University HOSPITAL
Newark, NJ

MEDICAL STAFF BYLAWS

September 2023

Part I: Governance

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at University Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board of Directors.

1.2 Authority

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies and under the corporate bylaws of the University Hospital. Henceforth, whenever the term "the hospital" is used, it shall mean University Hospital. Whenever the term "Chief Executive Officer" is used, it shall mean the Chief Executive Officer appointed by the Board to act on its behalf in the overall management of the University Hospital. The term Chief Executive Officer includes a duly appointed acting administrator serving when the Chief Executive Officer is away from the hospital.

1.3 Definitions

"Advanced Practice Professional" or "APP" means those individuals who are Advanced Practice Registered Nurses, Certified Nurse Midwives, Certified Registered Nurse Anesthetists (CRNAs), and Nurse Practitioners), and Physician Assistants (PAs). APPs are Members of the Medical Staff.

"Allied Health Professionals" means those individuals eligible for privileges, who are not Medical Staff Members, who are qualified by academic education and clinical experience or other training to provide patient care services in a clinical or supportive role. Allied Health Professionals exercise privileges only under supervision of a Member of the Medical Staff; these Allied Health Professionals are privileged clinical nurse specialists, speech/language pathologists performing endoscopy, registered nurse first assistants (RNFAs), cath lab techs, scrub techs, operating room technicians, and other individuals providing a medical or surgical level of care.

"Application" means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the ***Medical Staff Bylaws.***

"Appointee" means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, or APP holding a current license to practice within the scope of their license who is a Member of the Medical Staff.

"Board of Directors" or "Board" is the governing body of University Hospital

"Board Certification" is 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 Foot and Ankle Surgery as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

"Chief Executive Officer" or "CEO" is the individual appointed by the Board of Directors to serve as the Board's representative in the overall administration of University Hospital. The CEO may, consistent with their authority granted by the University Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

"Chief Medical Officer" or "CMO" is the individual, appointed by the University Hospital CEO, to serve as the chief liaison between administration and the Medical Staff.

"Clinical Privileges" or "Privileges" mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services with the Hospital.

"Days" shall mean calendar days unless otherwise stipulated in the ***Medical Staff Bylaws.***

"Denial" means an adverse action or recommendation regarding privileges made by the Medical Executive Committee (MEC) or Board which is based on the competence or professional conduct of an individual Practitioner.

"Dentist" means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in New Jersey.

"Ex-Officio" means serving as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights, without being counted for quorum purposes, or attend executive sessions.

"Good Standing" means having no adverse actions, limitations, or restriction on privileges or Medical Staff membership at the time of inquiry based on a reason of competence or conduct.

"Governing Council" means those six elected Members, who are the At-Large Voting Members of the MEC, who participate in advising the officers of the Medical Staff.

"Hearing committee" means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these ***Medical Staff Bylaws.***

"Hospital" means University Hospital and facilities operating under the UH Hospital License.

"Hospital Bylaws" mean those Bylaws established by the Board.

"Hospital Policy" means and includes the Bylaws Policies and Procedures of the Hospital; the Bylaws and Rules and Regulations of the Medical Staff as approved by the Board, rules and regulations of the Departments and other established policies, practices, and procedures of the Hospital.

"Licensed Practitioner" or "LP" means an individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision.

"Limitation" or "limited" means a restriction such that not the full extent of licensure/privileges are granted.

"Medical Executive Committee" or "MEC" shall mean the Executive Committee of the Medical Staff of University Hospital as provided for in Part I, Section 6 of the ***Medical Staff Bylaws.***

"Medical Staff or "Staff" means the organization of those individuals who are either medical physicians, osteopathic physicians, dentists, oral and maxillofacial surgeons, podiatrists, and APPs who have obtained membership status.

"Medical Staff Bylaws*"* means these Bylaws covering the operations of the Medical Staff of

University Hospital.

“Medical Staff leader” means Officers of the Medical Staff, Chief of Service, or Governing Council At-Large Members.

“Medical Staff Rules and Regulations” means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

“Medical Staff Year” is defined as the 12-month time period beginning on January 1 of each year and ending December 31.

“Member” is a physician, dentist, oral and maxillofacial surgeon, podiatrist, or APP who has been granted this status by the Board of Directors of University Hospital.

“Nominating Committee” means the committee that nominates candidates for available Medical Executive Committee, At-Large positions, and the Officers of the Medical Staff. The composition of this committee is noted in the Organization and Function Manual of the Rules and Regulations.

"Notice" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

“Oral and Maxillofacial Surgeon” means a licensed dentist with advanced training qualifying them for board certification by the American Board of Oral and Maxillofacial Surgery. The term “dentist” as used in these Bylaws includes oral surgeons.

“Patient care activity” is defined as an inpatient admission, inpatient or outpatient or practitioner encounter in a Hospital based provider practice setting.
“Physician” means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of New Jersey.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in New Jersey.

“Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, clinical psychologist, Advanced Practice Professional, or Allied Health Professional who has been granted clinical privileges.

“Prerogative” means the right to participate, by virtue of Medical Staff category or otherwise, granted to a Practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

“President of the Medical Staff” means the President of the Medical Staff as noted in Part I, Section 4 of these ***Medical Staff Bylaws.***

“Reduction” means a limitation of previously granted prerogatives

“Relinquished” means a surrender of previously granted prerogatives

“Representative” or “Hospital Representative” means the Board and any Director or committee thereof; the CEO or their designee; other employees of the Hospital; a Medical Staff organization or any Member, Officer, Service or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to

gathering, analysis, use of dissemination of information.

“Restricted” or “restriction” means a limitation such as to not grant the full extent of licensure/privileges.

“Revocation” means a nullification, or withdrawal, of previously granted prerogatives.

“Service” means a grouping of like Practitioners as noted in Part I, Section 5 of the Medical Staff Bylaws and further defined in the Rules and Regulations, Article VIII, Organization and Functions of the Medical Staff.

“Service Chief” also known as Chief of Service means an Active Medical Staff Member who has been selected in accordance with and has the qualifications and responsibilities for Service Chief as outlined in Part I, Section 5.2 and Section 5.3 of these Bylaws.

“Special Notice” means written notice sent via certified mail, return receipt requested or by hand delivery evidenced by a receipt signed by the Practitioner to whom it is directed.

“Summary suspension” means a suspension imposed immediately, by the individuals identified in these Bylaws based on a good faith belief, in order to protect patients or staff from imminent danger

“Suspension” or “suspended” means a temporary limitation on the prerogatives of membership and/or privileges

“Termination” means a permanent limitation on the prerogatives of membership and/or privileges.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and APPs who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated Rules and Regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The Hospital shall not discriminate in granting membership and/or clinical privileges on the basis of national origin, race, ethnicity, sex, gender identity or expression, sexual orientation, religious beliefs, age, military status, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other legally impermissible basis.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the MEC to the Board except for temporary, emergency and disaster privileges as outlined in Part III, Credentials Procedures Manual. Appointment and reappointment to the Medical Staff shall be for no more than thirty-six (36) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

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

2.6 Responsibilities

2.6.1 Each Practitioner must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.6.2 Each Practitioner must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Each Practitioner , consistent with their granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the Rules and Regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each Practitioner must submit to any pertinent type of health evaluation, which may include blood, urine, or other testing as requested by any two (2) of the following: the Officers of the Medical Staff, CMO, and/or applicable Service Chief when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the Member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment.

2.6.5 Each Practitioner must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and hospital.

2.6.6 Each Practitioner must abide by the Hospital Code of Conduct policy.

2.6.7 Each Practitioner must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. Each Medical Staff Member and practitioner with privileges shall notify the Medical Staff Office within thirty (30) calendar days of any and all malpractice claims filed in any court of law against the Practitioner.

2.6.8 Each Practitioner must comply with Medical Staff approved clinical protocols and guidelines.

2.6.9 Each Practitioner agrees to notify the Medical Staff Office of any changes of information in the following manner:

a. Immediate, within twenty-four (24) hours:

i. notification for changes related to professional liability insurance, licensure, DEA, ability to participate in federally funded programs;

ii. a felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder);

iii. or termination of membership or privileges from a hospital unaffiliated with University Hospital.

Prompt notification, within one (1) month, for changes related to:

i. felony conviction other than noted above;

ii. conviction of any alcohol or drug offenses;

iii. suspension of Medical Staff membership and/or privileges at any hospital unaffiliated with the University Hospital, and;

iv. any final judgments in professional liability suits.

2.6.10 Each Practitioner agrees to fulfill the continuing education requirements as defined by the appropriate New Jersey licensing board and will provide documentation of such upon demand by the Medical Staff.

2.6.11 Each Practitioner agrees to release from any liability performed or made in good faith and without malice, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the credentials and quality of care or professional conduct provided by the Medical Staff Member or Practitioner.

2.6.12 Each Practitioner shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the Practitioner provides care in the hospital, or within its facilities and Services.

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

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

c. The content of complete and focused history and physical examinations is delineated in the Rules and Regulations.

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

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

2.6.15 Each Practitioner shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical Staff leadership will address conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.6.16 Each Medical Staff Member shall pay dues. The annual dues are determined by the Medical Staff Governing Council. Failure to pay Medical Staff dues will result in the loss of voting privileges and other membership benefits.

2.7 Medical Staff Member Rights

2.7.1 Each Medical Staff Member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such Practitioner is unable to resolve a matter of concern after working with their Service Chief or other appropriate Medical Staff leader(s), the Practitioner may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each Medical Staff Member in the Active category has the right to initiate a recall election of a Medical Staff Officer or Medical Executive Committee At-Large Member by following the procedure outlined in Section 4.5 of these Bylaws regarding removal and resignation from office.

2.7.3 Each Medical Staff Member in the Active category may initiate a call for a general Medical Staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the Active category. Upon presentation of such a petition, the MEC shall schedule a general Medical Staff meeting for the specific purposes addressed by the petitioners. No business other than detailed in the petition may be transacted.

2.7.4 Each Medical Staff Member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event a rule, regulation, or policy is thought to be inappropriate, any Medical Staff Member may submit a petition signed by twenty percent (20%) of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each Medical Staff Member in the Active category may call for a Service meeting by presenting a petition signed by twenty percent (20%), but not less than two (2) of the Members of the Service. Upon presentation of such a petition the Service Chief will schedule a Service meeting.

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

2.7.7 Any Practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's Hearing and Appeal Plan (Part II of these Bylaws).

2.8 Indemnification

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

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

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Members of this category must be a licensed Physician, Dentist, or Podiatrist and be involved in:

a. at least sixty (60) patient care activities per three (3) years. A patient care activity is defined as an inpatient admission, inpatient or outpatient or practitioner encounter in a Hospital based provider practice setting.

In the event a Member of the Active category does not meet the qualifications for reappointment to the Active category, and if the Member is otherwise abiding by all Bylaws, Rules and Regulations, and policies of the Medical Staff and hospital, the Member may be appointed to another Medical Staff category if they meet the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

a. Attend Medical Staff, Service, and committee meetings of which they are a Member and any Medical Staff or hospital education programs;

b. Vote on all matters presented by the Medical Staff, Service, and committee(s) to which the Member is assigned; and

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other Medical Staff functions as may be required; and

c. Shall pay dues. The annual dues are determined by the Medical Staff Governing Council. Failure to pay Medical Staff dues will result in loss of voting privileges and other membership benefits.

d. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

3.2 The Courtesy Category

3.2.1 Qualifications

The Courtesy category is reserved for licensed Physician, Dentist, or Podiatrist Medical Staff Members who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives

Members of this category may:

a. Attend Medical Staff and Service meetings of which they are a Member and any Medical Staff or hospital education programs;

b. Not vote on matters presented by the entire Medical Staff or Service, or be an At-Large Member or Officer of the Medical Staff; and

c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities

Members of this category shall:

a. Have the same responsibilities as Active category Members.

3.3 The Affiliate Category

3.3.1 Qualifications

The affiliate category is reserved for members who primarily have an office-based practice, but who refer their patients to other Members of the Medical Staff for admission, evaluation and treatment.

3.3.2 Prerogatives

Members of this category may:

a. Not be eligible for clinical privileges, not manage patient care in the hospital and not vote on medical staff affairs or hold office.

3.3.3 Responsibilities

Members of this category shall:

a. Fulfill or comply with any applicable Medical Staff or Hospital policies and procedures.

b. Be appointed to a specific Service and be responsible to the appropriate Chief of Service.

3.4 **The Adjunct Category**

3.4.1 Qualifications

The Adjunct category is reserved for Advanced Practice Professional "APP" who are Advanced Practice Registered Nurses (certified nurse midwives, certified registered nurse anesthetists (CRNAs), and nurse practitioners), and physician assistants (PAs).

3.4.2 Prerogatives

Members of this category may:

a. Exercise judgment within the APP's area of competence, providing that a physician Member of the Medical Staff has the ultimate responsibility for patient care;

b. Shall not admit patients and may attend patients only in collaboration with or under the supervision of a member the Active or Courtesy Staff;

c. May vote on all matters presented to the committees to which the member is appointed.

d. Elect an Adjunct representative to be a member of the Medical Executive Committee.

3.4.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other Medical Staff functions as may be required; and

c. Shall pay dues. The annual dues are determined by the Medical Staff Governing Council. Failure to pay Medical Staff dues will result in loss of voting privileges and other membership benefits.

d. Fulfill or comply with any applicable medical staff or hospital policies and procedures.

3.5 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those practitioners who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff or Service meetings, continuing medical education activities, and may be appointed to committees. They are not Members and shall not hold clinical privileges, hold office or be eligible to vote.

Section 4. Officers of the Medical Staff, At-Large, and Adjunct Members of the MEC

4.1 Officers of the Medical Staff

4.1.1 President of the Medical Staff

4.1.2 President-Elect of the Medical Staff

4.1.3 Secretary/Treasurer

4.1.4 Immediate Past President of the Medical Staff

4.2 Qualifications of Officers and At-Large Members of the MEC

4.2.1 Officers and At-Large Members of the MEC must be Members in good standing of the Active category; indicate a willingness and ability to serve; have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges; have previous leadership experience or membership on a performance improvement committee for at least one (1) year; be willing to attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of office, and be in compliance with the professional conduct policies of the hospital. The President and President-Elect of the Medical Staff must be either a physician, dentist, or podiatrist. The Medical Staff Nominating Committee will have discretion to determine if a Medical Staff Member wishing to run for office meets the qualifying criteria.

4.2.2 Officers and At-Large Members of the MEC may not simultaneously hold a leadership position (Medical Staff Officer or Service Chief) on another hospital's or Health System's medical staff. Noncompliance with this requirement will result in the Officer being automatically removed from office.

4.2.3 Officers and At-Large Members of the MEC may not serve as the CEO, CMO, CQO, Dean or any other administrative role at University Hospital or another hospital or any other administrative role in the affiliated or any other medical or dental schools.

4.3 Election of Officers and At-Large Members of the MEC

4.3.1 The Nominating Committee shall meet at least two (2) months prior to the election and nominate at least one (1) candidate for each of the positions of President-Elect of the Medical Staff, Secretary-Treasurer, and six (6) At-Large Members. Nominations must be announced, and the names of the nominees announced at least thirty (30) days prior to the election. All nominees for office must disclose conflicts of interest as described in Part I, 2.6.15.

4.3.2 A petition signed by at least twenty percent (20%) of the Members of the Active Medical Staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Nominating Committee at least forty-five (45) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before they can be placed on the ballot at least thirty (30) days prior to the election.

4.3.3 Elections shall take place by ballots cast by Active Medical Staff Members in good standing returned by the election deadline. The nominee(s) who receives the most votes wins. In the case of a tie vote, a run-off election will be held between the top two vote receivers.

4.3.4 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position.

4.4 Qualification, Nomination and Election of Adjunct Staff Member of the MEC

One member of the Adjunct Staff shall be elected as a representative member to the MEC with vote.

4.4.1 Qualification of Adjunct Staff Member of the MEC

The Adjunct Staff Member of the MEC must be a member in good standing of the Adjunct staff, indicate a willingness and ability to serve; have no pending adverse recommendations concerning Adjunct Staff appointment or clinical privileges; be in compliance with the professional conduct policies of the hospital. The Medical Staff Nominating Committee will have discretion to determine if an Adjunct Staff Member wishing to run for office meets the qualifying criteria. All nominees must disclose conflicts of interest as described in Part I, 2.6.15.

4.4.2 Nominations of Adjunct Staff Member of the MEC

Nominations of Adjunct Staff member to the MEC shall be by petition signed by at least twenty percent (20%) of the Members of the Adjunct Staff in good standing with written consent of the individuals being nominated. Nominations must be announced, and the names of the nominees announced at lest thirty (30) days prior to the election.

4.4.3 Election of the Adjunct Staff Member of the MEC

Election shall take place by ballots cast by Adjunct Staff Members returned by the election deadline. The nominee(s) who receives the most votes wins. In the case of a tie vote, a run-off election will be held between the top two vote receivers.

4.5 Term of Office

All Officers, At-Large Members and Adjunct Staff serve a term of two (2) years. They shall take office on January 1st following their election. Each officer shall serve in office until the end of their term of office or until a successor is appointed/elected or unless they resign sooner or is removed from office. The President and President-Elect may serve only one term, as there is automatic succession from President-Elect to President. The Secretary-Treasurer may serve up to two (2) consecutive terms.

4.6 Removal and Resignation of elected members (Officers, At-Large and Adjunct) from Office

4.6.1 **Automatic Triggers for Removal:** Automatic triggers for removal shall be for failure to meet or maintain any of the qualifications for being an elected Member of the MEC. If the MEC determines that this has occurred, the elected member shall be removed automatically. If the individual considered for removal is the President of the Medical Staff, then the failure to meet or maintain the qualifications of Office will be determined by the MEC.

4.6.2 **Removal by Vote of the Medical Staff:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs. The Medical Staff may initiate the removal of any elected Member of the MEC, if at least twenty percent (20%) of the Active Members sign a petition advocating for such action or twenty percent (20%) of the Adjunct Members for Adjunct Member of the MEC. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those Medical Staff Members casting ballot votes.

4.6.3 **Resignation:** Any elected Officer, or At-Large Member of the MEC, may resign at any time by giving thirty (30) days' written notice to the MEC. Such resignation takes effect on the date that the request for resignation is made, when a successor is elected, or any later time specified therein.

4.7 Vacancies of Office

a. If there is a vacancy in the office of the President of the Medical Staff, the President-Elect of the Medical Staff shall serve the remainder of the term, and then their own term.

b. If there is a vacancy in the office of the President-Elect, the Secretary/Treasurer shall serve the remainder of the term.

c. If there is a vacancy in the office of the Secretary-Treasurer, the President of the Medical Staff shall appoint an Active Member who meets qualifications to the vacant position for the remainder of the term.

d. If there is a vacancy in the office of the Immediate Past President, the position shall remain vacant.

e. If there is an At-Large Member vacancy, the Medical Staff President shall appoint an Active Member of the Medical Staff who meets qualifications to the vacant position for the remainder of the term.

f. If there is an Adjunct Member vacancy, the Medical Staff President shall appoint an Active Member of the Medical Staff who meets qualifications to the vacant position for the remainder of the term.

4.8 Duties of Officers

4.8.1 President of the Medical Staff**:** The President of the Medical Staff shall represent the interests of the Medical Staff to the MEC and the Board. The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, Rules and Regulations, and policies. Specific responsibilities and authority of the President of the Medical Staff, or designee, are to:

a. Call and preside at all general and special meetings of the Medical Staff;

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

c. Serve as the individual assigned the responsibility for the organization and conduct of the hospital's Medical Staff;

d. Enforce Medical Staff bylaws, Rules and Regulations, and Medical Staff/hospital policies;

e. Except as stated otherwise, appoint committee chairs of the Medical Staff Standing Committees in consultation with the Chiefs of Service and the CMO, subject to the approval of the MEC.

f. Appoint all members of Medical Staff standing and ad hoc committees in consultation with the Chiefs of Service and the committee chair;

g. In consultation with hospital administration and the Chiefs of Service, appoint Medical Staff Members to appropriate hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions;

h. In consultation with the chair of the Board and the Chiefs of Service, appoint the Medical Staff Members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

i. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

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

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

l. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

m. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

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

o. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and

p. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff bylaws.

4.8.2 **President-Elect of the Medical Staff:** In the absence of the President of the Medical Staff, the President-Elect of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. This officer shall serve as chair or co-chair of the Hospital wide quality committee. They shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.8.3 **Secretary/Treasurer:** This officer will collaborate with the hospital's Medical Staff Office, assure maintenance of minutes, attend to correspondence, act as Medical Staff treasurer, and coordinate communication within the Medical Staff. They shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.8.4 **Immediate Past President of the Medical Staff:** This officer will serve as a consultant to the President of the Medical Staff and President-Elect of the Medical Staff and shall serve as Co-Chair of the Medical Staff Bylaws Committee

4.8.5 **At-Large Members of the MEC:** These Members will advise and support the Medical Staff officers and are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff is organized into Services. The Medical Staff may create Divisions and/or Sections within a Service in order to facilitate Medical Staff activities. A list of Services organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is part of the Rules and Regulations.

The MEC, with approval of the Board, may designate new Medical Staff Services or dissolve current Services as it determines will best promote the Medical Staff needs for patient care, promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Service Chiefs

5.2.1 Qualifications. All Service Chiefs must be faculty members of the Rutgers New Jersey Medical School or the Rutgers School of Dental Medicine with the exception of podiatry. They must also be Active Members of the Medical Staff, be in good standing, have relevant clinical privileges, and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. Service Chiefs may not simultaneously hold a leadership position (Medical Staff Officer or Service Chief) on another hospital's or Health System's medical staff; however, exceptions can be made by the CEO when it is deemed in best interest of the organization.

5.2.2 Selection. After mutual consultation with the CEO, the Dean of the Rutgers New Jersey Medical School or the Dean of the Rutgers School of Dental Medicine shall nominate candidates for Chiefs of Services. The CEO shall either appoint the Dean's nominee as Chief of Service or reject the nominee. If the CEO rejects the nominee as Chief of Service, the Dean shall nominate a different candidate for the position of Chief of Service.

The Chief of Service for Podiatric Services shall be selected by the CEO of the hospital in consultation with the CMO.

5.2.3 Term. Chiefs of Service serve at the discretion of the CEO.

5.2.4 Removal. The Chief of Service shall be reviewed annually by the Hospital CEO or designee.

Upon petition by twenty percent (20%), but not less than two (2), of the Clinical Service Members in the Active category or upon recommendation of the MEC, the Hospital CEO shall review the performance of the Chief of Service and determine whether or not to continue the individual in that capacity in consultation with the Dean of the Rutgers New Jersey Medical School or Rutgers School of Dental Medicine.

5.3 Responsibilities of the Service Chief

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

b. To oversee all administratively-related activities of the Service, unless otherwise provided by the hospital;

c. To provide ongoing surveillance of the performance of all individuals in the Medical Staff Service who have been granted clinical privileges;

d. To recommend to the Credentials Committee the criteria for requesting clinical privileges relevant to the care provided in the Service;

e. To recommend clinical privileges for each Member of the Service and other licensed practitioners practicing with privileges within the scope of the Service;

f. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the Service or the hospital;

g. To integrate the Service into the primary functions of the hospital;

h. To coordinate and integrate functions and communication between and within Services;

i. To develop and implement Medical Staff and hospital policies and procedures to guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

j. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service;

k. To provide input to the CEO regarding the qualifications and competence of Service personnel who are not LIPs but provide patient care, treatment, and services;

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

m. To maintain quality control programs as appropriate;

n. To orient and continuously educate all persons in the Service; and

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

5.4 Assignment to Service

The MEC will, after consideration of the recommendations of the Chief of the appropriate Service, recommend Service assignments for all Members in accordance with their qualifications. Each Member will be assigned to one primary Service. Clinical privileges are independent of Service assignment.

Section 6. Committees

6.1 Addition or Consolidation of Committees

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions noted in Article IX of the Rules and Regulations. The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition of voting members: The MEC shall be a standing committee consisting of the following voting members: Medical Staff Officers, Clinical Service Chiefs, Credentials Committee Chair, Bylaws Committee Chair, the six (6) At-Large Members of the MEC, and an Adjunct staff Member elected by the Adjunct Staff.

b. Composition of the nonvoting members: The non-voting attendees to the MEC shall consist of the CEO, CMO, COO, CNO, Executive Vice President, Dean of the Rutgers New Jersey Medical School and the Dean of the Rutgers School of Dental Medicine and any designee or representative of a voting member not in attendance.

c. Removal from MEC: An elected Member of the MEC who is removed from their position in accordance with Section 4.5 above will automatically lose their membership on the MEC. When an elected Member resigns or is removed from their positions, their replacement will serve on the MEC.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;

b. Coordinate the implementation of policies pertaining to the Medical Staff that are adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, Medical Staff category, Service assignments, clinical privileges, and corrective action;

d. Report to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of Practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from Medical Staff committees, Services, and other assigned activity groups;

j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures;

k. Request evaluations of Practitioners privileged through the Medical Staff process when there is question about an applicant or Practitioner's ability to perform privileges requested or currently granted;

l. Make recommendations to the Board concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee the Medical Staff's participation in the University Hospital corporate compliance plan;

o. Hold Medical Staff leaders, committees, and Services accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws; and

q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting of the Medical Staff shall be held at a time and place as determined by the President of the Medical Staff or the MEC. Other meetings may be called as noted below in Part I, Section 7.1.3. The President of the Medical Staff or the MEC may call additional general meetings for any reason they deem appropriate, including promoting communication with the Medical Staff, providing a forum for discussion on matters of Medical Staff interest to review quality and safety data and concerns, or present educational programs. Notice of the meeting shall be given to all Medical Staff Members via appropriate media and posted conspicuously.

7.1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, all items to be taken either through electronic voting or voting in person at the meeting, at the discretion of the Medical Staff President or the MEC.

7.1.3 Special Meetings of the Medical Staff

a. Special meetings may be called by the President of the Medical Staff, MEC, Board, or by a twenty percent (20%) petition of the Active Medical Staff. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff at least three (3) business days before the date of such meeting. No business shall be transacted at any special meeting, except stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Services

Services shall meet on an as needed basis by call of the Service Chief. Committees and Services may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Services

A special meeting of any committee or Service may be called by the committee chair or Service Chief thereof or by the President of the Medical Staff. Special meetings of a committee or Service may also be called upon a twenty percent (20%) petition of the Active Members of the committee or Service, but not less than two (2) members. No business other than detailed in the petition may be transacted.

7.4 Quorum

7.4.1 Medical Staff Meetings: A quorum is those Active Members voting on an issue.

7.4.2 MEC, Credentials Committee, and Peer Review Committee(s): A quorum will exist when fifty percent (50%) of the members are present. When dealing with Category 1 requests for expedited credentialing the MEC quorum will consist of at least two (2) members.

7.4.3 Service meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible Medical Staff Members voting on an issue shall be considered quorum.

7.5 Attendance Requirements

7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

a. MEC, Credentials Committee, and Peer Review Committee(s) meetings: members of these committees are expected to attend at least fifty percent (50%) of the meetings held.

b. Services and committees other than those noted in Section 7.5.1.a above: Members of these Services and committees are encouraged to attend.

c. Special meeting attendance requirements: Whenever there is a reason to believe a Practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, any two (2) of the following (Medical Staff Officer, applicable Service Chief, CEO, or the CMO, or their designees) may require the Practitioner to confer with them or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given special notice of the meeting at least five (5) business days prior to the meeting. This notice shall include the date, time, place, issue involved and the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic suspension of the Practitioner's membership and privileges. Such suspension would not give rise to a fair hearing and would automatically be rescinded if and when the Practitioner participates in the previously referenced meeting, however, may result in reporting to the NPBD in accordance with their reporting guidelines.

d. Telephonic/virtual meetings may occur. When sensitive items are discussed, confidentiality should be assured.

e. Nothing in the foregoing paragraphs shall preclude the initiation of a summary suspension of clinical privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the Chief Executive Officer

The CEO or their designee may attend any general, committee, or Service meeting of the Medical Staff as an ex-officio member without vote.

7.7 Parliamentary Procedures

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of an accepted book on parliamentary procedure shall determine procedure.

7.8 Action of Committee

Action may be taken either through electronic voting or voting at a meeting. The recommendation of a majority of its members present at a meeting at which a quorum is present, at any point in time, shall be the action of a committee. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.9 Rights of Ex officio Members

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

7.10 Minutes

A summary of issues, events, or decisions that are deemed by the committee to be important to communicate to the medical staff shall be reported to the MEC or Leadership.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of appointment/re-appointment, patient care or safety, or other issues of importance to the Medical Staff, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the Chair of the Board, CEO, CMO or the President of the Medical Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these Bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff shall have the responsibility to formulate, review at least triennially, and recommend to the Board any Medical Staff Bylaws, Rules and Regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws and Rules and Regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

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

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Initiation by MEC. Proposed amendments to these Bylaws may be originated by Medical Staff leadership or the Medical Staff. All proposed amendments will be reviewed by the Bylaws Committee and forward to the MEC. Once approved by the MEC, the amendment will be sent to the Medical Staff for review and then for vote in fourteen (14) days.

9.2.2 Initiation by the Medical Staff. Proposed amendments to these Bylaws may be originated by a petition signed by twenty percent (20%) of the Members of the Active category. All proposed amendment will be reviewed by the Bylaws Committee and forwarded to the MEC prior to vote by the Medical Staff. All Active Members of the Medical Staff shall receive at least fourteen (14) days advance notice of the proposed changes.

9.2.3 Approval Process.

a. Each Active Member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. The amendment shall be considered approved by the Medical Staff if the amendment receives a simple majority of the ballots cast by Active Members.

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

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

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

9.3.2 If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff at least fourteen (14) days prior to the vote.

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

9.3.4 The MEC may adopt such amendments to these Bylaws, Rules and Regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

9.4 Need for Urgent Amendments to Bylaws

In cases of a documented need for an urgent amendment to the Bylaws and Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

UNIVERSITY HOSPITAL

MEDICAL STAFF BYLAWS

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

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

1.1 Criteria for Initiation

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

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Addressing the use of Voluntary Enhancement Programs, in accordance with the Provider Professionalism Policy;

c. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged Practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

d. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

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

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff Officer, committee chair, Service Chief, CMO, CEO, or Board to the MEC. The request must be supported by references to the specific activities or conduct of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the Practitioner.

2.2 Investigation

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

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

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

2.3 MEC Action

The MEC shall review the report of the investigation in closed session. The MEC will consider all input from the affected Practitioner prior to any decision of the MEC regarding corrective action. As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner’s file;

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

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

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

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

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

g. Recommending suspension, revocation, or probation of Medical Staff membership; or

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the Practitioner's membership or privileges, the Practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board shall act on the MEC's recommendation unless the Member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the Practitioner's privileges and/or membership will be considered suspended, relinquished, or limited as described, and the action shall be final without a right to hearing. The timeframe for reporting these events is noted in Part I, Section 2.6.9 of these Bylaws. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The President of the Medical Staff, with the approval of the CMO or designee, may reinstate the Practitioner's privileges or membership after determining the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty days, the Practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

3.1.1 **Licensure**

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

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

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

3.1.2 **Participation in federally funded programs such as Medicare, Medicaid, Tricare (a managed-care program replacing the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs:** Whenever a Practitioner is excluded or precluded from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished their privileges.

3.1.3 **Controlled substances**

a. **DEA certificate and New Jersey Controlled and Dangerous Substances (CDS). registration:** Whenever a Practitioner's United States Drug Enforcement Agency (DEA) certificate or New Jersey CDS registration is revoked, limited, placed on probation, or suspended, the Practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

3.1.4 **Professional liability insurance:** Failure of a Practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a Practitioner's clinical privileges. If within 60 calendar days of the suspension the Practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the Practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The Practitioner must notify the Medical Staff Office immediately of any change in professional liability insurance carrier or coverage.

3.1.5 **Felony conviction:** A Practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder) shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

3.1.6 **Failure to satisfy the special appearance requirement:** A Practitioner who fails without good cause to appear at a meeting where their special appearance is required in accordance with these Bylaws shall be considered to have all clinical privileges automatically suspended. These privileges will be restored when the Practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.7 **Failure to participate in an evaluation:** A Practitioner who fails to participate in an evaluation of their qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills) and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.8 **Failure to become board certified or failure to maintain board recertification:** A Practitioner who fails to become board certified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have voluntarily relinquished their Medical Staff appointment and clinical privileges. If a Practitioner fails to become recertified, they shall have a grace period of two (2) years in which to become recertified, including any necessary maintenance of certification requirements only if required for recertification. A Practitioner who fails to be recertified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished their Medical Staff appointment and clinical privileges. The board certification requirements are noted in Part III, Section 2.2 of these Bylaws; any board certification exceptions are noted in Part III, Section 2.4 of these Bylaws.

3.1.9 **Involuntary Termination at another hospital:** A Practitioner who has their privileges involuntarily terminated at another hospital, for a reason of competence or conduct, shall result in automatic termination at this Hospital.

3.1.10 **Failure of an APP or Allied Health Professional to Maintain a Collaborating or Supervisory Agreement, if required:** The privileges of these APPs and Allied Health Professionals who require either a collaborating or supervisory agreement shall terminate immediately, without right to due process, in the event the employment of the APP or Allied Health Professional with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP or Allied Health Professional with a physician Member of the Medical Staff organization is terminated for any reason.

3.1.11 **Failure to Fulfill Mandatory Health Requirements:** A Practitioner who fails to be compliant with the Hospital policy on required testing (i.e., Tb testing) or required vaccinations/immunizations shall be automatically suspended until compliance is noted. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.12 **Failure to Execute Release and/or Provide Documents:** A Practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the President of the Medical Staff or designee to evaluate the competency and credentialing/privileging qualifications of the Practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the Practitioner may be reinstated. After thirty (30) calendar days, the Member will be deemed to have resigned voluntarily from the Medical Staff and must reapply for Medical Staff membership and privileges.

3.1.13 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC may convene in closed session to review and consider the facts, and may subsequently recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

3.2 Precautionary (Summary) Suspension

3.2.1 **Criteria for Initiation:** A precautionary (summary) suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CEO or their designee determines that there is a need to carefully consider any event, concern, or issue, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances, any two (2) of the following (Medical Staff Officer, applicable Service Chief, CEO, or the CMO, or their designees) may restrict or suspend the Medical Staff membership or clinical privileges of such Practitioner. A suspension of all or any portion of a Practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the Practitioner's clinical privileges at this hospital.

Unless otherwise stated, such summary suspension shall become effective immediately upon imposition and the person or body responsible shall promptly, within twenty-four (24) hours give written notice to the Practitioner, the MEC, the CEO, and the Board. The summary suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances causing the suspension.

Unless otherwise indicated by the terms of the summary suspension, the Practitioner's patients shall be promptly assigned to another Medical Staff Member by the President of the Medical Staff or designee, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute Practitioner.

3.2.2 **MEC action:** In the event that the summary suspension has not been automatically lifted, as soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary, begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the Practitioner will be given the opportunity to address the MEC in closed session concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary suspension, but in any event, it shall furnish the Practitioner with notice of its decision.

3.2.3 **Procedural rights:** Unless the MEC promptly terminates the summary suspension prior to or immediately after reviewing the results of any investigation described above, the Member or other physician or dentist with privileges without membership shall be entitled to the procedural rights afforded by this hearing and appeal plan once the summary suspension lasts more than fourteen (14) calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any Practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an adverse recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

a. Denial of Medical Staff appointment or reappointment;

b. Revocation of Medical Staff appointment;

c. Denial or restriction of requested clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the Member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;

d. Involuntary reduction or revocation of clinical privileges;

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

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

4.2 Hearings Will Not Be Triggered by the Following Actions

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

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

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

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

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

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

g. Imposition of a summary suspension that does not exceed fourteen (14) calendar days;

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

i. Determination an application is incomplete or untimely;

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

k. Decision not to expedite an application;

l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

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

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

o. The imposition of supervision lasting 14 days or less pending completion of an investigation to determine whether corrective action is warranted;

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

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the Practitioner;

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

t. Change in assigned Medical Staff category;

u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges for a period of five (5) years after a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

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

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

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

4.3 Notice of Recommendation of Adverse Action

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

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

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

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

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

4.4 Practitioner Right to Request for Hearing

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

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the Practitioner's timely request for a hearing, the CEO or designee shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

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

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

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

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

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

4.6 Witness List

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

Section 5. Hearing Committee and Presiding Officer

5.1 Hearing committee

a. When a hearing is requested, a hearing committee of not fewer than three individuals will be appointed. This panel will be appointed by a joint decision of the CEO or designee and the President of the Medical Staff or MEC. No individual appointed to the hearing committee shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing committee. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing committee. When the issue before the panel is a question of clinical competence, all panel members shall be clinical Practitioners. Panel members need not be clinicians in the same specialty as the Member requesting the hearing.

b. The hearing committee shall not include any individual who is in direct economic competition with the affected Practitioner or any such individual who is in professional practice with or related to the affected Practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

c. The CEO, or designee, shall notify the Practitioner requesting the hearing of the names of the panel members and the date by which the Practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing committee or to the presiding officer shall be made in writing to the CEO or designee, who, in conjunction with the President of the Medical Staff, shall determine whether a replacement panel member should be identified. Although the Practitioner who is the subject of the hearing may object to a panel member, they are not entitled to veto the member's participation. Final authority to appoint panel members will rest with the CEO or designee and the President of the Medical Staff.

5.2 Hearing Committee Chairperson or Presiding Officer

5.2.1 In lieu of a hearing committee chair, the CEO or designee, acting for the Board and after considering the recommendations of the President of the Medical Staff (or those of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no previous relationship with either the hospital, organized Medical Staff, or the Practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing committee and may serve as a legal advisor to it but shall not be entitled to vote on its recommendation.

5.2.2 If no presiding officer has been appointed, a chair of the hearing committee shall be appointed by the CEO or designee to serve as the presiding officer and shall be entitled to one vote.

5.2.3 The presiding officer (or hearing committee chair) shall do the following:

a. Act to ensure all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or causes undue delay. In general, it is expected a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions pertaining to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing committee in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing committee; and

h. Seek legal counsel when they feel it is appropriate. Legal counsel to the hospital may advise the presiding officer, panel chair, and hearing committee members.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

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

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at their expense;

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee minutes;

d. Copies of any other documents relied upon by the MEC or the Board;

e. No information regarding other Practitioners shall be requested, provided, or considered; and

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

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

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

6.2 Pre-Hearing Conference

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

6.3 Failure to Appear

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

6.4 Record of Hearing

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

6.5 Rights of the Practitioner and the Hospital

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

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by legal counsel, or may select a Medical Staff Member in good standing or a Member of the affected Member's local professional society, who may be present at the hearing, advise their client, and participate in resolving procedural matters. Attorneys may argue the case for their client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

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

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

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

6.6 Admissibility of Evidence

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

6.7 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing committee may request such a memorandum to be filed within ten (10) business days, following the close of the hearing.

6.8 Official Notice

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

6.9 Postponements and Extensions

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

6.10 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Medical Staff. All members of the Hearing Committee shall be present, absent good cause, for all stages of the hearing and deliberations. If a Hearing Committee member is absent from any portion of the Hearing, that committee member may continue on the committee if they read the transcript for the portion of the Hearing in which they were absent.

6.11 Order of Presentation

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

6.12 Adjournment and Conclusion

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

6.13 Basis of Recommendation

The Hearing Committee shall recommend in favor of the MEC (or the Board) unless it finds the individual who requested the hearing has proved, by a preponderance of the evidence, the recommendation prompting the hearing was arbitrary, capricious, or not supported by credible evidence.

6.14 Deliberations and Recommendation of the Hearing committee

Within twenty (20) calendar days after final adjournment of the hearing, the hearing committee shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation. A hearing committee member absent from any part of the hearing may not vote unless they read the transcript for the portion of the hearing which they were absent.

6.15 Disposition of Hearing committee Report

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

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

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

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or

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

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

7.3 Time, Place, and Notice

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

7.4 Nature of Appellate Review

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

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing committee. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate it is new, relevant evidence and any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at the individual's expense. The review panel may, but shall not be required to, order oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of New Jersey.

c. Each party shall have the right to present a written statement in support of its position on appeal. The review panel shall recommend final action to the Board.

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

7.5 Final Decision of the Hospital Board

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

7.6 Right to One Appeal Only

No applicant or Medical Staff Member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current Member or a physician or dentist with privileges without membership, that individual may never apply for Medical Staff appointment or for those clinical privileges at this hospital.

7.7 Fair hearing and appeal for those with privileges without Medical Staff membership and who are not physicians or dentists

Clinical psychologists and Allied Health Professionals are not entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. In the event one of these Practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect their exercise of clinical privileges, the Practitioner and their supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the MEC to discuss the recommendation. The Practitioner and the supervising physician, if applicable, must request such a meeting in writing to the CEO or their designee within ten (10) business days from the date of receipt of such notice. At the meeting, the Practitioner and the supervising physician, if applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected Practitioner, the MEC and the Board.

The Practitioner and the supervising physician, if applicable, may request an appeal in writing to the CEO or designee within ten (10) days of receipt of the findings of the review body. Two members of the Board assigned by the Chair of the Board shall hear the appeal from the Practitioner and the supervising physician. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The Practitioner and the supervising physician will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the Practitioner, they will not be allowed to reapply for privileges.

UNIVERSITY HOSPITAL

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Section 1. Medical Staff Credentials Committee

1.1 Composition

Voting membership of the Credentials Committee shall consist of at least nine (9) Active Members of the Medical Staff that represent the main specialties of the Hospital. All committee members are appointed by the President of the Medical Staff. Members shall be appointed to staggered three (3) year terms, with no term limits. The Credentials Committee Chair shall be an experienced Credentials Committee member appointed by the President of the Medical Staff for a three (3) year term, with no term limits.

Nonvoting membership of the Credentials Committee shall consist of the CMO (or designee) and the Director, Medical Staff Services.

1.2 Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or President of the Medical Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible Practitioners;

1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports referred to it from other Medical Staff committees, Medical Staff or hospital leaders;

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

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

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

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

Review will occur only upon written request approved by the President of the Medical Staff, CMO, CEO, or credentials chair. Review of such files will be conducted in the presence of the Medical Staff Services Professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by Practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a Practitioner. Nothing may be removed from the file. Only items supplied by the Practitioner or directly addressed to the Practitioner may be copied and given to the Practitioner. No photos or recordings of the file may be made by the Practitioner. The Practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

2.1 No Practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.2.2 Demonstrate they have successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.3 Have a current, state license as a Practitioner, applicable to their profession, and providing permission to practice within the state of New Jersey. This license must be unrestricted upon initial appointment;

2.2.4 Possess a current, valid, drug enforcement administration (DEA) number and New Jersey Controlled and Dangerous Substances (CDS) registration, if applicable to their specialty;

2.2.5 Possess a valid NPI number;

2.2.6 Be a US citizen or have work permit or Visa if not a US citizen;

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

2.2.8 Have a record free from past or current Medicare/Medicaid exclusions and not be on the OIG List of Excluded Individuals/Entities;

2.2.9 Have a record showing the applicant has not been convicted of, or entered a plea of guilty or no contest to, any felony related to insurance or health care fraud or abuse, violence in any jurisdiction, abuse (physical, sexual, or elder) for the past seven (7) years;

2.2.10 Have a record showing the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony related to child abuse;

2.2.11 Have a record showing the applicant has never had appointment or privileges denied, limited, or terminated for a reason related to competence or conduct (or resigned while under investigation) at any hospital within the past ten (10) years;

2.2.12 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), and the American Osteopathic Association (AOA) and be currently board certified or become board certified within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties, the American Osteopathic Association, or foreign boards that are accepted by the corresponding ABMS or AOA board;

2.2.13 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.14 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery or successfully complete the alternative pathway;

2.2.15 A podiatric physician, DPM, must have successfully completed at minimum, a two-year (2) residency program in surgical, orthopedic, and/or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery.

2.2.16 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA or by a predecessor or successor agency to either) is required for initial applicants and reapplicants. Initial applicants may be actively seeking initial certification and must obtain the same on the first examination for which eligible.

2.2.17 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB) is required for initial applicants and reapplicants. Initial applicants may be actively seeking initial certification and obtain the same on the first examination for which eligible.

2.2.18 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) for family nurse practitioners, psychiatric-mental health nurse practitioners, or adult-gerontology acute care nurse practitioners , the American Academy of Nurse Practitioners Certification Board for family nurse practitioners, adult-gerontology nurse practitioner, or emergency nurse practitioners, the American Association of Critical Care Nurses (AACN) for adult/adult-gerontology/pediatric and neonatal nurse practitioners, or an equivalent body is required for initial applicants and reapplicants. Initial applicants may be actively seeking certification and obtain the same on the first examination for which they are eligible.

2.2.19 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and for reapplicants.

2.2.20 A radiology assistant (RA) must have current certification and registration in radiography by the American Registry of Radiologic Technologists (ARRT). Successful completion of a radiologist assistant educational program that is recognized by ARRT is required for initial applicants and for reapplicants.

2.3 In addition to privilege-specific criteria, the following qualifications must also be met and maintained by all applicants requesting clinical privileges:

2.3.1 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of their responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant;

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

2.3.3 Demonstrate recent clinical performance within the last thirty-two (32) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria or as outlined in the delineation of privilege request form;

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

2.3.5 Have appropriate written and verbal communication skills; and

2.3.6 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

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

2.4 Exceptions

2.4.1 All Practitioners who are current Medical Staff Members and/or hold privileges as of April 25, 2007, and who have met prior qualifications for membership and/or privileges, shall be exempt from board certification requirements.

2.4.2 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence a Practitioner demonstrates an equivalent competence in the areas of the requested privileges.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant with the pre-application. Upon submission of the completed pre-application, and it is determined that the applicant meets criteria, the Medical Staff Office will provide the applicant with the application package, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

d. Application processing fee (non-refundable);

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport)

f. Current CV, in to/from mm/yyyy format;

g. A current distinguishable professional color photo;

h. Receipt of three (3) references; References include two (2) peers and one (1) confidential evaluator. The two (2) peer references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one (1) peer reference must be from someone in the same professional discipline. The confidential evaluator shall be a current Chief/Chair, Training Program Director, or someone in a clinical leadership position that has knowledge of and can attest to their current clinical competencies;

i. Relevant practitioner-specific data as compared to aggregate data;

j. ECFMG for foreign graduates only;

k. Visa, or work permit, for non-US citizens only;

l. DD-214 to document military service, if applicable; and

m. Proof of current health screening, including vaccination status in accordance with Hospital policies.

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

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure the Medical Staff Office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, communication requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff Office within thirty (30) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the credentials chair, or designee, in collaboration with the Medical Staff Office, will determine if the requirements of Sections 2.2 and 2.3 are met. In the event the requirements of Sections 2.2 and 2.3 are not met, the potential applicant will be notified they are ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Sections 2.2 and 2.3 are met, the application will be accepted for further processing.

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

3.1.5 Upon receipt of a completed application, the Medical Staff Office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the Medical Staff Office will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past five (5) years;

b. Verification of the applicant's past hospital affiliations for at least the past 10 years.

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the Medical Staff Office will primary source verify current licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

d. Verification of DEA, New Jersey Controlled Dangerous Substance (CDS), and NPI status;

e. Information from the AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities or SAM (System for Award Management);

f. Information from professional training programs including residency and fellowship programs;

g. Information regarding board certification status;

h. Information from the National Practitioner Data Bank (NPDB); Each practitioner will be enrolled in the NPDB's Continuous Query/Proactive Disclosure Service. In addition, at the time of renewal of privileges and whenever a new privilege(s) is requested, confirmation that no new information has been received from the NPDB;

i. Other information about adverse credentialing and privileging decisions;

j. At least three (3) recommendations from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges. One recommendation must be from someone of the same professional discipline; One recommendation shall be a current Chief/Chair, Training Program Director or someone in a clinical leadership position who has knowledge of and can attest to their current clinical competencies;

k. Information from a seven (7) year criminal background check, for initial application only;

l. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and

m. Nomination letter from the UH Chief of Service or Department Chair

Note: In the event there is an undue delay in obtaining the required information, the Medical Staff Office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after thirty (30) calendar days will be deemed a withdrawal of the application.

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

3.2 Applicant's Attestation, Authorization, and Acknowledgement

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

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

3.2.2 Consents to appear for any requested interviews in regard to their application.

3.2.3 Authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on their professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to hospital and Medical Staff representatives' inspection of all records and documents material to an evaluation of:

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

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

p. Professional and ethical qualifications;

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

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

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

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

3.2.7 Acknowledges the applicant has had access to the Medical Staff Bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

Notwithstanding Sections 3.2.5 through 3.2.6, if an individual institutes legal action and does not prevail, they shall reimburse the Hospital and any Member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.2.8 Agrees to provide accurate answers to the application questions, and agrees to immediately, within twenty-four (24) hours, notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the questions affirmatively and/or provides information identifying a problem with any of the questions, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

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

Category 1: A completed application is received. All relevant primary source verifications are received and there are no raised concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Service Chief, credentials chair acting on behalf of the Credentials Committee, the MEC and a Board committee consisting of at least two individuals.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Service Chief, Credentials Committee, MEC, and the Board. The Credentials Committee may request an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence they meet the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC is adverse or with limitation;

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

d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

e. Applicant has had two (2) or more, or an unusual pattern, of malpractice claims within the past five (5) years;

f. Applicant has unexplained changes in medical schools or residency programs or has unexplained gaps in training or practice;

g. Applicant has changed practice affiliations more than three times in the past ten (10) years, excluding telemedicine and locum tenens practitioners;

h. Applicant has one or more reference responses that raise concerns or questions;

i. Substantive discrepancy is found between information received from the applicant and references or verified information;

j. Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions;

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

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

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

3.3.2 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Service Chief, Credentials Committee, MEC, or Board. The interview may take place in person, by video conference, or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

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

3.3.3 Service Chief Action

a. All completed applications are presented to the Service Chief for review, and recommendation. The Service Chief reviews the application to ensure it fulfills the established standards for membership and/or clinical privileges. The Service Chief, in consultation with the Medical Staff Professional, determines whether the application is forwarded as a Category 1 or Category 2. The Service Chief may obtain input if necessary, from an appropriate subject matter expert. If a Service Chief believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation, they will notify the credentials chair and forward the application without comment.

b. The Service Chief forwards to the Medical Staff Credentials Committee the following:

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

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

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

iv. Comments to support these recommendations.

3.3.4 Medical Staff Credentials Committee Action

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

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

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

c. Comments to support these recommendations.

3.3.5 MEC Action

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

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;

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

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

d. Comments to support these recommendations.

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

3.3.6 Board Action:

The Board reviews the application and votes for one of the following actions:

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

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

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

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

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

3.3.7 **Notice of final decision:** Notice of the Board's final decision shall be given, through the CEO or designee to the MEC and to the Service Chief concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the Medical Staff category to which the applicant is appointed, the Service to which they are assigned, the clinical privileges they may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.8 **Time periods for processing:** All individual and groups acting on an application for Medical Staff appointment and/or clinical privileges must do so in a timely and good faith manner. Except for good cause, each application once fully completed per 3.1 and 3.2 of Part III of these Bylaws will be processed within 120 (one-hundred twenty) calendar days.

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

Section 4. Reappointment

4.1 Criteria for Reappointment

4.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those Practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine the Practitioner provides effective care consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The Practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed thirty-six (36) months. The granting of new clinical privileges to existing Medical Staff Members or other Practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation. A suitable peer shall substitute for the Service Chief in the evaluation of current competency of the Service Chief and recommend appropriate action to the Credentials Committee.

4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff Office notifies the Practitioner of the date of expiration and supplies them with an application for reappointment for membership and/or privileges. At least ninety (90) calendar days prior to this date the Practitioner must return the following to the Medical Staff Office:

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

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

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 From internal and/or external sources: The Medical Staff Office collects and verifies information regarding each Practitioner's professional and collegial activities to include those items listed on the application.

4.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this hospital for each Practitioner due for reappointment;

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

c. Attestation of sufficient continuing medical education activity to comply with state licensure;

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

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

f. Verification of current licensure;

g. Verification of DEA, New Jersey Controlled Dangerous Substance (CDS) where applicable to the specialty practice;

h. National Practitioner Data Bank query and information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management);

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

j. Malpractice history for the past two (2) years, which is primary source verified by the Medical Staff Office with the Practitioner's malpractice carrier(s).

4.2.4 Failure, without good cause, to provide any requested information, at least sixty (60) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff Office verifies this additional information and notifies the Practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

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

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

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

Section 5. Clinical Privileges

5.1 Exercise of privileges

A Practitioner providing clinical services at the hospital may exercise only those privileges granted to them by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to Practitioners who are not Members of the Medical Staff. Such individuals may be clinical psychologists, physicians serving short locum tenens positions, telemedicine physicians, house staff such as residents or fellows moonlighting in the hospital, and Allied Health Professionals such as speech and language pathologists, registered nurse first assistants (RNFAs) and operating room technicians who perform a surgical level of care, or others deemed appropriate by the MEC and Board.

5.2 Requests

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

5.3 Basis for Privileges Determination

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

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

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

5.4 Special Conditions for Dental Privileges

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

5.5 Special Conditions for Podiatric Privileges

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

5.6 Special conditions for Practitioners eligible for privileges without membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of Practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Clinical Psychologists are practitioners who are granted privileges, without membership. Allied Health Professionals such as registered nurse first assists (RNFAs) and operating room technicians may not exercise independent judgment and must work under the direct supervision of a physician who has been accorded privileges to provide such care. The privileges of these Allied Health Professionals shall terminate immediately, without right to due process, in the event the employment of the Allied Health Professional with the hospital is terminated for any reason or if the employment contract or sponsorship of the Allied Health Professional with a physician Member of the Medical Staff organization is terminated for any reason.

5.7 Special Conditions for Residents and Fellows in Training

5.7.1 Residents and fellows in ACGME or CPME accredited training programs in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges, unless they are functioning in an unaccredited program. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Designated Institutional Official (DIO) in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances that they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

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

5.8 Telemedicine Privileges

Telemedicine privileges are limited to those services the MEC, acting for the Medical Staff, has approved for telemedicine delivery. Telemedicine privileges do not automatically confer Medical Staff Membership; however, Medical Staff may participate in telemedicine activities for hospital patients.

5.8.1 Requests for telemedicine privileges at the Hospital that includes patient care, treatment, and services will be reviewed by the MEC and will be processed through one of the following mechanisms:

a. The Hospital fully privileges and credentials the Practitioner; **OR**

b. The Hospital privileges Practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited or a Medicare-participating organization and the information is then processed through the routine Medical Staff credentialing and privileging process. The distant-site Practitioner must have a license that is issued or recognized by the State of New Jersey; **OR**

c. The Hospital uses the credentialing and privileging decision from the distant site if all of the following requirements are met:

i. The distant site is a Joint Commission-accredited or a Medicare-participating organization;

ii. The Practitioner is privileged at the distant site for those services to be provided at this Hospital and the Practitioner has a license that is issued or recognized by the State of New Jersey;

iii. The distant site provides this Hospital with a current list of the licensed Practitioner's privileges; and

iv. The hospital has evidence of an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed Practitioner from patients, licensed Practitioners, or staff at the Hospital.

5.9 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

5.9.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies NPDB, current licensure and current competence.

5.9.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff Membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include 1) complete application 2) fully verified application, 3) positive recommendation from the Department Chief, and 4) positive recommendation from the Credentials Committee. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in Section 3 of this manual.

5.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations and policies of the Medical Staff and hospital in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, these Bylaws, Rules and Regulations, and policies control all matters relating to the exercise of clinical privileges.

5.9.4 Termination of temporary privileges: The CEO or designee, acting on behalf of the Board and after consultation with the President of the Medical Staff, may terminate any or all of the Practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the Practitioner's patients then will be assigned to another Practitioner by the President of the Medical Staff or their designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

5.9.5 Rights of the Practitioner with temporary privileges: A Practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because their request for temporary privileges is refused or because all or any part of their temporary privileges are terminated or suspended.

5.10 Emergency Privileges

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

5.11 Disaster Privileges

Disaster privileges will be granted using the following process:

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

a. A current picture hospital ID card clearly identifies professional designation;

b. A current license to practice;

c. Primary source verification of the license;

d. Identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

e. Identification indicating the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

f. Identification by a current hospital or Medical Staff Member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed practitioner during a disaster.

5.11.2 The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer Practitioners who have been granted disaster privileges.

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

5.11.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the organization. If primary source verification cannot be completed in seventy-two (72) hours, there is documentation of the following: 1) why primary source verification could not be performed in seventy-two (72) hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

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

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

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, after receiving a recommendation from the Service Chief, will define the circumstances which require monitoring and evaluation of the clinical performance of each Practitioner following their initial grant of clinical privileges or newly requested privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers indicating the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

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

6.3 Practitioner Re-Entry

A Practitioner who has not provided care within an area of practice within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, acceptable to the Credentials Committee and MEC, either with a current Member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the hospital. If a Practitioner has not provided any clinical care within the past five (5) years as determined by the New Jersey Composite Medical Board or the MEC, they may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other formal process to assess and confirm clinical competence. The Practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Service Chief and/or Credentials Committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a. The scope and intensity of the required activities;

b. The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

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

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a Practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges.

7.2 Request for modification of appointment status or privileges

A Practitioner, either in connection with reappointment or at any other time, may request modification of Medical Staff category, Service assignment, or clinical privileges by submitting a written request to the Medical Staff Office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested and will require FPPE as per Part III, Section 6.1. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A Practitioner who determines they no longer exercise, or wish to restrict or limit the exercise of, particular privileges they have been granted shall send written notice, through the Medical Staff Office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the Practitioner's credentials file.

7.3 Resignation of Medical Staff appointment or privileges

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

7.4 Exhaustion of administrative remedies

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

7.5 Reporting requirements

The CEO or their designee shall be responsible for assuring the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a Practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Reportable actions include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Practitioners Providing Contracted Services

8.1 Practitioners Providing Contracted Services

When the hospital contracts for care services with licensed practitioners who provide readings of images, tracings, or specimens through a telemedicine mechanism, all LPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

8.2 Exclusivity Policy

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

8.3 Qualifications

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

8.4 Disciplinary Action

The terms of the Medical Staff Bylaws will govern disciplinary action taken by or recommended by the MEC.

8.5 Effect Of Contract or Employment Expiration or Termination

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

Section 9. Medical Administrative Officers

9.1 A medical administrative officer is a Practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the officer's direction.

9.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge Medical Staff obligations appropriate to their Medical Staff category in the same manner applicable to all other Medical Staff Members.

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

9.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's Medical Staff appointment and privileges and the effect an adverse change in the officer's Medial Staff appointment or clinical privileges has on their remaining in office. Termination of the medical administrative contract does not result in fair hearing rights.

9.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

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

Adopted and Approved:

Medical Executive Committee: September 8, 2023

Medical Staff Affirmed: September 18, 2023

Hospital Board of Directors: September 28, 2023