception to the 30 day completion requirement is the post operative note. In accordance with section 9.21, a post operative note is required immediately after the procedure is complete

a. DELINQUENT MEDICAL RECORDS

This is addressed in Hospital / Health Information Management Policy # 7528.

b. AUTOMATIC RELINQUISHMENT OF PRIVILEGES

Physician failing to complete their delinquent chart deficiencies within the specified time frames will be subject to automatic relinquishment of all elective Hospital privileges (MS Bylaws 5.5).

During the period of suspension the practitioner may not:

a. Admit patients;
b. Write orders for patients admitted by another physician who had not been seen or treated prior to the effective date of the suspension;
c. Schedule, perform or assist with any elective surgeries;
d. Act as a consultant on any case.

Practitioners must continue to fulfill their ER call obligations during this period, including performance of emergent or urgent surgeries, during all times that automatic relinquishment of ELECTIVE privileges has occurred and is in effect.

Privileges will be reinstated upon completion of the delinquent medical records. However, if any practitioner has automatically relinquished their privileges for failure to complete medical records more than two times within any three year period, or have failed to complete immediate post operative notes more than 5 times in any given 12 month period, the practitioner will automatically relinquish their clinical privileges for all CTH affiliated facilities for thirteen calendar days during which time ER call responsibilities must still be fulfilled but no elective hospital work will be permitted.

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9.28 AUTHENTICATION

All clinical entries in the patient's record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials or computer key.

9.29 OWNERSHIP AND REMOVAL OF RECORDS

All patient medical records, including x-ray film, pathological specimens and slides are the property of the Hospital and may be removed only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from the Hospital is grounds for corrective action.

9.30 ACCESS TO RECORDS

Access to patient records is permissible to appropriately credentialed practitioners.

9.31 CONSENTS

Except in an emergency, a general consent form must be signed by the patient or on the patient's behalf by a duly authorized representative and witnessed by a legally competent third party, at the time of admission. The Attending Physician will be notified whenever such consent has not been obtained. It is the responsibility of the Attending Practitioner to obtain such consent.

In the event of any life-threatening emergency whereby the patient or guardian is unable / unavailable to sign, two practitioners may certify that any delay incurred in attempting to obtain such signature is unwarranted and thereby waive the requirement for such consent. The

practitioner shall at least make a comprehensive note in the record regarding the patient's condition prior to the induction of anesthesia and/or start of any procedure.

APPENDIX A

Principles of Medical Ethics

As adopted by the AMA's House of Delegates June 17, 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and to self.

The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

All members of the Medical Staff of Carson Tahoe Regional Healthcare / Carson Tahoe Regional Medical Center are expected to practice within the following:

Principles of Medical Ethics

1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

2. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

4. A physician shall respect the rights of patients, colleagues, and other health professionals and shall safeguard patient confidences and privacy within the constraints of the law.

5. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical care.

7. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

8. A physician, while caring for a patient, regard responsibility to the patient as paramount.

9. A physician shall support access to medical care for all people.

The Medical Staff Bylaws, Rules and Regulations been reviewed and are accepted.

Approved by the Medical Staff:

Timothy McFarren, MD, Chief of Staff	05/21/2015 Date

Approved by the CTHR Board of Trustees:

Don Hattaway, MD, Chair	05/27/2015 Date

CARSON TAHOE
HEALTH

The Medical Staff Bylaws, Rules and Regulations have been reviewed and are accepted.

Approved by the Medical Staff:

Timothy McFarren, MD, Chief of Staff — 05/21/2015 Date

Approved by the CTRH Board of Trustees:

Don Hataway, MD, Chair — 05/27/2015 Date