



The Nebraska Medical Center

MEDICAL STAFF BYLAWS

Part I: Governance

Implemented July 1, 2018

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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 Nebraska Medicine in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital 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 Nebraska Medicine. Henceforth, whenever the term “the hospital” is used, it shall mean The Nebraska Medical Center, and whenever the term “the Board” is used, it shall mean the Board of Directors of Nebraska Medicine, a Nebraska non-profit corporation, which is the governing body legally responsible for the conduct of the hospital. Whenever the term “CEO” is used, it shall mean the Chief Executive Officer appointed by the Board to act on its behalf in the overall management of the hospital. The term CEO includes a duly appointed acting administrator serving when the CEO is away from the hospital.

1.3 Definitions

- 1.3.1 "Academic Chair" means a person who oversees an academic clinical department;
- 1.3.2 "APP" or Advance Practice Professional means a APRN-NP, APRN-CNM, APRN-CRNA, PA, psychologist, licensed mental health practitioner or optometrist.
- 1.3.3 Clinical Program Director" means a person appointed by Nebraska Medicine to oversee a clinical program of the hospital.
- 1.3.4 "CEO" means the Chief Executive Officer of the hospital.
- 1.3.5 "Dean" means the Dean of the UNMC College of Medicine.
- 1.3.6 "Bylaws" means Parts I, II and III of these Bylaws.
- 1.3.7 "Organization Manual" means Part IV of these Bylaws.
- 1.3.8 "LIP" or Licensed Independent practitioner means a physician, dentist or oral and maxillofacial surgeon or podiatrist.
- 1.3.9 "*Member*" means a physician, dentist, oral and maxillofacial surgeon or podiatrist who has been appointed to a category of membership under these bylaws.
- 1.3.10 "*Physician*" means an M.D., D.O. or M.B.B.S.
- 1.3.11 "*Practitioner*" means a physician, LIP or APP.

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, dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, 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 will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, sexual orientation, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

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 Medical Executive Committee (MEC). Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) 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 Medical Staff Responsibilities

- 2.6.1 Each staff member and practitioner with privileges must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.
- 2.6.2 Each staff member and practitioner with privileges 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 staff member, consistent with his/her granted hospital privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

- 2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation or competency evaluation as requested by the officers of the medical staff or the Chief Executive Officer (CEO) when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC 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 staff member and practitioner with privileges must abide by the applicable medical staff bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.
- 2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the medical staff office immediately of any and all malpractice claims filed in any court of law against the medical staff member. For physicians and CRNAs practicing in Nebraska, this shall include qualification and participation under the Nebraska Hospital-Medical Liability Act.
- 2.6.7 Each applicant for membership or privileges and each staff member and practitioner with privileges agrees to an absolute release from any liability, to the fullest extent permitted by law, of all persons for their conduct in connection with investigating and/or evaluating the credentials, quality of care or professional conduct provided by the applicant, medical staff member or practitioner with privileges.
- 2.6.8 Each staff member and practitioner with privileges 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, clinical services, or departments.
 - 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, or other qualified licensed individual in accordance with State law and hospital policy.
 - b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified practitioner in accordance with State law and hospital policy.

- c. The content of complete and focused history and physical examinations is delineated in policies.
- 2.6.9 Each staff member and practitioner with privileges will access, use and disclose confidential information only in accordance with HIPAA laws and regulations and Hospital policy as necessary for treatment, payment, or healthcare operations, 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.
- 2.6.10 Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.7 Medical Staff Member Rights

- 2.7.1 Each staff member in the active and ambulatory categories has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Service Chief or other appropriate medical staff leader(s), that 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 staff member in the active and ambulatory categories has the right to initiate a recall election of a medical staff officer by following the procedure outlined in Section 4.7 of this Part I of these bylaws, regarding removal and resignation from office.
- 2.7.3 Each staff member in the active and ambulatory categories may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff by presenting a petition signed by Twenty Five percent (25%) of the members of the active and ambulatory categories. Upon presentation of such a petition, the MEC shall schedule a general staff meeting within 60 days for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
- 2.7.4 Each staff member in the active and ambulatory categories may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any medical staff member may submit a petition signed by Twenty Five percent (25%) of the members of the active and ambulatory categories. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 of this Part I of these bylaws will be followed.
- 2.7.5 Except in matters described in section 2.7.6, below, each staff member in the active and ambulatory categories may call for a Service meeting by presenting a petition signed by Twenty Five percent (25%) of the members of the Service. Upon presentation of such a petition the Service Chief will schedule a Service meeting within 60 days.

- 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 membership 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).
- 2.7.8 Each staff member in the active and ambulatory categories shall have the ability to vote upon the acceptance of a unified medical staff structure. If the Board elects to have a unified medical staff, then the medical staff of each affected separately certified hospital must vote in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospitals.

2.8 Staff Dues

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

2.9 Indemnification

- 2.9.1 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.
- 2.9.2 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 the member is made a party by reason of such member having acted in an official 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.

2.10 Duty to Notify of Certain Actions

Each practitioner shall notify the Medical Staff Office as any of the following events occur:

- 2.10.1 Placement of conditions, restrictions, suspension or other action on any State medical license.
- 2.10.2 Placement of conditions, restrictions, suspension or other adverse action by any credentialing body, e.g., hospital, certification board, physician hospital organization, payor panel.
- 2.10.3 Placement of conditions, restrictions, suspension or other action on individual's DEA controlled substance authorization.
- 2.10.4 Termination or change in coverage of medical malpractice insurance.

- 2.10.5 A malpractice claim against the practitioner is filed in any court of law.
- 2.10.6 Termination, exclusion or preclusion by government action from participation in the Medicare/Medicaid or other federal healthcare program.
- 2.10.7 Indictment, conviction or a plea of guilty or no contest pertaining to any felony or misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid or insurance health care fraud or abuse, (iv) violence against another, or (v) alcohol-related offense.
- 2.10.8 Change in office or home contact information.

3.1 The Active Category

3.1.1 Qualifications

Members of this category shall be involved in at least 50 patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation or encounter, inpatient or outpatient procedure, outpatient clinic encounter, or requests for radiologic or laboratory procedures) at the hospital or demonstrates support of the organization as determined by the MEC.

In the event that a member of the active category does not meet the qualifications for reappointment to the active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

- a. Attend medical staff, and Service meetings of which s/he is a member and any medical staff or hospital education programs;
- b. Vote on all matters presented by the medical staff, Service, 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 staff functions as may be required; and
- c. Pay dues.

3.2 The Associate Category

3.2.1 Qualifications

The associate category is reserved for medical staff members who hold privileges at the hospital, but who do not meet the eligibility requirements for the active category or choose not to pursue active status.

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 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. Contribute to the organizational and administrative affairs of the medical staff;
- b. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion and in the discharge of other staff functions as may be required; and
- c. Pay dues.

3.3 The Courtesy Category

3.3.1 Qualifications

The courtesy category is reserved for members without privileges at the hospital who maintain a clinical practice in the hospital's geographic service area and wish to be able to follow the course of their patients when admitted to the hospital.

3.3.2 Prerogatives

- a. Members of this category may order non-invasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records and attend medical staff, Service, section meetings, CME functions and social events; and
- b. Members of this category are not be eligible for clinical privileges, may not manage patient care in the hospital and may 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 bylaws, policies and procedures; and
- b. Not be required to pay dues.

3.4 Ambulatory Category

3.4.1 Qualifications

The ambulatory category consists of practitioners who staff clinics operated by Nebraska Medicine that are located in the primary service area of the hospital. These practitioners do not practice or hold privileges at the hospital. They shall be credentialed for procedures within their areas of expertise, depending on the capabilities of the clinic or practice setting in which they work.

3.4.2 Prerogatives

Members of the ambulatory category may order outpatient diagnostic tests and services, visit patients in the hospital, review medical records, and exercise the privileges granted to them in the ambulatory setting. Additionally, members of the ambulatory category may serve on committees by appointment with vote and may attend meetings of the medical staff and applicable service with vote.

3.4.3 Responsibilities

Members of this category shall pay dues and fulfill or comply with any applicable medical staff or hospital bylaws, policies and procedures.

3.5 Affiliate Category

3.5.1 Qualifications

The affiliate category consists of practitioners who staff clinics operated by Nebraska Medicine that are located outside of the primary service area of the hospital. These practitioners do not practice or hold privileges at the hospital. They shall be credentialed for procedures within their areas of expertise, depending on the capabilities of the clinic or practice setting in which they work.

3.5.2 Prerogatives

Members of the affiliate category shall have the ability to exercise privileges granted to them in the ambulatory setting. Additionally, members of the affiliate category may serve on committees by appointment with vote and may attend meetings of the medical staff and applicable service without vote. Members of this category are not eligible to hold office or serve as Service Chief or committee chair.

3.5.3 Responsibilities

Members of this category shall not pay dues but shall fulfill or comply with any applicable medical staff or hospital bylaws, policies or procedures applicable to them.

3.6 Honorary Category

The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members 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 and Service meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.

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

- 4.1.1 President of the Medical Staff
- 4.1.2 President-elect of the Medical Staff
- 4.1.3 Secretary/Treasurer

4.2 Qualifications of Officers and MEC at-large members

- 4.2.1 Officers and MEC at-large members must be members in good standing of the active or ambulatory category for two years and be actively involved in patient care in the hospital or a Nebraska Medicine clinic, have previously served in a significant leadership position on the medical staff (e.g. Service Chief, committee chair, or a member of the MEC, Credentials Committee or Practitioner Quality Committee), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. Additionally, the President-elect must have served on MEC for at least two years. The medical staff Leadership and Succession Committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.
- 4.2.2 Officers and MEC at-large members may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Election of Officers and MEC at-large members

- 4.3.1 The Leadership and Succession Committee shall offer at least two (2) nominees for each available position. Nominations must be announced, and the names of the nominees distributed to all members of the active and ambulatory categories at least 30 days prior to the election.
- 4.3.2 A petition signed by at least Twenty Five percent (25%) of the members of the active and ambulatory categories may add nominations to the ballot. The medical staff must submit such a petition to the President of the Medical Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The Leadership and Succession Committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.

4.3.3 Officers and MEC at-large members shall be elected at least one month prior to the expiration of the term of the current officers. Only members of the active and ambulatory categories shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member's voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes cast will be elected. In the event of a tie vote, the MEC will make arrangements for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a greater number of votes.

4.4 Term of Office

The Officers and the elected MEC at-large members shall serve a term of two (2) years. The terms of the elected at-large members will be staggered, with two (2) elected each year. They shall take office in the month of January. An individual may be reelected for two (2) successive terms. Each officer and elected MEC at-large member shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the medical staff year, except the office of the President of the Medical Staff. 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.

4.6 Duties of Officers and MEC at-large members

4.6.1 **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, regulations, and policies. Specific responsibilities and authority are to:

- a. Call and preside at all general and special meetings of the medical staff;
- b. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;
- c. Enforce medical staff bylaws, rules, regulations, and medical staff/hospital policies;
- d. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

- e. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;
- f. 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;
- g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;
- h. 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;
- i. 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;
- j. Attend Board meetings and Board committee meetings as applicable;
- k. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and
- l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

4.6.2 **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. S/he 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.

4.6.3 **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. S/he 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.

4.6.4 **MEC at-large members:** These members will advise and support the medical staff officers and be responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.

4.7 Removal and Resignation from Office

4.7.1 **Automatic Removal:** An officer or MEC at-large member shall be automatically removed and shall be deemed to have resigned from office or the MEC without vote of the active and ambulatory members, if s/he: (i) ceases to be a member of the active or ambulatory category or hold privileges in his/her clinical practice area, or (ii) becomes subject to an automatic or precautionary suspension of clinical privileges that lasts longer than thirty days.

- 4.7.2 **Removal by Petition:** The medical staff may initiate the removal of any officer or MEC at-large member if at least Twenty Five percent (25%) of the active and ambulatory members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by a simple majority (50% +1) of those active and ambulatory staff members casting ballot votes. Grounds for removal by petition shall include: (i) failure to meet a qualification for the office or MEC position, (ii) failure to meet those responsibilities assigned within these bylaws (iii) failure to comply with policies and procedures of the medical staff, and (iv) conduct or statements that damage the hospital, its goals, or programs.
- 4.7.3 **Resignation:** Any officer or MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

5.1 Organization of the Medical Staff

- 5.1.1 The medical staff shall be organized into Services. The medical staff may create clinical 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 Part IV of the bylaws (Organization and Functions Manual).
- 5.1.2 The MEC, with approval of the Board, may designate new medical staff Services or clinical sections or dissolve current Services or clinical sections as it determines will best promote the medical staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

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

The following processes are adopted for the appointment and term of Service Chiefs.

- 5.2.1 The Leadership and Succession Committee shall identify at least one (1) nominee for each available position, and shall forward that recommendation to the CEO and Dean. Using consistent processes established by the CEO and Dean, the Department Chair(s) associated with a clinical program or service, a representative of the Clinical Community Advisory Board and the Chief Medical Officer, after consultation as they may deem appropriate, will provide input and approve the candidates identified by the CEO and Dean for each medical staff Service Chief.
- 5.2.2 Final appointments will be made by the MEC, subject to approval by the Board.
- 5.2.3 The term of office for a Service Chief will be for one (1) year, but a Service Chief may be appointed for up to three (3) successive terms.
- 5.2.4 Vacancies in the position of Service Chief shall be filled in the manner described above. Interim vacancies pending identification and approval of a new Service Chief will be filled by the Chief Medical Officer.
- 5.2.5 In the event a Service Chief cannot be approved in the manner described above, the Board will identify and appoint the Service Chief.
- 5.2.6 All Service Chiefs must be members of the active medical staff, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.

5.3 Removal of Service Chiefs

Service Chiefs may be removed from office as follows:

- 5.3.1 **Automatic Removal.** A Service Chief shall be automatically removed and shall be deemed to have resigned from the position if s/he: (i) ceases to be a member of the active category or hold privileges in his/her clinical practice area, or (ii) becomes subject to an automatic or precautionary suspension of clinical privileges that lasts longer than thirty days.

5.3.2 **Removal by Petition.** By petition, if a simple majority (50% +1) of the voting members of the Service recommend such action. Grounds for removal by petition include: (i) failure to meet the qualification for the position, (ii) failure to meet those responsibilities assigned within these bylaws, and (iii) failure to comply with policies of the hospital and medical staff, and (iv) for comments or statements that damage the hospital, its goals, or programs.

5.3.3 **By MEC.** The MEC, with approval of the CEO and Dean, may remove a Service Chief on its own initiative by a two-thirds vote. Grounds for removal by the MEC include: (i) failure to meet the qualifications for the position, (ii) failure to meet those responsibilities assigned within these bylaws, (iii) failure to comply with policies of the hospital and medical staff, (iv) for comments or statements that damage the hospital, its goals, or programs.

5.3.4 **Resignation.** A Service Chief may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

5.3.5 **Vacancy.** If a Service Chief is removed, a replacement shall be selected in accordance with Sections 5.2.1 and 5.2.2., above.

5.4 **Responsibilities.** Responsibilities of Service Chiefs, Academic Chairs and Clinical Program Directors often intersect around operation of Services, Academic Clinical Departments and clinical programs of the hospital.

5.4.1 **Responsibilities of the Service Chief.** Responsibilities of the Service Chiefs shall be:

- a. To oversee all administratively-related activities of the Service, unless otherwise provided by the hospital;
- b. To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Service;
- c. To recommend to the Credentials Committee clinical privileges for each member of the Service and other licensed independent practitioners practicing with privileges within the scope of the Service;
- d. To develop and implement medical staff policies and procedures that 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;

- e. To provide input to the Credentials Committee regarding the qualifications and competence of Service personnel who are not LIPs but who provide patient care, treatment and services (See Part V of these bylaws); and
- f. To orient and continuously educate all persons in the Service.

5.4.2 **Responsibilities of the Service Chief exercised in collaboration with the Academic Chairs and Clinical Program Directors.** The following responsibilities of the Service Chiefs shall be exercised in collaboration with the affected Academic Chairs and Clinical Program Directors:

- a. To provide ongoing surveillance of the performance of all individuals in the medical staff Service who have been granted clinical privileges;
- b. To integrate the Service into the primary functions of the hospital;
- c. To continually assess and improve the quality of care, treatment, and services; and
- d. To maintain quality control programs as appropriate.

5.4.3 **Academic Chairs and Clinical Program Directors.** The following responsibilities have been delegated to the Academic Chairs and Clinical Program Directors:

- a. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff Service or the hospital;
- b. To coordinate and integrate interdepartmental and intradepartmental services and communication;
- c. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service; and
- d. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff Service to provide patient care services.

5.5 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.

6.1 Designation and Substitution

There shall be a medical executive committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in Part IV of the bylaws (Organization and Functions Manual). Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions. The 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:** The MEC shall be a standing committee of the following voting members: the officers of the medical staff, the chairs of the Credentials and Practitioner Quality committees, four (4) Service Chiefs, and four (4) active or ambulatory medical staff members elected at-large. At least one of the Service Chief members should represent a Hospital-based Service. The chair will be the President of the Medical Staff. The CEO, Dean, Chief Medical Officer, Immediate Past President of the medical staff (with his/her consent) and Chief Nursing Officer shall be *ex officio* members without vote.
- b. **Removal from MEC:** An officer, MEC At-Large Member, or Service Chief who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2 above will automatically lose his/her membership on the MEC. When the chair of either the Credentials or Practitioner Quality Committees or Service Chief resigns or is removed from these positions, his/her replacement will serve on the MEC. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members. When a member of the MEC who was elected at-large resigns or is removed, the MEC will arrange for an at-large election for a replacement to serve out the remainder of the vacated term. Such an election will follow procedures established by the MEC and must take place within sixty (60) days of the removal of an MEC member.

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 adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Service assignments, clinical privileges, and corrective action;
- d. Act as a peer review committee and receive and act on information, recommendations and reports from other persons and bodies with peer

- review responsibility for the hospital, including the Credentials Committee, the Practitioner Quality Committee, the Service Chiefs, the officers, the academic chairs, the clinical program/service leaders, other committees and ad hoc investigating and hearing committees;
- e. As a peer review body, assure that relevant information, including peer review information, is communicated to other peer review bodies, including those listed in Section 6.2.2-d, above, for their use in conducting peer review activity.
 - f. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
 - g. 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;
 - h. Make recommendations to the Board on medical administrative and hospital management matters;
 - i. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
 - j. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
 - k. Review and act on reports from medical staff committees, Services, and other assigned activity groups;
 - l. Formulate and recommend to the Board medical staff rules, policies, and procedures;
 - m. 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;
 - n. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
 - o. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;
 - p. Oversee that portion of the corporate compliance plan that pertains to the medical staff;
 - q. Hold medical staff leaders, committees, and Services accountable for fulfilling their duties and responsibilities;

- r. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws; and
- s. 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 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 and other general meetings, if any, of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.
- 7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the voting members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or electronic means, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.
- 7.1.3 Special Meetings of the Medical Staff
 - a. The President of the Medical Staff may call a special meeting of the medical staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC. 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) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Services

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 Chief or of the Service thereof or by the President of the Medical Staff.

7.4 Quorum

- 7.4.1 Medical Staff Meetings: Those eligible medical staff members present and voting on an issue.
- 7.4.2 MEC, Credentials Committee, and Practitioner Quality Committee: A quorum will exist when fifty percent 50% of the members are present.
- 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.

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 Practitioner Quality Committee meetings: Members of these committees are expected to attend at least 2/3 of the meetings held. Any member not meeting the attendance requirements will automatically relinquish his/her position on the committee unless the MEC decides by a 2/3 vote to let them remain on the committee.
- b. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable Service Chief or medical staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and state that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic relinquishment of the practitioner's membership and privileges. Such relinquishment will not give rise to a fair hearing, but will automatically be rescinded if and when the practitioner participates in the previously referenced meeting, provided, however, that in the event the practitioner fails to schedule and appear for a requested meeting within sixty (60) days following the automatic relinquishment or by the end of his or her current appointment or reappointment cycle, whichever comes first, the relinquishment shall be deemed a voluntary surrender of privileges or resignation of membership. The practitioner in such case will be required to apply as a new applicant and the MEC may condition consideration of the application on the practitioner's appearance at a scheduled meeting.
- c. A surrender and resignation under this Section shall be treated as a surrender or resignation while under investigation and may require National Practitioner Data Bank and State reporting, depending on the circumstances.
- d. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the CEO

The CEO is an ex-officio member of all medical staff committees to encourage participation of management to assist the medical staff. The committee may go in to executive session, with medical staff members only, when desired.

7.7 Robert's Rules of Order

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 Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

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

7.9 Action of Committee or Service

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

7.10 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 that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Service Chief shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained.

7.12 Report to MEC

When minutes, recommendations, reports or actions of a committee, department or Service involve peer review of a practitioner, they shall be reported to the MEC.

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, 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, 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.
- 8.1.4 Any conflict between a Service Chief, an Academic Chair or Clinical Program Director related to administration of medical staff functions will be resolved by the MEC after consultation with the Dean and CEO.

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 biennially, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board
- 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 Proposed amendments to Parts I, II or III of these bylaws may be originated by the MEC or by a petition signed by Twenty Five percent (25%) of the members of the active and ambulatory categories.
- 9.2.2 Each active and ambulatory member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active and ambulatory members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff if the medical staff receives an affirmative vote by 2/3 of those members eligible to vote. An affirmative vote will be counted by returning the ballot marked “yes” or by not returning the ballot.

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

9.3 Methods of Adoption and Amendment to the Organization Manual, APP Manual and any Medical Staff Rules, Regulations, and Policies

- 9.3.1 The medical staff may adopt additional changes to the Organization Manual (Parts IV), the APP Manual (Part V), and the 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 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 the MEC, changes may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board.
- 9.3.3 In addition to the process described in section 9.3.2 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to the Organization Manual and APP Manual, any rule, regulation, or policy by submitting a petition signed by twenty-five percent (25%) of the members of the active and ambulatory category. Upon presentation of such petition, the adoption process outlined in section 9.2.1 above will be followed.
- 9.3.4 When a change to the Organization Manual or APP Manual, new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party prior to vote.

- 9.3.5 In cases of a documented need for an urgent amendment to the Organization Manual or APP Manual, rules and regulations, or policies and procedures 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.
- 9.3.6 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.



The Nebraska Medical Center

MEDICAL STAFF BYLAWS

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

Implemented July 1, 2018

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1.1 Criteria for Initiation

These bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management.

1.1.1 When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

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

1.1.2 Following collegial intervention efforts, if it appears that the practitioner's performance may adversely affect patient care 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, medical staff committee chair, Service Chief, CEO, CMO, or hospital board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons.

2.2 Investigation

- 2.2.1 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.
- 2.2.2 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.
- 2.2.3 The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO. The investigating body may require as an investigative step that the practitioner's cases be concurrently monitored. 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 that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. The MEC shall notify the applicable academic chair and seek information relevant to the investigation. 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.

- 2.2.4 An external peer review consultant should be considered when:
- a. Litigation seems likely;
 - b. The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;
 - c. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.
- 2.2.5 The following actions or events shall be deemed a resignation while under investigation or to avoid an investigation for purposes of determining whether a mandatory report to the National Practitioner Data Bank or state licensing board is necessary:
- a. A surrender of privileges, resignation of membership or acceptance of voluntary limitations while subject to an investigation initiated under Section 2.2.1 above.
 - b. A surrender or resignation for failure to attend a required meeting under Part I, Section 7.5.1.
 - c. Automatic relinquishment/voluntary surrender under Sections 3.1.8 (special appearance requirements), 3.1.9 (failure to participate in an evaluation, but not including failure to participate in an annual physical examination after age 70 under Part III, Section 5.8), and 3.1.11 (failure to execute a release or provide documents).
 - d. Any other surrender of privileges, resignation of membership or voluntary acceptance of limitations that is required to be reported under rules applicable to the National Practitioner Data Bank and applicable state licensing board.

2.3 MEC Action

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

- a. Determining no corrective action is warranted, and if the MEC determines there was 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 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;
- h. Making a report to the applicable academic chair and/or to appropriate officials or committees at affiliated hospitals for their peer review activities; or
- i. 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, that recommendation shall be immediately transmitted in writing to the board. 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.

3.1 Automatic Relinquishment/Voluntary Resignation

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

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, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 Federal Program Sanctions. Federal programs include Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs. Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other 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 his or her privileges.

3.1.3 **Controlled substances.**

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

3.1.4 **Medical record completion requirements:** A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to attending patients currently admitted when the relinquishment is imposed, attending emergency department patients while the relinquishment is in effect, rounding on inpatients, or procedures or deliveries that are posted for the first seven (7) days following the relinquishment. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **Professional liability insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage or if the practitioner terminates or is terminated from participation in the Nebraska Hospital-Medical Liability Act. .

3.1.6 **Medical Staff dues/special assessments:** Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, and any fines levied by the MEC, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

- 3.1.7 **Felony/misdemeanor conviction:** A practitioner who has been convicted of or entered a pleas of “guilty” or “no contest” or its equivalent to a felony or to a misdemeanor relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, or a charge involving moral turpitude in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.
- 3.1.8 **Failure to satisfy the special appearance requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges. This relinquishment of privileges shall not apply to attending patients currently admitted when the relinquishment is imposed, attending emergency department patients while the relinquishment is in effect, rounding on inpatients, or procedures or deliveries that are posted for the first seven (7) days following the relinquishment. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within 60 calendar days will be considered a voluntary resignation from the medical staff.
- 3.1.9 **Failure to participate in an evaluation:** A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. This relinquishment of privileges shall not apply to attending patients currently admitted when the relinquishment is imposed, attending emergency department patients while the relinquishment is in effect, rounding on inpatients, or procedures or deliveries that are posted for the first seven (7) days following the relinquishment. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within 60 calendar days will be considered a voluntary resignation from the medical staff.
- 3.1.10 **Failure to become board certified or failure to maintain board certification:** A practitioner who fails to become board certified or maintain board certification in compliance with these bylaws or medical staff credentialing policies shall notify the medical staff office of such and will be deemed to have voluntarily relinquished his or her medical staff appointment and clinical privileges unless an exception is granted, for a good cause, by the Board upon recommendation from the MEC.
- 3.1.11 **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. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

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

3.2 Precautionary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A precautionary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the health or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution. Under such circumstances the President of the Medical Staff or designee in consultation with the CEO or designee may restrict or suspend the medical staff membership or all or a portion of the clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO, and the board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

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

3.2.3 **Procedural rights:** Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, practitioner shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days. In the event that following or as a result of its investigation the MEC recommends a corrective action that itself affords the practitioner procedural rights, any hearing due on account of the precautionary restriction or suspension may be merged with a hearing held on account of the recommendation of corrective action.

4.1 Eligibility for Hearing

4.1.1 Any practitioner eligible for medical staff membership and physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation based on 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;
- d. Involuntary reduction or revocation of clinical privileges;
- e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or
- f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days.

4.1.2 Hearings Will Not Be Triggered by the Following Actions

- a. Issuance of a letter of guidance, warning, or reprimand;
- b. Imposition of a requirement for proctoring (i.e., observation of the practitioner’s performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or privileges;
- g. Imposition of a precautionary suspension or administrative time out 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 that an application is incomplete or untimely;

- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;
- l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
- m. Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;
- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;
- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of any contract with or employment by hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed 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 staff category;
- u. Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;
- v. Removal or limitations of emergency department call;
- 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;
- aa. A routine denial, restriction or suspension of privileges due to failure to timely complete medical records, unless the investigating body determines the failure relates to clinical competence or constitutes unprofessional conduct;
- bb. Termination of privileges or practice authority of an APP with whom the practitioner has a supervising or collaborating relationship; or
- cc. Appointment or reappointment for duration of less than 24 months.

4.2 Notice of Recommendation of Adverse Action

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

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation and instructions how to do so;
- c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and
- d. The individual shall receive a copy of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.3 Request for Hearing

A practitioner who is eligible for a hearing 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.

4.4 Notice of Hearing and Statement of Reasons

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

- a. The time, place, and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;
- c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

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

4.4.2 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.

4.5 Witness List

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

5.1 Hearing Panel

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

5.2 Hearing Panel Chairperson or Presiding Officer

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

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

- a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;
- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;
- g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

- 5.3.1 As an alternative to the hearing panel described above, the CEO, acting for the Board and in conjunction with the President of the Medical Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.
- 5.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

6.1 Provision of Relevant Information

- 6.1.1 There is no right to formal “discovery” in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the documents listed below, 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. The Hospital may condition delivery of documents containing protected health information under HIPAA to the practitioner or his counsel or consultants on evidence that such counsel and/or consultants have agreed to be covered as business associates of the practitioner directly subject to the privacy mandates of HIPAA.
- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;
 - b. Reports of experts relied upon by the MEC;
 - c. Copies of redacted relevant committee minutes;
 - d. Copies of any other documents relied upon by the MEC or the Board;
 - e. No information regarding other practitioners shall be requested, provided, or considered; and
 - f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- 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 his/her counsel.

6.2 Pre-Hearing Conference

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

6.3 Failure to Appear

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

6.4 Record of Hearing

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

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 counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for his/her 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 panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

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

6.7 Burden of Proof

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

6.8 Post-Hearing Memoranda

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

6.9 Official Notice

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

6.10 Postponements and Extensions

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

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Medical Staff or CEO. All members of the hearing panel shall be present for all stages of the hearing and deliberations.

6.12 Order of Presentation

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

6.13 Basis of Recommendation

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

6.14 Adjournment and Conclusion

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

6.15 Deliberations and Recommendation of the Hearing Panel

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

6.16 Disposition of Hearing Panel Report

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

7.1 Time for Appeal

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

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- 7.2.1 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
- 7.2.2 The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or
- 7.2.3 The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

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

7.4 Nature of Appellate Review

- 7.4.1 The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- 7.4.2 The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, 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 that individual's expense. The review panel

may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Nebraska.

- 7.4.3 Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.
- 7.4.4 The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board

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

7.6 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for medical staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Fair hearing and appeal for APPs

APPs are not entitled to the hearing and appeals procedures set forth in this Part II of the medical staff bylaws. Instead, APPs are subject to the rights and processes set forth in the APP Manual.



The Nebraska Medical Center

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Implemented July 1, 2018

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Section 1. **Medical Staff Credentials Committee**

1.1 Composition

Membership of the medical staff Credentials Committee shall consist of at least seven (7) members of the active and ambulatory categories. The President of the Medical Staff will appoint the chair and other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite members such as representatives from hospital administration and the Board.

1.2 Meetings

The medical staff Credentials Committee shall meet 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 that are 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 papers, 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 and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

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

Only upon written request approved by the President of the Medical Staff, CEO, credentials chair or CMO. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

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 that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry or applicable recognized course of training in a clinical profession eligible to hold privileges;
 - 2.2.2 Have a current state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Nebraska;
 - 2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities or the GSA Excluded Parties List System;
 - 2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or a charge involving moral turpitude or dishonesty within the last five (5) years; and
 - 2.2.5 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within (5) five years (or the appropriate number of years) of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association.
 - 2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;
 - 2.2.7 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;
 - 2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;

- 2.2.9 Possess a current, valid drug enforcement administration (DEA) number if applicable;
- 2.2.10 Have appropriate written and verbal communication skills;
- 2.2.11 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:
 - a. Abstinance 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.
- 2.2.12 Waiver of Board certification or other criteria:
 - a. Any individual who does not satisfy a criterion for board certification or approved school or training program may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
 - b. Requests for waiver of board certification due to international specialty boards will require the individual provide documentation of the following:
 - i) ECFMG certification;
 - ii) Board specialty certification in a country other than the United States;
 - iii) A comparison of his/her international specialty board training with those of the American Board of Medical Specialties American Osteopathic Association or American Dental Association with special attention to any deficiencies between his/her training and medical staff accepted board standards;
 - iv) A letter of support by The Nebraska Medical Center Service Chief or University of Nebraska Medical Center College of Medicine Academic Chairman that specifically addresses any limitations or deficiencies noted above.
 - c. The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Staff Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

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

- 2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;
- 2.3.2 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of medical staff membership and/or the specific privileges requested by and granted to the applicant;
- 2.3.3 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;
- 2.3.4 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria. Those practitioners not meeting this requirement may be eligible for the Physician Reentry process as defined in Section 6.3 of these bylaws.
- 2.3.5 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;
- 2.3.6 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.
- 2.3.7 Maintain authority to access and use Nebraska Medicine's electronic health record.

2.4 Exceptions

- 2.4.1 These requirements are applicable only to those individuals who apply for initial staff appointment after October 1, 1997. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments.
- 2.4.2 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

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 an 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. completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees;
- e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) ;
- f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested;
- g. Relevant practitioner-specific data as compared to aggregate data, when available; and
- h. Morbidity and mortality data, when available.

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

- 3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. 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 that s/he is ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.
- 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, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:
- a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any);
 - b. Verification of the applicant's past clinical work experience;
 - c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
 - d. Information from the AMA or AOA Physician Profile, Federation of State Medical Boards, OIG list of Excluded Individuals/Entities or EPLS (Excluded Parties List System);
 - e. Information from professional training programs including residency and fellowship programs;
 - f. Information from the National Practitioner Data Bank); in addition the National Practitioner Data Bank will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

- g. Other information about adverse credentialing and privileging decisions;
- h. 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;
- i. Information from a criminal background check from the past seven (7) years;
- j. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;
- k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and
- l. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after 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 that any 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 his/her 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 his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

- 3.2.4 Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:
- a. Professional qualifications and competence to carry out the clinical privileges requested;
 - b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
 - c. Professional and ethical qualifications;
 - d. Professional liability actions including currently pending claims involving the applicant; and
 - e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.
- 3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.
- 3.2.6 Authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications 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 that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff, and agrees to abide by their provisions.
- Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.
- 3.2.8 Agrees to provide accurate answers to the following questions, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

- a. Have any investigations or disciplinary actions been initiated or are any pending against you by any state licensure board?
- b. Has your license to practice or registration in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily?
- c. Have you ever been asked to surrender your professional license?
- d. Have you ever been suspended, sanctioned, excluded, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?
- e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?
- f. Has your DEA certificate ever been relinquished, limited, denied, suspended, or revoked?

Is your DEA certificate currently subject to an investigation?

- h. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?
- i. Has your employment, medical staff membership, or clinical privileges ever been terminated, reduced, suspended, diminished, revoked, refused, or limited at any hospital, physician group practice or other health care facility, or have you ever voluntarily accepted any such outcome or resigned or surrendered privileges while under a medical staff investigation or to avoid an investigation??
- j. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's Board made a decision?
- k. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?
- l. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions?
- m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?
- n. If you are not currently board certified please answer n. through r. below (if board certified skip to s below):
- o. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.
- p. If not certified, have you applied for the certification exam?
- q. Have you ever been accepted to take the certification exam?
- r. If yes, what dates are you scheduled to take the certification exam?

- s. Have any professional liability claims or suits ever been filed in a court of law against you or are any presently pending?
- t. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).
- u. Have you ever been refused or denied coverage, had coverage cancelled, failed to qualify under the Nebraska Hospital-Medical Liability Act (if a physician or CRNA) or had specific privileges excluded by a malpractice liability carrier?
- v. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?
- w. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?
- x. Do you suffer from any health condition that impairs your ability to safely exercise the privileges you have requested or have you been advised by a physician that you have such a health condition?
- y. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions?
- z. Have you ever been terminated from employment or from a group practice?

3.3 Application Evaluation

3.3.1 **Credentialing Process:** All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted medical staff membership and/or privileges after review and action by the following: Service 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 that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

- 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 clinic privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- d. The applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;
- e. The applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of \$250,000;
- f. The applicant changed medical schools or residency programs or has gaps in training or practice;
- g. The applicant has one or more reference responses that raise concerns or questions;
- h. A discrepancy is found between information received from the applicant and references or verified information;
- i. The applicant has an adverse National Practitioner Data Bank report, other than for malpractice payments;
- j. The requested privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- k. The applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- l. The applicant has potential relevant physical, mental, and/or emotional or health problems;
- m. The applicant has been charged or convicted of a misdemeanor or other criminal offense which raises concerns; and
- n. 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 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.

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 that 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 his/her ability to make an unbiased recommendation s/he will notify the credentials chair and forward the application without comment.
- b. The Service Chief forwards to the medical staff Credentials Committee the following:
 - A recommendation as to whether the application should be acted on as Category 1 or Category 2;
 - A recommendation 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
 - A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

3.3.4 **Medical Staff Credentials Committee Action.** If the application is designated Category 1, it is presented to the credentials chair for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair has the opportunity to determine whether the application is forwarded as a Category 1 or 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 as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

3.3.5 **MEC Action.** If the application is designated Category 1, it is presented to the MEC. The MEC has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

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:

- 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 that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) 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:

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 twenty-four (24) months;

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

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 to the MEC and to the Chief of each Service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Service to which s/he is assigned, the clinical privileges s/he 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 staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within one Hundred and Eighty (180) calendar days from receipt of a completed application.

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

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 and who have no outstanding unpaid medical staff dues. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) 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 him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the medical staff office:
- a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;
 - 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 in Section 3.2.8, items a. to z.
- 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 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. Documentation of any required hours of continuing medical education activity;
- d. Service on medical staff, Service, and hospital committees;
- e. Timely and accurate completion of medical records;
- f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;
- g. Any significant gaps in employment or practice since the previous appointment or reappointment;
- h. Verification of current licensure;
- i. National Practitioner Data Bank query and information from the OIG List of Excluded Individuals/Entities or the EPLS (Excluded Parties List System and ;
- j. 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
- k. 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 to Provide Information.** Failure, without good cause, to provide any requested information, at least thirty (30) 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 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 "staff appointee" and "reappointment."

5.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), psychologists, physicians serving locum tenens positions, telemedicine physicians, or house staff such as residents moonlighting in the hospital, 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 Privileges for which no criteria have been established: In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:
- a. Review the community, patient, and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;
 - b. Review with members of the Credentials Committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
 - c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information, and staffing plans; and

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

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

Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

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

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

5.5 Special conditions for LIPs and APPs eligible for privileges without membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Licensed Independent Practitioners (LIPs) and Advance Practice Professionals (APPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of these LIPs and APPs shall terminate immediately, without right to due process, in the event that the employment of the LIP or APP with the hospital is terminated for any reason or if the employment contract or sponsorship of the LIP or APP with a physician member of the medical staff is terminated for any reason. All LIPs and APPs required by licensure or these medical staff bylaws to have a scope of practice or supervision agreement with a physician shall provide the Hospital and keep updated a copy of such agreement.

5.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record.

5.7 Special Conditions for Residents or Fellows in Training

- 5.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the professional graduate education committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make

decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

- 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 that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.8 Special Conditions for the Aging Practitioner

At the age of 70 as an additional credentialing step practitioners shall be required to undergo proctoring of their clinical performance as part of the assessment of their capacity to perform the requested privileges. Such proctoring shall be required in the absence of any previous performance concerns. The scope and duration of the proctoring shall be determined by the MEC upon recommendation of the Service Chief and Credentials Committee. In addition to the proctoring, a practitioner will be required to complete an annual examination that addresses their physical and mental capacity to perform the privileges held or requested. The physical and mental exams are to be conducted by a physician acceptable to the MEC, and the outcome shall be documented on the approved form and submitted to the Credentials Committee by the date requested. The physical exam is a "fitness to work" evaluation and must indicate that the practitioner has no physical or mental condition that may interfere with the safe and effective exercise of privileges granted.

5.9 Telemedicine Privileges

Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through the following mechanism. The medical staff will utilize the credentialing and privileging information from the distant-site hospital/telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services. The hospital's governing body will ensure, through its written agreement with the distant-site hospital/telemedicine entity, that all of the required CMS/TJC provisions are met.

5.10 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.

- 5.10.1 **Important Patient Care, Treatment, or Service Need:** Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure and current competence and checks the OIG list of Excluded Individuals/Entities.

- 5.10.2 **Category I 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 the applicant providing evidence of the following which has been verified by the hospital: current licensure; education training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; a query to the OIG's list of Excluded Individuals/Entities, and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1 as noted in section 3 of this manual.
- 5.10.3 **Consultations and Reporting:** Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.
- 5.10.4 **Termination of temporary privileges:** The CEO, 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 precautionary 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 his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.
- 5.10.5 **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 his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.
- 5.10.6 **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, 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.

5.10.7 Disaster Privileges:

- a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs and APPs. 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 current picture hospital ID card that clearly identifies professional designation;

A current license to practice;

Primary source verification of the license;

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

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

Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

- b. The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.
- c. 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.
- d. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 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.

- e. 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.
- f. 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.

5.11 Role of Proctors and Monitors

5.11.1 **No Physician-Patient Relationship.** Proctoring and monitoring are activities conducted for the purpose of gathering information and observing practitioners in connection with peer review activity. The appointment of an individual to a proctor or monitor role shall not have the effect of creating a physician-patient relationship between the proctor or monitor and any individual patients whom the proctored practitioner treats,

6.1 Focused Professional Practice Evaluation (FPPE)

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

6.2 Ongoing Professional Practice Evaluation (OPPE)

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

6.3 Physician Re-Entry

A practitioner who has not provided clinical care in his or her specialty within the past twenty-four (24) months who requests clinical privileges at the hospital must arrange for a preceptorship, that is 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 twenty-four (24) months as determined by the MEC, s/he 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 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.

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 for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for modification of appointment status or privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of 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. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that s/he has been granted shall send written notice, through the medical staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

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

7.4 Exhaustion of administrative remedies

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

7.5 Reporting requirements

The CEO or his/her designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Reporting under HCQIA is required whenever the hospital takes adverse professional review action against a physician or dentist lasting longer than thirty (30) days based on competence or professional conduct, which conduct affects or may adversely affect patient welfare. Reporting may also be required when the physician or dentist accepts voluntary restrictions or resigns while under investigation or to avoid an investigation. Reporting under State law is required whenever the hospital takes adverse professional review action against a health care professional based on incompetence, professional negligence, unprofessional conduct or physician, mental or chemical impairment. Reporting obligations will be determined on a case-by-case basis.

8.1 Leave Request

A leave of absence must be requested for any absence from the medical staff and/or patient care responsibilities longer than one hundred and twenty (120) days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

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

8.3 Failure to Request Reinstatement

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

Section 9. **Practitioners Providing Contracted Services**

9.1 Telemedicine Providers

When the hospital contracts for care services with practitioners who provide services through a telemedicine mechanism, all practitioners 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 these Bylaws.

9.2 Exclusivity policy

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

9.3 Qualifications

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

9.4 Disciplinary Policies

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

9.5 Effect of contract or employment expiration or termination

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

9.6 Advice Regarding Contracted Services

The MEC will provide advice to Administration and the Board about the sources of clinical services to be provided through contractual arrangements.

Section 10. **Medical Administrative Officers**

- 10.1 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.
- 10.2 Each medical administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.
- 10.3 Effect of removal from office or adverse change in appointment status or clinical privileges:
 - 10.3.1 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 staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on his remaining in office.
 - 10.3.2 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.
 - 10.3.3 A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.



The Nebraska Medical Center

MEDICAL STAFF BYLAWS

Part IV: Organization and Functions Manual

Implemented July 1, 2018

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Section 1. **Organization and Functions of the Staff**

1.1 Organization of the Medical Staff

The medical staff shall be organized into the following Services and Divisions:

- a. Anesthesiology;
- b. Emergency Medicine;
- c. Pathology;
- d. Radiation Oncology;
- e. Radiology and Nuclear Medicine
- f. Family Medicine;
- g. Medicine

The Medicine Service shall include the following specialties, which may be organized as divisions:

- (1) Allergy and Immunology;
 - (2) Cardiology;
 - (3) Endocrinology;
 - (4) Gastroenterology;
 - (5) Geriatrics;
 - (6) Hematology/Oncology;
 - (7) Infectious Disease;
 - (8) General Internal Medicine
 - (9) Nephrology;
 - (10) Occupational Medicine;
 - (11) Pulmonary Disease;
 - (12) Rheumatology.
- h. Obstetrics/Gynecology;

The Obstetrics/Gynecology Service shall include the following specialties, which may be organized as divisions:

- (1) General Obstetrics/Gynecology;
- (2) Gynecologic Oncology;
- (3) Maternal Fetal Medicine; and
- (4) Reproductive Endocrinology and Infertility.

- i. Ophthalmology;
- j. Orthopedic Surgery;
- k. Otolaryngology;

- l. Pediatrics;

The Pediatrics Service shall include the following specialties, which may be organized as divisions:

- (1) General Pediatrics;
- (2) Pediatric Cardiology;
- (3) Pediatric Endocrinology;
- (4) Pediatric Gastroenterology;
- (5) Pediatric Hematology/Oncology;
- (6) Neonatology;
- (7) Pediatric Nephrology;
- (8) Pediatric Neurology; and
- (9) Pediatric Pulmonology.

- m. Psychiatry;

- n. Surgery

The Surgery Service shall include the following specialties which may be organized as divisions:

- (1) Cardiovascular/Thoracic;
- (2) General Surgery;
- (3) Neurosurgery;
- (4) Oral Surgery and Dentistry;
- (5) Plastic Surgery;
- (6) Transplantation; and

- (7) Urology.
- o. Physical Medicine and Rehabilitation;
- p. Neurology; and
- q. Dermatology.

A Service Chief shall head each Service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

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

1.3 Description of Medical Staff Functions

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

1.3.1 Governance, direction, coordination, and action

- a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from Services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
- b. Account to the Board and to the medical staff with written recommendations for the overall quality and efficiency of patient care at the hospital;
- c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;
- d. Make recommendations on medical, administrative, and hospital clinical and operational matters;
- e. Inform the medical staff of the accreditation and state licensure status of the hospital;
- f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;
- g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

- h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
- i. Assure quality and appropriate oversight and coordination of the care provided by residents, interns and students, and ensure that the same act within approved guidelines established by the medical staff and governing body; and
- j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

- a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;
- b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;
- c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:
 - Medical assessment and treatment of patients
 - Use of medications
 - Use of blood and blood components
 - Operative and other procedures
 - Education of patients and families
 - Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
 - Appropriateness of clinical practice patterns
 - Significant departures from established pattern of clinical performance
 - Use of developed criteria for autopsies
 - Sentinel event data
 - Patient safety data
 - Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient

Findings of the assessment process relevant to individual performance;
and

- d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

- a. Understand the medical staff's and administration's approach to and methods of performance improvement;
- b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
- c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials review:

See Part III: Credentials Procedures Manual)

1.3.5 Information Management

- a. Review and evaluate medical records to determine that they:

Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.
- b. Develop, review, enforce, and maintain surveillance over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and
- c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

- 1.3.6 **Emergency Preparedness:** Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.7 Strategic Planning

- a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;
- b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and
- c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.8 Bylaws review

- a. Conduct periodic review of the medical staff bylaw, rules, regulations, and policies; and
- b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations, and policies.

1.3.9 Nominating

- a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and
- b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight

- a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;
- b. Develop and approve policies describing the type and scope of surveillance activities including:
 - Review of cumulative microbiology recurrence and sensitivity reports; Determination of definitions and criteria for healthcare acquired infections;
 - Review of prevalence and incidence studies, as appropriate; and
 - Collection of additional data as needed.
- c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
- d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
- e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

- f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
- g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and
- h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics Functions

- a. Maintain a formulary of drugs approved for use by the hospital;
- b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
- c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);
- d. Perform drug usage evaluation studies on selected topics;
- e. Perform medication usage evaluation studies as required by The Joint Commission;
- f. Perform practitioner analysis related to medication use;
- g. Approve policies and procedures related to The Joint Commission Patient Care Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;
- h. Develop and measure indicators for the following elements of the patient treatment functions:
 - Prescribing/ordering of medications;
 - Preparing and dispensing of medications;
 - Administering medications; and
 - Monitoring of the effects of medication.
- i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;
- j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;
- k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and
- l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Health

- a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;
- b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;
- c. Notify the impaired practitioner's Service Chief and the MEC whenever an impairment that could adversely affect patient care is identified. The existence of the Practitioner Health Committee does not alter the primary responsibility of the Service Chief for clinical performance within that chair's Service;
- d. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible; and
- e. Report to the MEC all practitioners known or believed to be practicing with an impairment that could adversely affect patient care so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.3.13 Utilization Management

- a. Study recommendations from medical staff members, quality assessment coordinators and others to identify problems in utilization and the review program;
- b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;
- c. Forward all unjustified cases in any review category to the appropriate Service or committee for review and action;
- d. Review case-mix financial data and any other internal/external statistical data;
- e. Upon review of any data, conduct further studies, perform education or refer the data to the Practitioner Quality Committee for their review and action;
- f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, medical staff, and administration in matters of privileged communication and legal release of information.

2.1 General language governing committees

The following shall be the standing committees of the medical staff. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

2.3 Credentials Committee

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

2.4 Practitioner Quality Committee

2.4.1 **Composition:** The Practitioner Quality Committee shall consist of at least eight (8) members of the medical staff. Representatives from nursing service and hospital administration will serve as ex officio members at the invitation of the chair.

2.4.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.2 a-d above.

2.5 Pharmacy and Therapeutics Committee

2.5.1 **Composition:** The pharmacy and therapeutics committee shall consist of at least six (6) members of the medical staff. The CEO shall appoint hospital representatives from pharmacy, nursing service, and hospital administration. All members of the committee shall be voting members.

2.5.2 **Responsibilities:** The committee shall be responsible for making recommendations to the MEC for those functions described in section 1.3.11 above.

2.6 Bylaws Committee

2.6.1 **Composition:** The bylaws committee shall consist of at least five (5) members of the medical staff at least two of whom shall be past presidents of the Medical Staff, if available.

2.6.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.8 above.

2.7 Practitioner Health Committee

2.7.1 **Composition:** The practitioner health committee shall consist of at least three (3) members of the active or ambulatory categories.

2.7.2 **Responsibilities:** This committee shall be responsible for those functions described in section 1.3.12 above.

2.8 Leadership and Succession (Nominating) Committee

2.8.1 **Composition:** The Leadership and Succession Committee shall consist of seven (7) members. At least three (3) members will be Academic Practitioners and at least three (3) members will be Community-based Practitioners, so as to assure a broad-based diverse representation from the entire medical staff. The Academic Members will be recommended by the Clinical Chairs Advisory Board and the Community-based members will be recommended by the Clinical Community Advisory Board. The recommended members will be ratified by the MEC. The committee chair will be the President of the Medical Staff. All members should be members of the active or ambulatory category of the medical staff for at least five (5) years and have been in a leadership position, such as a Service Chief, medical staff committee chair, medical staff officer, or MEC member. Members shall be appointed for three (3) year terms and staggered so as to assure that members do not all rotate off the committee at the same time.

2.8.2 **Responsibilities:** The committee shall:

- a. Develop criteria for leadership positions to include tenure, leadership training, previous experience in leadership positions and character;
- b. Submit recommendations for and provide a slate of nominees for the elected medical staff positions and Service Chiefs;
- c. Provide an annual list of potential leaders;
- d. Define a process for evaluating current leaders e.g. Service Chiefs, committee chairs, medical staff officers, and MEC members and potential leadership candidates;
- e. Outline a plan and processes for developing potential leaders;
- f. Submit recommendations for medical staff committee chairs based on the potential leaders' needs for development and readiness to serve (the President of the Medical Staff will consider these recommendations for committee chairs but will not be bound by them);
- g. Develop position descriptions for officer positions;

- h. Report twice a year to the MEC; and
- i. Define a process for selecting the four (4) Service Chiefs to serve on the MEC.

3.1 Confidentiality of Information

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

- Proceedings, records, minutes and reports of peer review committees as described in the Nebraska Health Care Quality Improvement Act;
- Incident Reports and risk management reports as described in the act.
- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

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

Peer review committees for purposes of this section include the MEC, the Credentials Committee, the Practitioner Quality Committee, any hearing committee established under Part II, any investigating committee, the Service Chiefs and their designees when conducting peer review within their Services, any tissue review committee, utilization review committee, and any other committee established by the Board directly or through approval of these Bylaws that conducts professional credentialing or quality review activities, involving the competence of or professional conduct of or quality of care provided by an individual or institutional health care provider.

3.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The absolute release immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

3.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- a. Applications for appointment/affiliation, clinical privileges, or specified services;
- b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- c. Corrective or disciplinary actions;
- d. Hearings and appellate reviews;
- e. Quality assessment and performance improvement/peer review activities;
- f. Utilization review and improvement activities;
- g. Claims reviews;
- h. Risk management and liability prevention activities; and
- i. Other hospital, committee, Service, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

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

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source or vendor. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

The Nebraska Medical Center

MEDICAL STAFF BYLAWS

**Part V: Advance Practice Professionals
Policy Manual**

Implemented July 1, 2018

Revised August 5, 2019

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Section 1. Scope and Overview of Policy

1.1 Scope of Policy

- 1.1.1 This Manual is a Medical Staff Policy. This Manual addresses those Advance Practice Professionals ("APPs") who are permitted to provide services within The Nebraska Medical Center. It sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of APPs at the hospital.
- 1.1.2 This Manual shall apply to APPs who are permitted to provide services within The Nebraska Medical Center.
- 1.1.3 "Hospital," as used in this Manual, shall mean The Nebraska Medical Center.
- 1.1.4 The terms used in this Manual are defined in the Medical Staff Bylaws of the hospital, except as otherwise noted herein.

2.1 Categories of APPs

Only those specific categories of APPs that have been approved by the Board and granted privileges shall be permitted to practice at the hospital. All such categories shall be classified as either "Independent APPs" or "Dependent APPs," each having a slightly different relationship to the hospital.

2.2 Independent APPs

- 2.2.1 "Independent APPs" shall include all those APPs categorized as Professional Associates, who are licensed or certified under state law, authorized to function independently in the hospital, and granted clinical privileges. These individuals generally require no formal or direct supervision by a physician.
- 2.2.2 A current listing of the specific categories of APPs functioning in the hospital as Independent APPs is attached to this Manual as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Manual.

2.3 Dependent APPs:

- 2.3.1 "Dependent APPs" shall include all those APPs, categorized as Mid-Level Practitioners, who are permitted to practice in the hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who are granted clinical privileges. The supervising physician(s) is responsible for the actions of the Dependent APP in the hospital.
- 2.3.2 A current listing of the specific categories of APPs functioning in the hospital as Dependent APPs is attached to this Manual as Appendix B. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Manual.

3.1 **Additional Policies**

The Board shall adopt a separate policy for each category of APPs that it approves to practice in the hospital. These separate policies shall supplement this Manual and shall address the specific matters set forth in Section 2.2 of this Manual.

Section 2. Guidelines For Determining The Need For New Categories Of APPs

2.1 Determination of Need

Whenever APPs in a category that has not been approved by the Board requests permission to practice at the hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of APPs and to make a recommendation to the Board. As part of the process, the affected APPs shall be invited to submit information about the nature of the proposed practice, why hospital access is sought, and the potential benefits to the community by having such services available at the hospital. The ad hoc committee may consider the following factors when making a recommendation to the Board as to the need for the services of this category of APPs:

- 2.2.1 The nature of the services that could be offered;
- 2.2.2 Any state license or regulation which outlines the scope of practice for APPs;
- 2.2.3 Any state "non-discrimination" or "any willing provider" laws that would apply to APPs;
- 2.2.4 The business and patient care objectives of the hospital;
- 2.2.5 How well the community's needs are currently being met and whether they could be better met if the services offered by APPs were provided by the hospital or as part of its facilities;
- 2.2.6 The type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;
- 2.2.7 The availability of supplies, equipment, and other necessary hospital resources;
- 2.2.8 The availability of trained staff;
- 2.2.9 Patient convenience; and
- 2.2.10 The ability to appropriately supervise performance.

3.1 Development of Policy

If the ad hoc committee determines that there is a need for the particular category of APPs at the hospital, the committee shall recommend to the Board a separate policy for these practitioners that addresses: (1) any specific qualifications and/or training that they must possess beyond those set forth in this Manual; (2) a detailed description of their authorized clinical privileges; (3) any specific conditions that apply to their functioning within the hospital; and (4) any supervision requirements, if applicable. In developing such policies, the ad hoc committee shall consult the appropriate service chief(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of APPs that are needed in a particular category.

Section 3. Qualifications, Conditions, and Responsibilities

3.1 General Qualifications

To be eligible to apply for initial and continued permission to practice at the hospital, APPs must:

- 3.3.1 Have a current unrestricted license to practice in this state and current certification as an Advance Practice Registered Nurse or Physician Assistant by their approved board or subspecialty board and have never had a license to practice revoked or suspended by any state licensing agency;
- 3.3.2 Where applicable to their practice, have a current, unrestricted DEA registration;
- 3.3.3 Be located (office and residence) within the geographic service area of the hospital, as defined by the Board, close enough to fulfill their responsibilities and to provide timely and continuous care for patients in the hospital;
- 3.3.4 Have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the hospital;
- 3.3.5 Have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- 3.3.6 Have never been, and are not currently, excluded or precluded ("Excluded" from participation in Medicare, Medicaid or other federal or state governmental health care program);
- 3.3.7 Have never had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- 3.3.8 Have never been convicted of, or entered a plea of guilty or no contest to, any felony, or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse or violence;
- 3.3.9 Satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the hospital;
- 3.3.10 If seeking to practice as a Dependent APP, have a supervision agreement with a physician who is appointed to the Medical Staff and;
- 3.3.11 Be able to document his or her:
 - a. Relevant training, experience, demonstrated current competence and judgment;
 - b. Adherence to the ethics of his or her profession;
 - c. Good reputation and character;
 - d. Ability to perform, safely and competently, the clinical privileges requested; and
 - e. Ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them will receive quality care and that the hospital and its Medical Staff will be able to operate in an orderly manner.
- 3.3.12 Meet the requirements as noted in Part III: Credentials Procedures Manual, Section 5.8.

3.2 Waiver of Criteria

- 3.2.1 Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- 3.2.2 The Board may grant waivers in exceptional cases after considering the findings of the Credentials and Staff Executive Committees or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- 3.2.3 No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

3.3 No Entitlement to Medical Staff Appointment

APPs shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

3.4 Non-Discrimination Policy:

No individual shall be denied permission to practice at the hospital on the basis of national origin, race, gender, religion, sexual orientation, disability unrelated to the provision of patient care or required responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified

3.5 Assumption of Duties and Responsibilities

As a condition of permission to practice at the hospital, all APPs shall specifically agree to the following:

- 3.5.1 To provide continuous and timely care to all patients for whom the individual has responsibility;
- 3.5.2 To abide by all applicable bylaws, policies, rules and regulations of the medical staff and hospital;
- 3.5.3 To accept committee assignments and such other reasonable duties and responsibilities as may be assigned;
- 3.5.4 To provide, with or without request, new or updated information to the Chief Executive Officer, as it occurs, pertinent to any question on the application form;
- 3.5.5 To acknowledge that the individual has had an opportunity to read a copy of this Manual and any other applicable bylaws, Policies, rules and regulations and agrees to be bound by them;
- 3.5.6 To appear for personal interviews in regard to an application for permission to practice as may be requested;
- 3.5.7 To refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- 3.5.8 To refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- 3.5.9 To refrain from deceiving patients as to the individual's status as an APPs;

- 3.5.10 To seek consultation when appropriate;
- 3.5.11 To participate in the monitoring and evaluation activities;
- 3.5.12 To complete, in a timely manner, all medical and other required records, containing all information required by the hospital;
- 3.5.13 To perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- 3.5.14 To satisfy applicable continuing education requirements;
- 3.5.15 To promptly pay any applicable dues and assessments;
- 3.5.16 That, if there is any misstatement in, or omission from, the application, the hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Manual; and
- 3.5.17 Effective as of the date of appointment, to become a participant in an Organized Health Care Arrangement with the hospital and as part of the Organized Health Care Arrangement, each APPs and any other individual exercising clinical privileges in the hospital will provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices and to comply with any federal or state laws or hospital policies related to the use or disclosure of individually identifiable health information, including but not limited to the HIPAA Privacy Regulations at 45 C.F.R. Parts 160 and 164.

3.6 Burden of Providing Information

- 3.6.1 APPs seeking permission to practice 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 for resolving any doubts about such qualifications.
- 3.6.2 APPs seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- 3.6.3 An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- 3.6.4 It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

3.7 Application Form

- 3.7.1 The application forms for both initial and renewed permission to practice as an APPs shall require detailed information concerning the applicant's professional qualifications. The APPs applications existing now and as may be revised are incorporated by reference and made a part of this Manual. In addition to other information, the applications shall seek the following:

- a. Information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;
- b. Information as to whether the applicant's license or certification to practice any profession in any state or Drug Enforcement Administration registration is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;
- c. Information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Medical Executive Committee or Board may deem appropriate; and
- d. Current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of APPs.

3.7.2 The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of APPs.

3.8 Grant of Immunity and Authorization to Obtain/Release Information

By applying for permission to practice at the hospital, APPs expressly accept the following conditions during the processing and consideration of the application, whether or not permission to practice is granted, and as a condition of continued permission to practice, if granted:

3.8.1 Immunity:

To the fullest extent permitted by law, the APPs release from any and all liability, extends absolute immunity to, and agrees not to sue the hospital, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to permission to practice, clinical privileges, at the hospital, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the hospital, its authorized agents, or appropriate third parties.

3.8.2 Authorization to Obtain Information from Third Parties:

APPs specifically authorizes the hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on APPs' qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for permission to practice at the hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. APPs also specifically authorizes third parties to release this information to the hospital and its authorized representatives upon request.

3.8.3 Authorization to Release Information to Third Parties:

APPs also authorize hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility.

3.8.4 Procedural Rights:

APPs agree that the procedural rights set forth in this Manual shall be the sole and exclusive remedy with respect to any professional review action taken by the hospital.

3.8.5 Legal Actions:

If, notwithstanding the provisions in this Section, APPs institute legal action and does not prevail, he or she shall reimburse the hospital and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

3.8.6 Authorization to Share Information Among Affiliates of the hospital:

The individual specifically authorizes the hospital and its Affiliates to share credentialing and peer review information among them pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment. For purposes of this Section 3.1(f), an Affiliate shall be deemed to include but not be limited to Medical Staff Appointees, and their employers, employees and agents and shall specifically include the University of Nebraska College of Medicine, University Medical Associates and Private Practice Associates, LLC.

Section 4. **Credentialing Procedure**

4.1 Request for Application

- 4.0.1 Applications for permission to practice at the hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Executive Committee and Credentials Committee.
- 4.0.2 Any individual requesting an application for permission to practice at the hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the APPs' area of practice, and the application form.
- 4.0.3 APPs who are in a category of practitioners that has not been approved by the Board for access to the hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle APPs to the procedural rights outlined in Section 6 of this Manual.

4.1 Initial Review of Application

- 4.1.1 A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the APPs desire further consideration. The application must be accompanied by the application processing fee, if one is required.
- 4.1.2 Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 3.1(a-j) of this Manual will be notified that they are not eligible for permission to practice at the hospital and that their application will not be processed. A determination of ineligibility does not entitle an APPs to the procedural rights outlined in Section 6 of this Manual.
- 4.1.3 The Chief Medical Officer or designee shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

4.2 Service Chief Procedure

- 4.2.1 The hospital's office of Medical Staff Services shall transmit the complete application and all supporting materials to the appropriate Service chief or the individual to whom the Service chief has assigned this responsibility. Each chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested. As part of the process of making this report, the Service chief has the right to meet with the applicant and the supervising physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The Service chief may also confer with experts within the clinical Service and outside of the Service in preparing the report (e.g., other physicians, relevant hospital clinical service heads, nurse managers). In the event that the Service chief or the individual to whom the Service chief has assigned the responsibility is unavailable or unwilling to prepare a written report, the Chair of the Credentials Committee or the Chief of Staff shall appoint an individual to prepare the report.
- 4.2.2 The service chief shall be available to the Credentials Committee, Medical Executive Committee, or the Board to answer any questions that may be raised with respect to that chief's report and findings.

4.3 Credentials Committee Procedure

- 4.3.1 The Credentials Committee shall review the report from the appropriate Service chief and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.
- 4.3.2 The Credentials Committee may use the expertise of any individual on the Medical Staff or in the hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate service chief may participate in this interview.
- 4.3.3 After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges requested, the Credentials Committee shall review the applicant's application and request for privileges to determine if there is any question about the applicant's ability to perform the clinical privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

4.4 Medical Executive Committee Procedure

- 4.4.1 At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
 - a. Adopt the findings and recommendations of the Credentials Committee as its own; or
 - b. Refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee; or
 - c. Set forth in its report and recommendation clear and convincing reasons, along with supporting information for its disagreement with the Credentials Committee's recommendation.
- 4.4.2 If the Medical Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the Chief Executive Officer, including the findings and recommendation of the service chief and the Credentials Committee. The Medical Executive Committee's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

- 4.4.3 If the Medical Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Manual, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer who shall notify the applicant of the recommendation and his or her procedural rights. The Chief Executive Officer shall then hold the Medical Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Manual.

4.5 Board Action

- 4.5.1 Upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges, the Board may:
- a. Grant the applicant permission to practice and clinical privileges as recommended; or
 - b. Refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the hospital for additional research or information; or\
 - c. Reject or modify the recommendation.
- 4.5.2 If the Board determines to reject a favorable recommendation, it will first discuss the matter with the chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable, the Chief Executive Officer shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Manual.

4.6 Renewal of Permission to Practice

- 4.6.1 Renewal of an APPs' clinical privileges shall be considered only upon submission of a completed application for renewed permission to practice. Four months prior to the date of expiration of an APPs' clinical privileges, Medical Staff Services shall give the individual notice of the date of expiration and an application form for renewed clinical privileges.
- 4.6.2 Failure to return a completed application to Medical Staff Services within 30 days may result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of permission to practice and clinical privileges at the end of the then current term, and the individual may not practice until an application is processed.
- 4.6.3 Renewed permission to practice, if granted, shall be for a period of not more than two years.
- 4.6.4 Once an application for renewed permission to practice has been completed and submitted to Medical Staff Services, it shall be evaluated in the same manner and follow the same procedures outlined in this Manual for initial applicants.
- 4.6.5 As part of the process for renewal of permission to practice for Dependent APPs, the competency of the Dependent APP shall be assessed by the supervising physician(s) and the applicable Service Chief or designee biennially. The evaluation along with other reasonable indicators of continuing qualifications shall be factors for the renewal of the Dependent APP's permission to practice.

- 4.6.6 As part of the process for renewal of permission to practice for Licensed Independent Practitioners, the following factors shall be considered:
- a. The competency of the Licensed Independent Practitioner as assessed by the appropriate service chief(s) or designee and documented on a biennial evaluation form;
 - b. A recommendation from a peer; and
 - c. Use of the hospitals' facilities taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

4.7 Administrative Suspension

- 4.7.1 The Chief of Staff, the relevant Service Chief, the Chief Medical Officer, and the Chief Executive Officer shall each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any APPs whenever a concern has been raised about such individual's clinical practice or conduct.
- 4.7.2 An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer or designee and the Chief of Staff, and shall remain in effect unless or until modified by the Chief Executive Officer, Chief of Staff or the Medical Executive Committee.
- 4.7.3 Upon receipt of notice of the imposition of an administrative suspension, the Chief Executive Officer and the Chief of Staff shall forward the matter to the full Medical Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Medical Executive Committee's recommendation is to restrict or terminate the APPs' clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Section 6 of this Manual before the Medical Executive Committee's recommendation is considered by the Board.

5.1 Supervision by Supervising Physician

- 5.1.1 Any activities permitted by the Board to be done at the hospital by a Dependent APP shall be done only under the direct supervision of the physician supervising that individual. Except as provided by law or hospital policy, "direct supervision" shall not require the actual physical presence of the employing or supervising physician.
- 5.1.2 Dependent APPs may function in the hospital only so long as (i) they are directly supervised by a physician currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the staff physician supervising a Dependent APP be revoked or terminated, the Dependent APP's permission to practice at the hospital and clinical privileges shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).
- 5.1.3 As a condition for permission to practice at the hospital, each Dependent APP and his/her supervising physician must submit a copy of their written supervision agreement to the hospital. This agreement must meet the requirements of all applicable state statutes and regulations, as well as any additional requirements of the hospital. It is also the responsibility of the Dependent APP and his/her supervising physician to provide the hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

5.2 Questions Regarding Authority of a Dependent APP

- 5.2.1 Should any Medical Staff Appointee or hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Dependent APP either to act or to issue instructions outside the physical presence of the supervising physician in a particular instance, the Medical Staff Appointee or hospital employee shall have the right to require that the Dependent APP's employer or supervisor validate, either at the time or later, the instructions of the Dependent APP. Any act or instruction of the Dependent APP shall be delayed until such time as the staff Appointee or hospital employee can be certain that the act is clearly within the scope of the Dependent APP's clinical privileges as permitted by the Board.
- 5.2.2 Any question regarding the clinical practice or professional conduct of a Dependent APP shall be immediately reported to the Chief of Staff, the relevant Service chief, the Chief Medical Officer or the Chief Executive Officer, who shall undertake such action as may be appropriate under the circumstances.

5.3 Responsibilities of Supervising Physician

- 5.3.1 The supervising physician shall be responsible for the actions of the Dependent APP in the hospital.
- 5.3.2 The number of Dependent APPs acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.

- 5.3.3 It shall be the responsibility of the physician supervising the Dependent APP to provide, or to arrange for, professional liability insurance coverage for the Dependent APP in amounts required by the Board that covers any activities of the Dependent APP at the hospital, and to furnish evidence of such coverage to the hospital. The Dependent APP shall act at the hospital only while such coverage is in effect.

Section 6. **Procedure Rights For APPs**

6.1 General

APPs shall not be entitled to the hearing and appeals procedures set forth in Part II of the Medical Staff Bylaws. Any and all procedural rights to which APPs are entitled are set forth in this Section.

6.2 Procedural Rights for APPs

- 6.2.1 In the event that a recommendation is made by the Medical Executive Committee that APPs not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted or terminated, the APP shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.
- 6.2.2 If an APP desires to request a hearing, he or she must make such request in writing and direct it to the Chief Executive Officer within 30 days after receipt of the written notice of the adverse recommendation.
- 6.2.3 If a request for a hearing is made in a timely manner, the Chief Executive Officer, in conjunction with the Chief of Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, APPs, hospital management, individuals not connected to the hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the APPs, or any competitors of the affected individual.
- 6.2.4 As an alternative to the Ad Hoc Committee described in Section 6.2.3, above, the Chief Executive Officer, in conjunction with the Chief of Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Section to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.
- 6.2.5 The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

6.3 Hearing Process for APPs

- 6.3.1 At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The APP shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the APPs.
- 6.3.2 APPs shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer (or the Hearing Officer) that the failure to permit witnesses to appear would be fundamentally unfair. In the event witnesses are allowed, the Presiding Officer (or the Hearing Officer) shall permit reasonable questioning of such witnesses.
- 6.3.3 Neither APPs nor the Medical Executive Committee shall be represented by counsel at this hearing.
- 6.3.4 The APP may be directly questioned by the Ad Hoc Committee (or Hearing Officer).
- 6.3.5 The APP shall have the burden of demonstrating that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the hospital shall be the paramount considerations. Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

6.4 Ad Hoc Committee or Hearing Officer Report

- 6.4.1 The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to APPs. A copy shall also be provided to the Medical Executive Committee.
- 6.4.2 Within ten days after receiving notice of the recommendation, either the APP or the Medical Executive Committee may make a request for an appeal. The request must be in writing and must include a statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the Chief Executive Officer either in person or by certified mail.
- 6.4.3 If a written request for appeal is not submitted within the ten (10) day time frame specified above, the recommendation and supporting information shall be forwarded by the Chief Executive Officer to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairman of the Board.

6.5 Appeals Process for APPs

- 6.5.1 The grounds for appeal shall be limited to the following assertions: (i) there was substantial failure to comply with this Manual and/or other applicable bylaws or policies of the hospital or the Medical Staff and/or (ii) the recommendation was arbitrary, capricious, or not supported by evidence.
- 6.5.2 The Chairman of the Board, or a committee of the Board appointed by the Chairman, will consider the request for appeal and the record upon which the adverse recommendation was made. This review shall be conducted within 30 days after receiving the request for appeal.
- 6.5.3 APPs and the Medical Executive Committee shall each have the right to present a written statement in support of its position on appeal.
- 6.5.4 At the sole discretion of the Chairman of the Board or the committee appointed by the Chairman, APPs and a representative of the Medical Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.
- 6.5.5 Upon completion of the review, the Chairman of the Board or the committee appointed by the Chairman shall provide a report and recommendation to the full Board for action. The Chairman (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the hospital.

6.6 Exceptions to Procedural Rights

- 6.6.1 APPs' clinical privileges shall automatically terminate, without entitlement to the procedural rights outlined in this Section, in the following circumstances:
 - a. The APP's license is revoked; or
 - b. The APP no longer satisfies all of the threshold eligibility criteria set forth in Section 3.1.1 to 3.1.11 of this Manual, or any additional threshold credentialing qualification set forth in the specific hospital policy relating to their discipline.
- 6.6.2 APPs' clinical privileges shall be automatically suspended, until reinstatement is verified by the hospital's Office of Medical Staff Services and granted by the Chief of Staff, without entitlement to the procedural rights outlined in this Section, in the following circumstances:
 - a. APPs' license expires or is suspended;
 - b. APPs' liability insurance coverage is not in effect.

- c. A Dependent APP ceases to be directly supervised by a physician currently appointed to the Medical Staff (unless the Dependent APP will be supervised by another physician on the Medical Staff). A two (2) week suspension shall automatically give rise to a termination of appointment unless reinstatement is granted by the Chief of Staff.
- d. The APP becomes an Excluded provider described in Section 3.1.6 of this Manual.

Section 7. **Hospital Employees**

7.1 Employer of Hospital

7.1.1 APPs who are employees of the hospital shall not be governed by this Manual, except as expressly indicated in this Section. Rather, they shall be governed by such hospital employment policies, manuals, and descriptions as are appropriate and as may be established from time to time.

7.2 Employment; Dependent APPs

Dependent APPs who are seeking employment with, or are employed by, the hospital will be credentialed and/or recertified using the same process set forth in Section 4 of this Manual. As they are credentialed through Section 4 of this Manual, a report regarding their qualifications shall be made to the hospital to assist it in making employment decisions. In addition, all employed Dependent APPs shall be subject to the same supervision requirements set forth in Section 5 of this Manual.

Section 8. **Amendments**

8.1 This Manual may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Executive Committee meeting where action on the amendments will be taken, and any member of the Medical Staff may submit written comments to the Medical Executive Committee. No amendment to this Manual shall be effective unless and until it has been approved by the Board.

Section 9. **Adoption**

9.1 This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, or hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

Date: October 5, 2017

George M. Greene, MD
Chief of Staff

Approved by the Board:

Date: October 23, 2017

Jeffrey P. Gold, MD
Chair, Board of Directors

APPENDIX A

Those individuals currently practicing as Independent APPs, categorized as Professional Associates, at the hospital are as follows:

Optometrist
Licensed Mental Health Practitioner
Psychologists

APPENDIX B

Those individuals currently practicing as Dependent APPs, categorized as Mid- Level Practitioners, at The Nebraska Medical Center are as follows:

Physician Assistant

Advance Practice Registered Nurse – Nurse Practitioner

Advance Practice Registered Nurse – Certified Nurse Midwife

Advance Practice Registered Nurse – Certified Registered Nurse Anesthetist

