

**BYLAWS OF THE PROFESSIONAL STAFF OF
THE UNIVERSITY OF UTAH NEUROPSYCHIATRIC INSTITUTE**

DEFINITIONS

1. **HOSPITAL BOARD** means the University of Utah Health Care Hospital Board.
2. **EXECUTIVE DIRECTOR** means the individual appointed by the Hospital Board to act on its behalf in the overall administrative management of the hospital.
3. **MEDICAL DIRECTOR** means the physician appointed by the Hospital Board to act on its behalf to promote the clinical excellence of the hospital's programs, activities, and systems.
4. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical or other clinical services in this hospital.
5. **EX OFFICIO** means service as a member of a committee by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.
6. **HOSPITAL** means The University of Utah Neuropsychiatric Institute of Salt Lake City, Utah and includes related services and programs.
7. **PROVIDER** means the individual member of the Professional Staff.
8. **EXECUTIVE COMMITTEE** means the Executive Committee of the Professional Staff, unless otherwise stated.
9. **PROFESSIONAL STAFF or STAFF** means the formal organization of all licensed physicians, psychologists, and Mental Health Professionals who are members and exercise clinical privileges in this hospital.
10. **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested, or e-mail.
11. **CLINICAL DIRECTOR** means the Medical Director, psychology or social work supervisor (appointed by the Executive Director) who promotes the clinical excellence of the appropriate programs.

NOTE: The masculine pronoun shall be used throughout these bylaws to denote Professional Staff of either sex.

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PREAMBLE

WHEREAS, The University of Utah Neuropsychiatric Institute is organized under the laws of the State of Utah; and

WHEREAS, its purpose is to serve as a psychiatric and neuropsychiatric institute providing patient care, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the Professional Staff is to strive to provide patient care of professionally recognized quality, that the Professional Staff is a self-governing body that must work with and is accountable to the ultimate authority of the Hospital Board, and that the cooperative efforts of the Professional Staff, the University of Utah Department of Psychiatry, the Executive Director, and the Hospital Board are necessary to fulfill the hospital's obligations to its patients. The University of Utah Neuropsychiatric Institute Professional Staff Bylaws and the Hospital Board bylaws are compatible with each other and are compliant with law and regulation. The Hospital board upholds the Professional Staff bylaws, rules and regulations, and policies that have been approved by the Hospital Board.

THEREFORE, the professionals practicing in this hospital are recognized as a Professional Staff in conformity with these bylaws.

ARTICLE I: NAME

Appointees to the Professional Staff shall be known collectively as the Professional Staff of The University of Utah Neuropsychiatric Institute.

ARTICLE II: PURPOSES

The purposes of the Professional Staff are:

1. To be the formal organizational structure through which;
 - (a) the benefits of appointment to the staff may be obtained by individual practitioners; and
 - (b) the obligations of staff appointment may be fulfilled.
2. To serve as the primary means for accountability to the Hospital Board for the appropriateness of the professional performance and ethical conduct of staff appointees and to foster the policy that the pattern of patient care in the hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.
3. To provide a means whereby policies and procedures relating to the quality of medical care, and whereby issues concerning the Professional Staff and the hospital may be discussed by the Professional Staff with the Hospital Board.

ARTICLE III: RESPONSIBILITIES

The responsibilities of the Professional Staff are:

1. To account for the quality and appropriateness of patient care rendered by all practitioners authorized to practice in the hospital through the following measures:
 - (a) A credentialing procedure, including mechanisms for appointment and reappointment and the delineation of clinical privileges;
 - (b) A continuing medical education program fashioned at least in part on the needs demonstrated through patient care evaluation and other quality improvement programs;
 - (c) A Utilization Review program based on the requirements of the UNI Utilization Review Plan;
 - (d) An organizational structure that allows for continuous monitoring of patient care practices;
 - (e) Evaluation of the quality of patient care and the reporting of results to the Hospital Board;
 - (f) Initiation and pursuit of collegial intervention, performance improvement plans and investigations with respect to practitioners when warranted;

- (g) Development, administration and compliance with these bylaws and the rules and regulation of the Professional Staff, and other medical care-related hospital policies;
 - (h) The exercise of authority granted by these bylaws to adequately fulfill the foregoing responsibilities.
2. To provide patients with continuous care at a generally recognized professional level of quality and efficiency;
 3. To conduct the following examinations:
 - (a) Each patient admitted to the hospital shall have a history and physical examination (H&P). The H&P may be performed by a member of the Professional Staff who has been granted clinical privileges to do so or by specifically assigned residents in training. H&Ps performed by residents in training must be reviewed and countersigned by the attending physician.
 - (b) The admission H&P will include (but not be limited to) identifying Data, Reason for Admission, History of Present Illness, Past Medical History, Family and Social History, Review of Systems, Mental Status Exam, Vital Signs, Physical Findings (General, Skin, HEENT, Neck, Lungs, Heart, Abdomen, Back, Extremities, and Neuro), Impression and Plan. It will be completed and dictated within 24 hours after arrival of the patient on an inpatient unit.
 - (c) All partial hospital patients and intensive outpatient treatment patients will have a physical health screening by the patient's fourth visit to determine if a physical exam is necessary. The physical health screening includes significant past treatments, past and current diagnoses or problems, currently and recently used medications, and a nutrition screen. If indicated, the physical exam will be performed or referred by the eighth visit.
 - (d) Prior to each ECT, the anesthesiologist will document a history and physical examination including History of Present Illness, Current Medications, Adverse Drug Reactions, Review of Systems, Surgery/Anesthetic History, Vital Signs, Physical Findings (cardiopulmonary examination and other elements [e.g., hyoid to mandible distance, teeth, uvula, mouth opening, cervical spine flexion and extension] as indicated), and pre-anesthetic assessment.
 4. To abide by the current Professional Staff Bylaws, by all other lawful standards, and by current policies and rules of the hospital;
 5. To discharge such staff, committee, and hospital functions for which the Professional Staff is responsible by appointment, election, or otherwise;

6. To prepare and complete in a timely fashion the medical and other required records for all patients admitted to, or in any way provided care in the hospital; and
7. To abide by the lawful and ethical principles of the profession.

ARTICLE IV: PROFESSIONAL STAFF APPOINTMENT

SECTION I: Nature of Professional Staff Appointment

Appointment to the Professional Staff of The University of Utah Neuropsychiatric Institute is a privilege which shall be extended only to professionally competent, qualified providers with training and current experience in providing services in a hospital setting who continuously meet the qualification, standards and requirements set forth in these bylaws. Appointment shall also be based on the hospital's need and ability to accommodate additional appointees to the staff.

SECTION II: Qualifications for Appointment

- (a) Only providers licensed in the State of Utah who can document their background, training and experience, who can demonstrate competence, adherence to the ethics of their profession, and their good capability – based on current attitude and evidence of performance – to work with and relate to other staff appointees, to professionals in other health disciplines, to hospital management and employees, to visitors and the community in general in a cooperative professional manner that is essential for maintaining a hospital environment appropriate to quality and efficiency of patient care with sufficient adequacy to assure the Professional Staff and the Hospital Board that any patient treated by them in the hospital will be given professional care within recognized standards, shall be qualified for appointment to the Professional Staff. No provider shall be automatically entitled to appointment to the Professional Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or in any other State, or because he is a member of any professional organization, or because he is certified by any clinical board, or because he had, or presently has, staff appointment at this hospital or another healthcare facility or in another practice setting. Qualifications for appointment include a willingness and capability, also based on current attitude and evidence of performance, to discharge the basic obligations of staff appointment and to participate equitably in the discharge of staff obligations specific to Professional Staff category. Applicants for appointment to the Professional Staff are to be free of or have under adequate control any significant physical or behavioral impairment and to be free of any difficulty in communicating verbally or in writing in the English language that interferes with or presents a substantial probability of interfering with the quality and efficiency of patient care.
- (b) The applicant must provide certification by his insurance carrier of having professional liability insurance in the amount of at least \$1,000,000/\$3,000,000 on a per occurrence or claims made basis as part of his application or reapplication

for appointment. In the event that the applicant is insured under a claims made policy, he shall continue to purchase such coverage for a minimum of two years following the discharge of the last patient he treats at this facility. The applicant shall give immediate notice to the credentialing service office if the policy is ever canceled, altered or replaced. Proof of present and continued employment by a Utah governmental entity, as defined by Utah's Governmental Immunity Act, Utah Code Ann. Sections 63-30d-101 et seq. (as amended), such as the University of Utah, satisfies this requirement of proof of professional liability insurance.

- (c) Professional Staff privileges are offered to all professionally qualified providers without regard to age, race, religion, disability, color, gender, or national origin.

SECTION III: Factors for Evaluation

The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested; and
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams.

SECTION IV: Conditions and Duration of Appointment

- (a) By applying for appointment to the Professional Staff each applicant thereby signifies his willingness to appear for interviews in regard to his application, authorizes the hospital to consult with members of Professional Staffs of other hospitals with which the applicant has been associated and to consult with others who may have information regarding the applicant's competence, character and ethical qualifications. In addition, the applicant consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges requested.
- (b) Initial appointment and reappointment to the Professional Staff shall be made by the Hospital Board. The Hospital Board shall act on appointments, reappointments or revocation of appointments within a reasonable amount of time after there has been a recommendation from the Executive Committee as provided in these bylaws; provided that in the event of unwarranted delay on the part of the Executive Committee, that is, failure by that Committee to act within 45 days of

receipt of the Credentials Committee report, the Hospital Board may act without such recommendation on the basis of documented evidence of the applicant's or staff appointee's professional and ethical qualifications obtained from reliable sources other than the Professional Staff.

- (c) All new members of the Professional Staff and Allied Mental Health Professional Staff will be granted provisional Professional Staff/Allied Mental Health Professional Staff membership for a period of two years. Provisional Professional Staff/Allied Mental Health Professional Staff members will be subject to proctoring per the Focused Professional Practice Evaluation policy. At the discretion of the Medical Director, the provisional period may be shortened once a determination has been made that the practitioner has fulfilled the proctoring requirements and the Medical Director recommends their advancement from the Provisional Staff. Reappointments shall be for a period of not more than two Professional Staff years.
- (d) Appointment to the Professional Staff shall confer on the appointee only such clinical privileges as have been granted by the Hospital Board in accordance with these bylaws.
- (e) For physicians and psychologists, appointment to the Professional Staff is contingent upon receiving a faculty appointment with the University of Utah School of Medicine; however, physicians who are on the Associate Professional Staff need not have faculty appointments at the School of Medicine.

ARTICLE V: UNI PROFESSIONAL STAFF CATEGORIES

(a) The Active Professional Staff

The Active Professional Staff shall consist of (1) physicians who shall have met all the prerequisites for application for examination to the American Board of Psychiatry and Neurology, (2) psychologists licensed in the State of Utah, and (3) physicians who have met all the prerequisites for application for board certification in a related field (e.g., Family Medicine, Internal Medicine, Pediatrics, Neurology, or Anesthesiology) when by additional training, clinical experience, and/or subspecialty certification they have acquired skills that fulfill an identified teaching and clinical need within the hospital, as determined by the Medical Director. Examples of such need could include, but should not be limited to, the treatment of patients with addictions, eating disorders, or chronic pain. Such providers will be required to seek consultation from a psychiatrist member of the Active Professional Staff if a patient under his/her care suffers from a secondary mental disorder (outside the provider's particular area of expertise) that by itself would warrant inpatient treatment. In addition, physicians on the Active Professional Staff who are not eligible for examination by the American Board of Psychiatry and Neurology must have a faculty appointment through the Department of Psychiatry, University of Utah School of Medicine.

The Active Professional Staff shall deliver the preponderance of professional services within the hospital and/or be willing to be actively involved in all the functions and responsibilities of appointment to the Active Professional Staff, including, where appropriate, emergency service care and consultation assignments. Appointees to the Active Professional Staff shall be eligible to vote, to hold an office and to serve on Professional Staff committees. They are encouraged to attend Professional Staff meetings, participate in assigned peer review activities, shall be expected to teach in the hospital's clinical training programs, and must provide services for at least (6) patients (either inpatients or partial hospital patients) per year in order to maintain Active Professional Staff status. The Chairman of the University of Utah Department of Psychiatry and Director of the University of Utah Division of Child and Adolescent Psychiatry shall be eligible for Active Professional Staff status, and shall be exempt from the requirements of meeting attendance and minimum patient care numbers.

(b) The Courtesy Professional Staff

The Courtesy Professional Staff shall consist of qualified providers who are known personally or by reputation within the local psychiatric community. These professionals, because of the nature of their practice, are unable to meet all of the responsibilities for Active Professional Staff appointment and admit less than six patients per year. They must, however, submit appropriate peer review data from other Joint Commission accredited institutions, as determined by the UNI Credentials Committee. Any provider holding Active privileges at the University Medical Center is eligible to hold Courtesy Staff privileges at UNI. Appointees may occasionally be asked to assume teaching responsibility in the hospital's medical and non-medical training programs. Appointees to the Courtesy Staff may neither vote nor hold office.

(c) The Associate Professional Staff

The Associate Professional Staff shall consist of licensed physicians. These staff appointees are privileged to admit patients to the hospital, however, if the physician is a resident in training, he can admit patients only after the prior approval of the Medical Director or his designee. It is expected that each member of the Associate Professional Staff will participate in the care of at least six (6) patients per year. Associate Staff appointees may be asked to teach in the hospital's medical and non-medical training programs. These staff appointees are neither eligible to vote at Professional Staff Meetings nor hold elected office.

(d) The Consulting Professional Staff

There shall be a Consulting Professional Staff consisting of providers of recognized professional ability who have signified a willingness to accept such appointment and who are given privileges to consult on patients admitted to the hospital. Any provider holding Active Staff appointment and privileges at the University Medical Center is eligible to hold Staff privileges at UNI. Appointees to the Consulting Staff may neither vote, hold office, nor admit patients.

ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

SECTION I: General Description

The appointment/reappointment process is administered through the Medical Staff Office of the University of Utah Hospitals and Clinics. Full authority has been given to administer the collection, assembly, processing and authentication of credentials for all Professional Staff. The Professional Staff, through its designated committees and officers, shall evaluate and consider each application for appointment or reappointment to the staff and each request for modification of staff appointment status and shall adopt and transmit recommendations thereon to the Hospital Board, which shall be the final authority on granting, extension, termination, or reduction of Professional Staff privileges. The Institute does not offer temporary privileges to practice without completion of an application to the Professional Staff.

SECTION II: Application for Appointment

- (a) All applications for appointment to the Professional Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Hospital Board after consultation with the Executive Committee. The applicant's request for application will be reviewed by the Clinical Director or his designee. The application shall require detailed information concerning the applicant's professional qualifications, shall require the applicant to provide the names of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character, shall request information as to whether the applicant's appointment status and/or clinical privileges have ever been denied, voluntarily or involuntarily relinquished, revoked, suspended, reduced or not renewed at any other hospital or institution, as to whether his membership in local, state or national medical societies or his license to practice any profession in any jurisdiction has ever been suspended or terminated, and whether any investigatory or disciplinary actions (including DEA) are currently pending, and shall require documentation of the applicant's past and current history of any professional liability actions including any settlement awards.
- (b) The applicant shall specifically request the staff category and clinical privileges for which he wishes to be considered.
- (c) In demonstrating satisfaction of the foregoing qualifications, a provider may, when suspicion or knowledge of a problem exists based on physical or behavioral manifestations on the job, on recent events or performance, or as follow-up to or concurrent monitoring as part of participation in a treatment program, be required to provide such information or to submit to such examination or tests as may be reasonably requested by any two of the following: Professional Staff President, Clinical Director, or Executive Director.

- (d) The applicant must show evidence of current licensure, relevant training and/or experience, current competence, and current ability to perform the privileges requested and the essential functions of Staff appointment.
- (e) The applicant shall be interviewed by the Clinical Director, by his designee or by the director of the program for which the applicant seeks privileges.
- (f) Every application for staff appointment shall contain the applicant's specific acknowledgment of every Professional Staff appointee's obligations to provide continuous care and supervision of his patients, to abide by the Professional Staff Bylaws, Rules and Regulations, and policies, to accept committee assignments and to accept consultation assignments.
- (g) The application form shall include a statement that the applicant has been provided access to the Bylaws, Rules and Regulations, and policies of the Professional Staff and that he agrees to be bound by the terms thereof if he is granted appointment and/or clinical privileges.
- (h) The hospital must query the federal National Practitioner Data Bank for each health care provider who applies for appointment to the Professional Staff and for each provider who applies for clinical privileges.
- (i) The completed application shall be submitted to the Credentialing Specialist. After collecting the references and other materials deemed pertinent, but in any event within 90 days of receiving the application, he shall transmit the application and all supporting materials to the Credentials Committee for evaluation.
- (j) Any provider holding Attending privileges at the University of Utah Hospitals and Clinics may hold Staff privileges at UNI. These provider applications are reviewed at UNI in the credentials and executive committee meetings before they have received Hospital Board Approval at the University Medical Center.
- (k) As a condition of consideration of an application for appointment or reappointment, and as a condition of continued appointment, if granted, every applicant and member specifically agrees to report to the Medical Director and to the UNI Credentials Committee, any events relative to the following:
 - (1) Loss of license or other penalties imposed by state licensing agencies;
 - (2) Loss of Drug Enforcement Administration (DEA) certificate or other penalties placed on it;
 - (3) Any investigation initiated regarding privileges or other penalties placed on provider by facilities at which appointments are currently held;
 - (4) Reductions in privileges or other penalties placed on provider by facilities at which appointments are currently held;
 - (5) Any investigation initiated regarding participation in Medicare/Medicaid;
 - (6) Any sanction or exclusion imposed restricting participation with Medicare/Medicaid;

- (7) Any charge of a misdemeanor or felony related to the practice of medicine or crimes against children, or any members of vulnerable populations;
- (8) Any action, whether voluntary or involuntary, to enter a substance abuse treatment program;
- (9) Any other significant professional problem;
- (10) Any malpractice claim and/or any private negotiation or settlement of a claim alleging professional malpractice;

Failure to report may be grounds for automatic and permanent relinquishment of staff membership.

SECTION III: Burden of Providing Information

- (a) All applicants and members 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.
- (b) Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- (e) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Medical Director and President of the Professional Staff will review the response and determine whether the application should be processed further. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

SECTION IV: Appointment Process

- (a) Upon receipt of the application for appointment, the Credentials Committee shall determine whether the application is complete, shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in the references

given by the applicant and from other sources available to the committee, whether he has established and meets all of the necessary qualifications for the category of staff appointment and the clinical privileges requested by him.

- (b) The Credentials Committee shall act on an application within 45 days of completion. Upon deeming the application complete and upon completion of its review of the application and related materials, the Credentials Committee shall make a recommendation as to whether the applicant is to be appointed, denied, or deferred for further consideration to the Executive Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may, where appropriate, be qualified by probationary conditions. The Credentials Committee shall transmit to the Executive Committee the completed application and all other documentation considered in arriving at its recommendation.
- (c) The Executive Committee shall review the recommendations of the Credentials Committee and all supporting documentation and shall make its recommendation within 45 days after receiving the Credentials Committee's report.
- (d) When the recommendation of the Executive Committee is favorable to the provider, the information shall be forwarded to the Hospital Board for approval.
- (e) When the recommendation to the Executive Committee is adverse to the applicant, either in respect to appointment or in granting of clinical privileges, the applicant will be provided special notice within a reasonable time. No such adverse recommendation need be forwarded to the Hospital Board until after the applicant has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Plan, described in Appendix II of these Bylaws.
- (f) If the applicant requests and is granted a hearing, the Executive Committee will consider the report and recommendation of the Hearing Committee and the hearing record. If the Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph d. of this Section III. If such recommendation continues to be adverse, the applicant will be provided special notice within a reasonable time.
- (g) At its next regular meeting after receipt of a favorable recommendation, the Hospital Board or its Executive Committee shall act in the matter. If the Hospital Board's decision is adverse to the applicant in respect to either appointment or clinical privileges, the applicant will be provided special notice within a reasonable time and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his rights under the Fair Hearing Plan of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- (h) At its next regular meeting after all of the applicant's rights under the Fair Hearing Plan have been exhausted or waived, the Hospital Board or its duly authorized committee shall act on the matter. The Hospital Board's decision shall be conclusive except that the Hospital Board may defer final determination by

referring the matter back for further recommendation. Any such referral back shall state the reasons therefore, shall set the time limit within which a subsequent recommendation of the Hospital Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendations and of any new evidence in the matter, the Hospital Board shall make a decision either to appoint the applicant to the staff or to reject him for staff appointment. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

- (i) When the Hospital Board's decision is final, it shall send special notice of such decision to the Chairman of the Executive Committee, and by certified mail, return receipt requested, to the applicant.
- (j) The time periods in this Article are intended to be guidelines only and will not create any right for the applicant to have the application processed within the precise time periods.

SECTION V: Emergency Privileges

In the case of emergency, any provider or appointee, to the degree permitted by his license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling of any consultation necessary or desirable. When an emergency situation no longer exists, such provider must request the privileges necessary to continue to treat the patient. In the event that such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate appointee to the Professional Staff. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient, in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

SECTION VI: Disaster Privileges

- (a) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the President of the Professional Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (b) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (1) A volunteer's identity may be verified through valid government-issued photo identification (i.e., Driver's license or passport).
 - (2) A volunteer's license may be verified in any of the following ways:
 - (i) current hospital picture ID card that clearly identifies the individual's professional designation;
 - (ii) current license to practice and/or proof of

membership and good standing in a relevant professional organization; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current hospital or Professional Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

- (c) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the hospital.
- (d) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (e) The Professional Staff will oversee the care provided by volunteer licensed independent practitioners.

SECTION VII: Reappointment Process

Description:

Every other year, all members of the Professional Staff shall apply for reappointment and renewal. The reappointment process shall be based on a review of current licensure, health status, professional performance, judgment, clinical/technical skills (as indicated by results of performance improvement and other continuing medical activities), peer recommendation, and specifically:

- (a) Demonstrated professional competence in the treatment of patients in terms of both ethics and conduct;
- (b) Participation in staff affairs, including attendance at Professional Staff and appointed committee meetings;
- (c) Compliance with the Bylaws and Rules and Regulations of the Professional Staff;
- (d) Pertinent data from Quality Assurance/Utilization Review;
- (e) Participation in staff development and professional growth and development activities;
- (f) Professional Staff members shall have the responsibility to forward to the Credentials Committee documentation of insurance, license renewals,

professional liability actions and any legal professional judgments or settlements which occur during the calendar year; and

- (g) Ongoing and any Focused Professional Practice Evaluation.

Process:

- (a) The Credentialing Specialist shall, at least 90 days prior to the expiration date of the present staff appointment year, request staff appointees to reapply for appointment and to request the privileges for which they wish to be considered. He shall return the reappointment application form to each current Professional Staff appointee. Each appointee who desires reappointment shall return his reapplication to the Credentialing Specialist in a timely manner. Failure by the Professional Staff appointee to submit an application at least 60 days prior to the expiration of the Professional Staff appointee's current term may result in expiration of appointment and clinical privileges at the end of the then current term of appointment. The individual shall not practice until an application is processed and approved by the required bodies. The Credentialing Specialist shall forward the completed form to the Credentials Committee.
- (b) The appropriate Clinical Director shall review the completed form and the appointee's file of Professional Staff activities and make a recommendation to the Credentials Committee that appointment be renewed, renewed with modifications, or terminated.
- (c) The Executive Committee shall review all pertinent information available on each appointee scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Professional Staff and for the granting of clinical privileges for the ensuing period, and shall forward its recommendations to the Hospital Board before the current privilege dates of the provider expire. Where the non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented by the Executive Committee.
- (d) Each recommendation concerning reappointment and the clinical privileges to be granted upon reappointment shall be based upon review of documentation of the appointee's professional competence and clinical judgment in the treatment of patients, of current licensure, of his ethics and conduct, participation in Professional Staff affairs and participation in continuing education and other Staff activities, compliance with the hospital and Professional Staff Bylaws, Rules and Regulations, demonstration of proof of current malpractice insurance coverage in the prescribed amount, use of the hospital's facilities for his patients, relations with other providers and current ability to perform the clinical privileges requested and essential functions of appointment, the results of ongoing and focused (if any) professional practice evaluations and such other factors as the Executive Committee deems relevant. An applicant for reappointment is required to submit reasonable evidence of current health status if requested to do so by the Credentials or Executive Committee.

- (e) Thereafter, the procedure provided in Article VI relating to recommendations on applications for initial appointment shall be followed.

SECTION VIII: Change in Staff Category

Description:

An appointee to the Professional Staff may request a change in Staff category.

Procedure:

- (a) Request:
All members desiring a change in Staff category shall submit a written request/explanation to the appropriate Clinical Director/or designee.
- (b) Verification:
Upon receipt of the written request for change in Staff category, the Clinical Director/or designee, shall review it, verify the necessary data and forward request to the Credentials Committee for their review and approval or denial. The Credentialing Specialist will forward the information to the Executive Committee for their review and approval or denial.
- (c) Process:
 - 1. Approval:
The applicant shall be notified within 90 days of the request for change in Staff category.
 - 2. Denial:
If the request for change has been denied, the applicant shall be informed of the reason for the denial.
- (d) Appeal:
Individuals denied a request for change in Staff category do not have the right to an appeal process as defined in the Fair Hearing Plan.
- (e) Professional Practice Evaluation:
The Executive Committee shall establish parameters for evaluation on an individual basis for providers with any change in Professional Staff category.

ARTICLE VII: CLINICAL PRIVILEGES

SECTION I: Exercise of Privileges

- (a) Every practitioner or other professional providing direct clinical services at this hospital by virtue of Professional Staff appointment or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Hospital Board. In every case, a licensed physician will be responsible for all medical care rendered to patients at this facility.

- (b) Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, performance, experience, demonstrated competence, references, demonstrated ability and judgment in accordance with the criteria established in Section II(b) within this article, and other relevant information, including an appraisal by the service in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.
- (c) Biennial re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided and review of the records of the Professional Staff which document the evaluation of the appointee's participation in and the delivery of medical care.

SECTION II: Delineation of Privileges

(a) **Basis for Privilege Determination:**

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, performance, experience, demonstrated competence, demonstrated ability, references and judgment in accordance with the criteria established in Section (b) following. Determination of privileges made in connection with reappointment shall also include:

- (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
- (2) appropriateness of utilization patterns;
- (3) ability to perform the privileges requested competently and safely; and
- (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable.

Clinical privileges granted on initial appointment shall be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where the practitioner exercises or exercised clinical privileges. This information shall be added to and maintained in the credentials file established for a staff appointee. The applicant shall have the burden of establishing his qualifications and competencies relating to the clinical privileges requested.

(b) **Areas of Privileging and Criteria:**

Specific areas of privileging shall be defined by the Medical Director and the Credentials Committee of the Professional Staff. Areas of privileging shall be

specific as to program, patient group, age group, and special procedures and shall include:

- (1) specific privilege to be granted;
- (2) nature of privilege;
- (3) criteria required for granting of privilege;
- (4) ongoing and focused professional practice evaluation required.

All privileges defined in this manner shall be approved by the Executive Committee and the Hospital Board and shall form Appendix III to these Bylaws. Privilege delineation shall be reviewed, revised, and approved by the Executive Committee and the Hospital Board.

(c) **Professional Practice Evaluation**

All new appointees to the Professional Staff will be subject to focused professional practice evaluation during the provisional period, which may include proctoring, interviews or chart review in accordance with applicable policy. All Professional Staff appointees are subject to ongoing professional practice evaluation through the Professional Staff and hospital quality assurance program and through supervision as deemed appropriate by the Medical Director.

(d) **Modification of Privileges**

- (1) Any appointee of the Professional Staff may request additional privileges at any time by completing a delineation of privileges form stating privileges requested and providing documentation as required in this Article.
- (2) Procedure for reviewing and granting privileges shall follow the same procedure as for reappointment.

(e) **Denial of Privileges**

If a request for specific privileges is denied, the applicant shall be informed in writing by the Executive Director of the reason for such denial. Notification shall be sent within 120 days of receipt of the completed application and supporting documents. Individuals denied exercise of specific privileges have the right to an appeal process as defined in the Fair Hearing Plan.

(f) **National Practitioner Data Bank**

The hospital will comply with the National Practitioner Data Bank requirements in conformity with the hospital's National Practitioner Data Bank policies and procedures.

ARTICLE VIII: ALLIED MENTAL HEALTH PROFESSIONALS

SECTION I: Definition

Allied Mental Health Professionals shall consist of licensed individuals other than those eligible for Professional Staff appointment under Article V who, by virtue of their professional credentials and documented current competence, are privileged to provide patient assessment and care services. Appointment shall be based on the hospital's need and ability to accommodate additional appointees to the staff. These Professionals shall consist of Licensed Clinical Social Workers, Advanced Practice Registered Nurses (including nurse practitioners and clinical nurse specialists), and Physician Assistants. Such Professionals are licensed to practice with varying levels of supervision, including those who are licensed to practice without supervision. Appointment to the Allied Mental Health Professional Staff shall confer on the appointee only such privileges and prerogatives as are specifically granted by the Hospital Board in accordance with these Bylaws.

SECTION II: Qualifications

Only those Allied Mental Health Professionals currently licensed to practice in the State of Utah who:

- (a) Document their experience, background, and training and who can demonstrate competence and adherence to the ethics of their profession with sufficient adequacy to assure the Professional Staff and the Hospital Board that any patient treated by them will receive care of a generally recognized professional standard; and who
- (b) Demonstrate capability of working cooperatively with others and who are willing to participate in the discharge of staff responsibilities; shall be qualified for appointment as an Allied Mental Health Professional.
- (c) Independently licensed Allied Mental Health Professionals are required to carry, as a minimum, professional liability insurance in the amounts stipulated in Article IV, Section II.b. (\$1,000,000/\$3,000,000). Proof of present and continued employment by a Utah governmental entity as defined by Utah's Governmental Immunity Act Utah Code Ann. Sections 63-30d-101 et seq. (as amended), such as the University of Utah, satisfies this requirement of proof of professional liability insurance.

SECTION III: Prerogatives

Allied Mental Health Professionals shall:

- (a) Participate directly in the assessment and care of patients under the direction of, or in collaboration with, an active or courtesy appointee of the Professional Staff;
- (b) Record pertinent information in progress notes on the patient's records;

- (c) Be permitted only those practices delimited under Utah State Law and compatible with the Institute's mission and standards;
- (d) Advanced Practice Registered Nurses are permitted to practice independently in the Institute's outpatient behavioral health clinics;
- (e) Not independently admit or discharge patients at the hospital.

SECTION IV: Responsibilities

Each Allied Mental Health Professional shall:

- (a) Meet the basic responsibilities set forth in Article III;
- (b) Seek consultation whenever necessary;
- (c) Strive to attend the quarterly meetings of the Professional Staff as a non-voting member;
- (d) Attend department meetings as assigned;
- (e) Participate as requested in hospital education and training programs;
- (f) Complete all medical records in accordance with the requirements established by the hospital's policies and procedures.

SECTION V: Procedures

Procedures for application, appointment, and reappointment to the Allied Mental Health Professionals shall follow those specified for the Professional Staff in Article VI. The appeal and hearing rights for Allied Mental Health Professional Staff are as defined in the Fair Hearing Plan. The hospital must query the Data Bank for each Allied Mental Health professional who applies for privileges and the hospital must also query the Data Bank every two years for each health professional who presently possesses clinical privileges.

ARTICLE IX: PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING PROFESSIONAL STAFF MEMBERS

SECTION I: Collegial Intervention

- (a) These Bylaws encourage the use of progressive steps, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of the Medical Director, the President of the Professional Staff and the Executive Director, but is not mandatory.
- (b) Collegial intervention is a part of the hospital's peer review, professional review, and ongoing and focused professional practice evaluation activities and may include counseling, education, and related steps, such as the following:

- (1) implementation and enforcement of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
 - (2) proctoring, monitoring, consultation, and letters of guidance; and
 - (3) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (c) The Medical Director may determine whether a matter should be handled in accordance with a policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Executive Committee for further action.
 - (d) The Medical Director will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.
 - (e) All ongoing and focused professional practice evaluations will be conducted in accordance with applicable policy. Matters that cannot be appropriately resolved through collegial intervention may be referred to the Executive Committee.

SECTION II: Investigations

(a) Initial Review

- (1) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the Medical Director, President of the Professional Staff, the chairperson of a standing committee, or the Executive Director:
 - (i) clinical competence or clinical practice, including patient care, treatment or management;
 - (ii) the known or suspected violation of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the hospital or the Professional Staff; or
 - (iii) conduct that is considered lower than the standards of the hospital or disruptive to the orderly operation of the hospital or its Professional Staff, including the inability of the member to work harmoniously with others.
- (2) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Professional Staff member, the matter will be referred to the President of the Professional Staff, the Medical Director, or the Executive Director.

- (3) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Executive Committee.
 - (4) No action taken pursuant to this section will constitute an investigation.
- (b) Initiation of Investigation
- (1) The Executive Committee will review the question, discuss the matter with the individual, if invited, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy. An investigation will commence only after a determination by the Executive Committee.
 - (2) The Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Executive Committee, informing the individual immediately would compromise the investigation or disrupt the operation of the hospital or Professional Staff.
 - (3) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.
- (c) Investigative Procedure
- (1) Once a determination has been made to begin an investigation, the Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee will not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Professional Staff.
 - (2) The Investigating Committee may:
 - (i) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
 - (ii) conduct interviews;
 - (iii) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or
 - (iv) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.
 - (3) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the

Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

- (4) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.
- (5) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Executive Committee with its findings, conclusions, and recommendations.

(d) Recommendation

- (1) The Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Executive Committee may:
 - (i) determine that no action is justified;
 - (ii) issue a letter of guidance, counsel, warning, or reprimand;
 - (iii) impose conditions for continued appointment;
 - (iv) require monitoring, proctoring or consultation;
 - (v) require additional training or education;
 - (vi) recommend reduction of clinical privileges;
 - (vii) recommend suspension of clinical privileges for a term;
 - (viii) recommend revocation of appointment or clinical privileges; or
 - (ix) make any other recommendation that it deems necessary or appropriate.
- (2) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.
- (3) A recommendation by the Executive Committee that would entitle the individual to request a hearing will be forwarded to the Executive Director, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

- (4) If the Board makes a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the Executive Director will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

SECTION III: Precautionary Suspension or Restriction of Clinical Privileges

Grounds for Precautionary Suspension or Restriction

- (a) Whenever failure to take action may result in imminent danger to the health or safety of any individual or may disrupt the orderly operation of the hospital, the Executive Director, the Medical Director, the President of the Professional Staff, or the Executive Committee is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges.
- (b) A precautionary suspension or restriction can be imposed at any time following a specific event, a pattern of events, or a recommendation by the Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, the person(s) considering the suspension will meet with the individual and review the concerns.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (d) A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported to the Executive Director and the President of the Professional Staff, and will remain in effect unless it is modified by the Executive Director or Executive Committee.
- (e) Within three days of the imposition of a suspension or restriction, the individual will be provided a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).

Executive Committee Procedure

- (a) The Executive Committee will review the reasons for the precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time, not to exceed 14 days. As part of this review, the individual will be given an opportunity to meet with the Executive Committee or a subgroup of the Executive Committee to discuss the concerns. This meeting is not a hearing and the individual will not have the right to call and examine or cross-examine witnesses. The individual may be accompanied by counsel, who may advise the individual, but counsel will not be

permitted to address the Executive Committee. A stenographic reporter will be present to make a record of the meeting.

- (b) The individual may propose ways other than precautionary suspension or restriction to protect patients, employees or the orderly operation of the hospital.
- (c) After considering the reasons for the suspension or restriction and the individual's response, if any, the Executive Committee will determine whether the precautionary suspension or restriction should be continued, modified, or terminated. The Executive Committee will also determine whether to begin an investigation.
- (d) There is no right to a hearing or appeal based on the imposition or continuation of a precautionary suspension or restriction.
- (e) Upon the imposition of a precautionary suspension or restriction, the Medical Director will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges.

SECTION IV: Automatic Relinquishment

- (a) **License**
Action by the State of Utah that revokes, suspends or modifies the license or certificate or other legal credentials authorizing the practice of an appointee of the Professional Staff or Allied Mental Health Professional Staff shall immediately result in the relinquishment of appointment and privileges of the practitioner or Allied Mental Health Professional from the staff. As soon as possible after such automatic relinquishment, the Executive Committee shall convene to review and consider the facts under which the license was revoked or suspended. The Committee may then take such further action as is appropriate in view of the facts disclosed in its investigation.
- (b) **Drug Enforcement Administration (DEA) Number**
A practitioner whose DEA number is revoked or suspended shall immediately and automatically be divested of his right to prescribe medications covered by such number. As soon as possible after such automatic relinquishment, the Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The committee may then take such further action as is appropriate in view of the facts disclosed in its investigation.
- (c) **Medical Records**
A relinquishment of a practitioner's admitting privileges may, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion, as established by hospital policy. Such relinquishment may continue until such records are completed unless the practitioner satisfies the Executive Director and the Medical Director that he has a justifiable excuse for such omissions.
- (d) **Enforcement**

It shall be the duty of the Medical Director to cooperate with the Executive Director in enforcing all automatic relinquishments. The Medical Director shall notify the practitioner and/or Allied Mental Health Professional regarding automatic relinquishment of privileges.

SECTION V. Fair Hearing Plan

Grounds for a Hearing:

- (a) An applicant or member is entitled to request a hearing whenever one of the following recommendations has been made by the Executive Committee or the Hospital Board:
 - (1) denial of initial Professional Staff appointment
 - (2) denial of Professional Staff reappointment
 - (3) revocation of Professional Staff appointment
 - (4) denial of requested initial clinical privileges
 - (5) denial of requested additional clinical privileges
 - (6) decrease of clinical privileges
 - (7) suspension of clinical privileges (other than precautionary suspension)
 - (8) imposition of mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance), or
 - (9) denial of reinstatement from a leave of absence, or imposition of modifications of privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.
- (b) No other recommendations shall entitle the individual to request a hearing.
- (c) The hearing shall be conducted in as informal a manner as possible, subject to the provisions of this policy.

Actions Not Grounds for Hearing:

- (a) None of the following actions shall constitute grounds for a hearing, and shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:
 - (1) the issue of a letter of guidance, warning or reprimand
 - (2) the imposition of conditions, monitoring, or general consultation requirement, (i.e., the individual must obtain a consult but need not get prior approval for the treatment)

- (3) the termination of any interim or temporary privileges
- (4) automatic relinquishment
- (5) the imposition of a requirement for additional training or continuing education
- (6) the imposition of precautionary suspension
- (7) denial of a request for leave of absence, or for an extension of a leave, or denial of reinstatement, or modifications to privileges or conditions for reinstatement, if no report to the National Practitioner Data Bank is required.

THE HEARING

Notice Of Recommendation:

- (a) When a recommendation is made which entitles an individual to request a hearing prior to a final decision of the Hospital Board, the Chief Executive Officer shall give special notice to the affected individual within ten (10) days from the date of the recommendation was made. This notice shall contain:
 - (1) a statement of the recommendation and the general reasons for it
 - (2) a statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice; and
 - (3) a copy of this Fair Hearing Plan

Request for Hearing:

- (a) An individual shall have thirty (30) days following the date of the receipt of the notice within which to request the hearing. The request shall be in writing to the Chief Executive Officer, and shall include the name, address and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing and the recommendation shall become effective immediately upon final Hospital Board action. An individual may not request a hearing after expiration of this time, absent good cause, if the Hospital has made reasonable efforts to notify the individual.

Notice of Hearing and Statement of Reasons:

- (a) The Chief Executive Officer shall schedule the hearing and shall give special notice to the individual who requested the hearing. The notice shall include:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses, as known at that time, who will give testimony at the hearing regarding the recommendation and a brief summary of the nature of the anticipated testimony;

- (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications. The individual shall have, at the discretion of the presiding officer, time to study this additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the individual and the Hospital.

Witness List:

- (a) At least ten (10) days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of the individuals expected to offer testimony on his or her behalf.
- (b) The individual's witness list shall include a brief summary of the nature of the anticipated testimony.
- (c) The witness list of either party may, thereafter, in the discretion of the Presiding Officer or Hearing Panel Chair, 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.

Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

The Chief Executive Officer, acting for the Hospital Board and after considering the recommendations of the President of the Professional Staff (and that of the Chair of the Hospital Board, if the hearing is occasioned by a Hospital Board determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members, one (1) of whom shall be designated as Chair. The Hearing Panel shall be composed of Professional Staff members who did not actively participate in the consideration of the matter involved at any previous level, or of physicians or others not connected with the Hospital. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.
- (b) Presiding Officer:
 - (1) In lieu of a Hearing Panel Chair, the Chief Executive Officer may appoint a Presiding Officer who may be an attorney at law. The Presiding Officer must 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 be a legal advisor to it, but shall not be entitled to vote on its recommendations.

- (2) If no Presiding Officer has been appointed, the Chair of the Hearing Panel shall serve as the Presiding Officer, and shall be entitled to one (1) vote.
- (3) The Presiding Officer (or Hearing Panel Chair) shall:
 - (i) allow the participants in the hearing to 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 as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure throughout the hearing;
 - (v) have the authority and discretion to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
 - (vi) see that all information relevant to the appointment or clinical privileges of the individual requesting the hearing is presented to the Hearing Panel; and
 - (vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (4) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, the Chief Executive Officer, after consulting with the President of the Professional Staff (and the Chair of the Hospital Board if the hearing was occasioned by a Hospital Board determination), may appoint a Hearing Officer to perform the functions that would otherwise be carried out by a Hearing Panel. The Hearing Officer shall preferably be an attorney at law.
- (2) The Hearing Officer shall 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 must not represent clients in direct economic

competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

Hearing Procedure:

Discovery:

- (a) There is no right to discovery in connection with the hearing. However, the affected individual shall be entitled, upon specific request, to the following, subject to the individual's written agreement that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Medical Board or the Hospital Board;
 - (3) copies of relevant committee or department minutes (such provision is not intended to waive the state peer review protection law) (documents shall be redacted to remove information unrelated to the affected individual); and
 - (4) copies of any other documents relied upon by the Medical Board or the Hospital Board.
- (b) There shall be no discovery regarding other practitioners.
- (c) 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 its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (d) Neither the affected individual, nor his or her attorney, nor any other person acting on behalf of the affected individual, shall contact individuals appearing on the Medical Board's or Hospital Board's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

Pre-Hearing Conference:

The Presiding Officer may require a representative (who may be counsel) for the individual and for the Medical Board or the Hospital Board to participate in a pre-hearing conference to deal with all procedural questions in advance of the hearing. The Presiding Officer may specifically require that:

- (a) all documentary evidence/exhibits to be submitted by the parties be presented to each other prior to this conference and that any objections regarding the documents be made at this conference and resolved by the Presiding Officer;
- (b) evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges be excluded;
- (c) any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;
- (d) the time granted to each witness's testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and
- (e) witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall result in transmittal of the matter to the Hospital Board for final action.

Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be shared by the parties. Copies of the transcript are at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this State.

Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer or Hearing Panel Chair:
 - (1) to call and examine witnesses to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit a written statement at the close of the hearing.
- (b) Any individual requesting a hearing who does not testify in his or her own behalf may be called and questioned.
- (c) The Hearing Panel may question the witnesses, call additional witnesses, and/or request documentary evidence.

Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it is 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. The guiding principle shall be that the Hospital's Board, which must ultimately decide about the affected individual's appointment and clinical privileges, shall have before it all information relevant to the individual's qualifications.

Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request such a statement to be filed, following the close of the hearing.

Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Chief Executive Officer and the President of the Professional Staff.

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 Chief Executive Officer on a showing of good cause.

Hearing Conclusion, Deliberations, and Recommendations:**Order of Presentation:**

The Executive Committee or the Hospital Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the individual who requested the hearing shall present evidence.

Basis of Decision:

- (a) The burden shall be on the Medical Board to prove, by a preponderance of the evidence, that the recommendation that prompted the hearing was supported by credible evidence and was not arbitrary or capricious.
- (b) The recommendation of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:
 - (1) oral testimony of witnesses;
 - (2) written statements presented in connection with the hearing; and
 - (3) any information regarding the individual who requested the hearing (and his or her practice or conduct) so long as that information has been admitted into evidence at the hearing and the person who requested the

hearing had the opportunity to comment on and, by other evidence, refute it.

Adjournment and Conclusion:

The Presiding Officer may adjourn the hearing and reconvene it at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.

Deliberations and Recommendation of the Hearing Panel:

Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for the Panel's decision.

Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report and recommendation to the Chief Executive Officer who shall forward it, along with all supporting documentation, to the Hospital Board for further action. The Chief Executive Officer shall also send a copy of the report and recommendation by certified mail, return receipt requested, to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy to the Medical Board for its information.

Appeal Procedure:

Time for Appeal:

Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within ten (10) days, an appeal is deemed to be waived, and the Hearing Panel's report and recommendation shall be forwarded to the Hospital Board for final action.

Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure to comply with this Policy, and/or the Hospital or Professional Staff bylaws during or prior to the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; and/or
- (c) the recommendations of the Hearing Panel were not supported by substantial evidence.

Time, Place and Notice:

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

Nature of Appellate Review:

- (a) The Chair of the Hospital Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Hospital Board or others, including but not limited to reputable persons outside the Hospital, or the Hospital Board may hear the appeal as a whole body.
- (b) The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination provided at the hearing only if the party seeking to admit it can demonstrate that it is new, relevant evidence not previously available or that a request to admit it at the hearing was improperly denied.
- (c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Hospital Board.
- (d) The Hospital 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 Hospital Board's ultimate legal responsibility to grant appointment and clinical privileges. If the Hospital Board determines to modify or reverse the recommendation of the Review Panel in such a manner that would entitle the affected individual to another hearing, it shall so notify the affected individual through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has waived a hearing.

Final Decision of the Hospital Board:

Within thirty (30) days after receipt of the Review Panel's recommendation, the Hospital Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the affected individual. A copy shall also be provided to the Medical Board for its information.

Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Hospital Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and

recommendation, such recommendation shall be promptly made to the Hospital Board in accordance with the instructions given by the Hospital Board. This further review process and the report back to the Hospital Board shall in no event exceed thirty (30) days except as the parties may otherwise agree.

Right to One Hearing and One Appeal Only:

No applicant or Professional Staff member shall be entitled to more than one (1) hearing and one (1) appellate review on any matter. If the Hospital Board denies initial Professional Staff appointment or reappointment or revokes the Professional Staff appointment and/or clinical privileges of a current member, that individual may not apply for staff appointment or for clinical privileges for a period of five (5) years unless the Hospital Board provides otherwise.

SECTION VI: Leaves of Absence

- (a) Individuals appointed to the Professional Staff may request a leave of absence by submitting a written request to the Medical Director. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave, such as military duty, additional training, family matters, or personal health condition. Absence from Professional Staff and patient care responsibilities for longer than 120 days shall require an individual to request a leave.
- (b) The Medical Director shall make determinations in connection with requests for leaves of absence, provided that the Executive Committee reserves the right to make final determinations, in its discretion.
- (c) The individual must request reinstatement to the Medical Director and Professional Staff Office at least 60 days prior to the conclusion of the leave of absence. The individual bears the burden of providing information and documentation sufficient to demonstrate satisfaction of any condition imposed at the beginning of the leave, current competence and all other applicable qualifications. The individual shall provide any other information requested by the Medical Director or Medical or Executive Committee, including executing any releases that may be necessary to allow third parties, including the individual's physician, to respond to any requests for information or clarification.
- (d) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (e) The Medical Director or Executive Committee may modify the clinical privileges upon reinstatement or impose conditions for the individual's practice deemed reasonably necessary for patient safety or the effective operation of the hospital. In the event that the Medical Director or Executive Committee denies reinstatement or recommends modifications or conditions that would require a

report to the National Practitioner Data Bank, the individual shall be given special notice and the opportunity to request a hearing within 30 days.

Absence for longer than 12 months shall result in automatic relinquishment of Professional Staff appointment and clinical privileges. Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal (except for those limited circumstances outlined in paragraph (e)).

ARTICLE X: OFFICERS

SECTION I: Officers of the Professional Staff

- (a) President
- (b) President Elect

SECTION II: Qualifications of Officers

- (a) Officers must be members of the Active Professional Staff at the time of nomination and election and must remain so, in good standing, during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- (b) Officers must have a record of clinical competence, committee service and continuing education.
- (c) Officers cannot have an investigation pending or in force.
- (d) The President of the Professional Staff shall be a medical doctor.

SECTION III: Election of Officers

- (a) Officers are elected as needed at a meeting of the Professional Staff. Only appointees to the Active Professional Staff shall be eligible to vote. The candidate receiving a majority of votes from those eligible to vote shall be elected. In the event that there are more than two candidates and no single candidate receives a majority, the candidate receiving the least number of votes will be eliminated and a second vote taken. If no single candidate receives a majority in the second vote taken, the above procedure will be used for all successive ballots until a candidate receives a majority.
- (b) The Executive Committee shall act as the nominating committee. This committee shall offer one or more nominees for the elected offices. Nominations may also be made from the floor.

SECTION IV: Term of Office

The Officer's term of office shall be a minimum of two years. Officers shall take office on the first day of the Professional Staff Year.

SECTION V: Vacancies in Office

The Executive Committee shall make appointments to fill vacancies in office.

SECTION VI: Duties of Officers

- (a) President: The President shall serve as the Chief Administrative Officer of the Professional Staff to (1) represent the views, policies and needs of the Professional Staff to the Hospital Board and Executive Director; (2) act in coordination and cooperation with the Medical Director and hospital Executive Director in all matters of mutual concern within the hospital; (3) call, preside at, and be responsible for the agenda of all general meetings of the Professional Staff; (4) serve as chairman of the Professional Staff and its Executive Committee; (5) be responsible for the enforcement of the Professional Staff's compliance with procedural safeguards in investigations; (6) appoint committee members to all standing and special staff committees except the Executive Committee; and (7) receive and interpret the policies of the Hospital Board on the performance and maintenance of quality with respect to the Professional Staff's delegated responsibilities.
- (b) President Elect: In the absence of the President, he shall assume all the duties of and have the authority of the President.

SECTION VII: Removal of Officers

Except as otherwise provided, recall of an officer may be initiated by the Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the Professional Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Professional Staff members eligible to vote for Professional Staff officers who actually cast votes at the special meeting in person or by mail ballot. Permissible conditions for removal of a staff officer include, without limitations:

- (a) failure to perform the duties of the position in a timely and appropriate manner;
- (b) failure to continuously satisfy the qualifications for the position;
- (c) having a conflict of interest with the hospital;
- (d) conduct or statements inimical or damaging to the best interests of the Professional Staff or the hospital or to their goals, programs or public image; and
- (e) physical or mental infirmity that renders the officer incapable of fulfilling official duties.

ARTICLE XI: PROFESSIONAL STAFF COMMITTEES

SECTION I: Professional Staff Committees

- (a) **Committee Structure**
The Professional Staff Committees are as follows

- Executive
- Quality/Patient Safety Council
- Credentials
- Medical Records
- Utilization Review
- Pharmacy and Therapeutics
- Environment of Care
- Ethics
- Infection Control

(b) **Membership**

- (1) The President of the Professional Staff, in consultation with the Medical Director, shall appoint membership to all Professional Staff committees except as expressly required by these Bylaws.
- (2) Appointments to committees shall take place at a Professional Staff meeting and shall consist of one year, renewable terms.
- (3) Chairpersons of committees shall be appointed by the President of the Professional Staff in consultation with the Medical Director unless stipulated otherwise in the Bylaws.

(c) **Minutes and Meeting Frequency**

Minutes shall be the official records of committee proceedings. Meeting frequency shall be determined by the Executive Committee

SECTION II: Executive Committee

(a) **Membership**

The Executive Committee shall consist of the President of the Professional Staff, President Elect, the Medical Director, Quality Coordinator, the Executive Director (ex officio without vote), one nurse manager, either the Adult or Youth Medical Director, and one additional Professional Staff member appointed by the President of the Professional Staff. A majority of the Executive Committee shall at all times be composed of medical doctors.

(b) **Duties and Responsibilities**

- (1) Represent and act on behalf of the Professional Staff, subject to such limitations as may be imposed by these Bylaws.

- (2) Receive and act upon reports and recommendations from the following Professional Staff committees: Credentials Committee, and Quality/Patient Safety Council.
- (3) Provide liaison between Professional Staff and the Executive Director and the Hospital Board, fulfilling the Professional Staff's accountability to the Hospital Board for evaluation of medical care rendered to patients.
- (4) Implement Professional Staff Bylaws, Rules and Regulations by establishing an ongoing and focused professional practice evaluation to assess the quality and appropriateness of Professional Staff activities, to evaluate the system annually, and to revise as needed.
- (5) May make recommendations on hospital management matters regarding long range planning to the Hospital Board.
- (6) Recommend action to the Hospital Board on matters of a medical-administrative nature.
- (7) Review recommendations from the Credentials Committee for reappointments and renewal or changes in clinical privileges and make recommendations to the Hospital Board.
- (8) Take all reasonable steps to promote ethical conduct and competent clinical performance on the part of all appointees of the Professional Staff, including the initiation of and/or participation in Professional Staff ongoing and focused professional practice evaluation, performance improvement measures, and investigations, when warranted.
- (9) Inform the Professional Staff of accreditation requirements and status and that areas of non-compliance are identified and recommendations for appropriate action made to the Executive Director and the Hospital Board.
- (10) Report at each Professional Staff meeting.
- (11) Perform other related duties as requested by the Hospital Board.
- (12) In instances when there is a conflict between the organized Professional Staff and the Executive Committee, the President of the Professional Staff shall appoint an ad hoc committee to deal with the issues at hand. In the event the conflict is not resolved, the members of the Professional Staff that have the conflict with the Executive Committee shall have an opportunity to present their concerns directly to the Hospital Board.
- (13) In instances when there is a conflict between the Executive Committee and the Hospital Board an ad hoc Joint Conference Committee shall be convened. The Joint Conference Committee may be convened at the request of the Executive Committee or the Hospital Board. The Joint Conference Committee shall consist of equal numbers of the Executive Committee and the Hospital Board. The purpose of the Joint Conference Committee shall be to resolve conflicts between the Executive Committee

and the Hospital Board. In instances where a conflict cannot be resolved, the decision of the Hospital Board shall prevail.

(c) **Removal of Executive Committee Members**

Removal of a member of the Executive Committee may be initiated by the by a petition signed by at least one-third of the members of the Professional Staff eligible to vote. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Professional Staff members eligible to vote who actually cast votes at the special meeting in person or by mail ballot. Permissible conditions for removal of a member of the Executive Committee includes, without limitations:

- (a) failure to perform the duties of Executive Committee membership in a timely and appropriate manner;
- (b) having a conflict of interest with the hospital;
- (c) conduct or statements inimical or damaging to the best interests of the Professional Staff or the hospital or to their goals, programs or public image; and
- (d) physical or mental infirmity that renders the member incapable of fulfilling Executive Committee duties.

SECTION III: Quality/Patient Safety Council

(a) **Membership**

The Quality/Patient Safety Council shall consist of at least one physician member plus a member of hospital administration, an adult services nurse manager, a youth services nurse manager, the Quality Specialist, the Information Systems Coordinator, the Clinical Services Director, and other members of the clinical Staff as appointed. A physician member shall serve as Council Chairperson.

(b) **Duties and Responsibilities**

- (1) Review key quality characteristics in medical, nursing, diagnostic and therapeutic services provided to patients in the hospital.
- (2) Monitor the progress of Process Improvement Teams.
- (3) Promote and maintain professionally accepted levels of care through review and evaluation of clinical practice.
- (4) Receive and act upon reports and recommendations from the following Professional Staff Committees: Medical Records, Utilization Review, Environment of Care Safety, Pharmacy and Therapeutics, Infection Control, and Ethics.
- (5) Develop, implement, and oversee the patient safety program.
- (6) Measure and assess performance and safety improvement activities.

- (7) Other monitoring activities as outlined in the Performance Improvement and Patient Safety Plans.

SECTION IV: Credentials Committee

(a) **Membership**

The Credentials Committee shall consist of at least two representatives of the Professional Staff (including at least one physician and at least one psychologist), the Executive Director or her/his designee, a social worker, and all others as invited.

(b) **Duties and Responsibilities**

- (1) Review and evaluate the qualifications, competence, and performance of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges and make appropriate recommendations.
- (2) Submit recommendations to the Hospital Board with respect to appointment, Staff category, clinical privileges, and special conditions attached thereto.
- (3) Investigate, review and report on matters, including the clinical or ethical conduct of any practitioner referred to it by: (a) the President of the Professional Staff; (b) the Governing Board; or (c) the Medical Director.
- (4) Serve as an advisory body to the Executive Committee.
- (5) Establish a confidentiality policy for the handling of credentials records.

SECTION V: Medical Records Standards Committee

(a) **Membership**

The Medical Records Standards Committee shall consist of at least two physician members, the Health Information Systems Supervisor, the Information Systems Coordinator, and members of the nursing and social work Staff.

(b) **Duties and Responsibilities**

- (1) Conduct quarterly reviews of currently maintained medical records to determine whether they accurately reflect the patient's condition and response to treatment and are sufficiently complete to meet the criterion of medical comprehensiveness in the event of transfer of physician responsibility for patient care.
- (2) Review and approve content and format of all forms prior to placement in the medical record.
- (3) Monitor the timeliness and clinical pertinence of medical record documentation.

SECTION VI: Utilization Review Committee

(a) **Membership**

The Utilization Review Committee shall consist of one physician and one social worker from each of the adult and youth inpatient services, a psychologist, the managers of Teenscope, Kidstar, and Recovery Works, one utilization review nurse, the Hospital Administrator and the Hospital Associate Administrator (chairperson of the committee), the manager of the Business Office, the Billing Supervisor, the manager of the Clinical Assessment Center, and the supervisor of the Patient Access staff (secretary for the committee).

(b) **Duties and Responsibilities**

- (1) Evaluate patterns and trends indicating over- or under-utilization.
- (2) Evaluate denied days and readmission rates and the contributing factors to each.
- (3) Make recommendations to the Quality/Patient Safety Council regarding Performance Improvement Teams needed to improve systems and processes associated with inefficient or inappropriate delivery of care and services.

SECTION VII: Pharmacy and Therapeutics Committee

(a) **Membership**

The Pharmacy and Therapeutics Committee shall consist of at least one physician, the hospital pharmacist, and at least one representative from the nursing Staff.

(b) **Duties and Responsibilities**

- (1) Develop and monitor all drug utilization policies and practices to determine whether professionally recognized clinical standards are being met.
- (2) Assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, dispensing, distribution, administration, and all other matters relating to medication use.
- (3) Serve as an advisory group to the hospital's Professional Staff, Nursing, Pharmacy, and other health care providers on matters pertaining to the use of medications. Provide all needed education to medical, nursing, and pharmacy personnel and other health care providers.
- (4) Approve all medications to be stocked on patient care areas.
- (5) Develop and approve a formulary or drug list for use in the hospital.
- (6) Develop and review at least biannually a medications list for floor stock, emergency, and crash cart medications.

- (7) Evaluate clinical data and approve use of new medications requested for use in the hospital.
- (8) Identify, monitor, and make recommendations for use of high risk medications at UNI.
- (9) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
- (10) Establish therapeutic substitution policy for UNI.
- (11) Participate in the hospital's overall quality management program by conducting studies to assess drug utilization and effectiveness. Review all drug utilization Policy and Procedures to assure optimal clinical results.
- (12) Monitor and report all adverse drug reactions. Make recommendations to prevent future adverse drug reactions.
- (13) Monitor, report, and make recommendations about preventing medication errors.
- (14) Review all medication management safety precautions.
- (15) Monitor and report unusual off-label medication use.

SECTION VIII: Environment of Care Committee

(a) **Membership**

Safety Officer, and representatives from Dietary, Housekeeping, Maintenance, Expressive Therapies, Regulatory Compliance, and Administration.

(b) **Duties and Responsibilities**

- (1) Establish, monitor and review the facility's environmental safety policies, procedures, and plans.
- (2) Evaluate the results of routine Hazardous Surveillance activities to assess adherence to good safety practices and develop corrective actions as needed.
- (3) Plan, direct and evaluate all fire and disaster drills as outlined in the hospital's fire and disaster plans.
- (4) Review and assess all environment of care-related incident reports and make recommendations to the Quality/Patient Safety Council to reduce the potential for future incidents.
- (5) Review safety plan monitoring data and approve corrective action as needed.

SECTION IX: Ethics Committee

(a) **Membership**

The Ethics Committee shall consist of at least one representative from nursing, social work, psychology, expressive therapies and physicians. A representative from the Social Sciences or Humanities faculty at the University of Utah also will be included as a core member of the Ethics Committee.

(b) **Duties and Responsibilities**

- (1) Function in an advisory capacity, and serve as a resource, with regard to ethical issues facing patients, their families, staff and clinicians.
- (2) Enhance the milieu and the delivery of care by promoting education regarding ethical issues.
- (3) Provide review of policies, guidelines and practices that impact patient and staff rights and responsibilities. Referrals for review by the Ethics Committee may come from concerned staff, clinicians, patients and/or their families.
- (4) Hold regular meetings and be available for "crisis consults" if and when such requests for immediate consults may be made.
- (5) Keep minutes for all meetings, and prepare a record of each case the Ethics Committee reviews. Records of a case will contain a summary of the facts pertinent to the case, areas of expertise brought to bear, a summary of alternatives considered in forming recommendations, and final recommendations.
- (6) Maintain the confidentiality of patients, their families, staff, and clinicians when processing ethical concerns.
- (7) Commit to the virtues of civility, empathy, mutual respect and rational discourse in the reception and processing of all matters addressed by the Ethics Committee.

SECTION X: Infection Control Committee

(a) **Membership**

The Infection Control Committee shall consist of at least the UNI Infection Control Coordinator, the UUH&C Infection Control liaison, and a representative from housekeeping, dietary, and maintenance.

(b) **Duties and Responsibilities**

- (1) Serve as an advisory group to the Professional Staff on matters pertaining to Infection Control.
- (2) Assess antibiotic utilization and coordinate with the Professional Staff on action relative to the findings.

- (3) Review all infection control reports to determine proper management and epidemic potential.
- (4) Monitor hospital infection control practices.
- (5) Educate staff on infection control issues.
- (6) Make recommendations to the Quality/Patient Safety Council and Professional Staff regarding policies and procedures relating to Infection Control.

ARTICLE XII: PROFESSIONAL STAFF MEETINGS

SECTION I: Regular Meetings

Professional Staff meetings shall be held at least annually. The Executive Committee shall designate the time and place for all regular Staff meetings. At each meeting of the Professional Staff a report will be given on the ongoing monitoring and evaluation of the quality and appropriateness of care provided to patients. A record that includes the resultant conclusions, recommendations, and actions taken shall be maintained.

SECTION II: Special Meetings

Special meetings of the Professional Staff may be called at any time by the Hospital Board, the President of the Professional Staff, the Executive Committee or not less than one quarter of the appointees to the Professional Staff.

SECTION III: Notice of Special Meetings

Written or printed notice stating the place, day and hours of any special meeting of the Professional Staff shall be delivered, either personally or by U.S. mail or electronic mail, to each appointee of the Active Professional Staff not less than seven days not more than fourteen days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each Staff appointee at his address as it appears on the records of the hospital. The attendance of the appointees of the Professional Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

SECTION IV: Attendance Requirements

- (a) Each appointee of the Active Professional Staff should strive to attend at least fifty percent of all regularly scheduled Professional Staff meetings in each year.
- (b) Quorum: Presence of 25 percent of the total number of appointees of the Active Professional Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment of these Bylaws, Rules and Regulations, and the presence of ten percent of such appointees is a quorum for all other actions.

SECTION V: Minutes

Minutes of each regular and special meeting of the Professional Staff shall be maintained and shall include a record of the attendance of members and the vote taken on each matter. A permanent file shall be kept of the minutes of each such meeting.

SECTION VI: Conflict Management Process

When there is a conflict between the Professional Staff and the Executive Committee with regard to:

- (a) proposed amendments to these Professional Staff Bylaws;
- (b) proposed amendments to the Professional Staff Rules and Regulations;
- (c) proposed amendments to an existing policy that is under the authority of the Executive Committee; or
- (d) a new policy proposed by the Executive Committee,

a special meeting of the Professional Staff to discuss the conflict may be called by a petition signed by not less than 25% of the Active Staff. The agenda for that meeting will be limited to the amendments(s) or policy at issue.

ARTICLE XIII: COMMITTEE MEETINGS

SECTION I: Regular Meetings

Committees may, by resolution, provide the time for holding regular meeting without notice other than such resolution.

SECTION II: Special Meetings

A special meeting of any committee may be called by or at the request of the chairman thereof, by the President of the Professional Staff, or by one-third of the group's then members, but not less than two.

SECTION III: Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than seven days before the time of such meeting by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a committee member at a meeting shall constitute a waiver of notice of such meeting.

SECTION IV: Quorum

A quorum at any committee meeting other than the Executive Committee shall be those voting members present, and 50% for the Executive Committee.

SECTION V: Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or service. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereon.

SECTION VI: Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of committees, unless otherwise indicated, shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

SECTION VII: Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be promptly submitted to the attendees for approval. Each committee and service shall maintain a permanent file of the minutes of each meeting. Each committee that reports to the Quality/Patient Safety Council shall submit quarterly reports to that committee. The Executive Committee and the Quality/Patient Safety Council shall prepare an annual committee report covering all Professional Staff committees. This annual report will be presented to the hospital Board for review and approval.

SECTION VIII: Attendance Requirements

Each committee member shall strive to attend not fewer than sixty-six percent of all meetings of his committees in each year.

ARTICLE XIV: GRANT OF IMMUNITY AND AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the hospital or the Board, any member of the Professional Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the hospital, its representatives, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the hospital, Professional Staff leaders, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

The applicant agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the hospital.

(e) Legal Actions:

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she will reimburse the hospital and any member of the Professional Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information within the System:

The applicant specifically authorizes the hospital and its affiliates to share information pertaining to the applicant's clinical competence or professional conduct.

ARTICLE XV: RULES AND REGULATIONS

The Professional Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Hospital Board. These shall relate to the proper conduct of Professional Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting after proper notice, by a majority vote of those present of the Active Professional Staff. Such changes shall become effective when approved by the Hospital Board.

ARTICLE XVI: AMENDMENTS

- (a) These Bylaws, Rules and Regulations may be amended after submission of the proposed amendment at any regular or special meeting of the Professional Staff. Any member of the Professional Staff may present proposed amendments at any regular or special meeting of the Professional Staff. A proposed amendment shall be referred to the Executive Committee which shall report on it at the next regular meeting of the Professional Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a majority vote of the Active Professional Staff present at a regular or special meeting of the Professional Staff, provided that at least ten days' written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action. The Professional Staff may also present proposed amendments to the Bylaws, Rules and Regulations directly to the Hospital Board.
- (b) The Executive Committee may present proposed amendments to the voting staff by mail or email ballot, returned to the Medical Director's office by the date indicated by the Executive Committee. Along with the proposed amendments, the Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 30% of the staff eligible to vote.
- (c) The Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed to comply with law or regulation or because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Professional Staff will be immediately notified by the Executive Committee. The Professional Staff will have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Professional Staff and the Executive Committee, the provisional amendment will stand. If there is a conflict over the provisional amendment, the process for resolving conflict between the Professional Staff and the Executive Committee is implemented. If necessary, a revised amendment is then submitted to the Hospital Board.
- (d) All amendments to the Bylaws shall become effective when approved by the Hospital Board. These Bylaws, Rules and Regulations shall be amended as necessary to reflect the facility's current practices regarding Professional Staff organization and functions.
- (e) Neither the Professional Staff nor the Hospital Board may amend these Bylaws unilaterally.

ARTICLE XVII: REVIEW

These Bylaws shall be reviewed periodically, but at least every three years, by the Executive Committee or by an ad hoc committee appointed by the President of the Professional Staff.

ARTICLE XVIII: ADOPTION

These Bylaws together with the appended Fair Hearing Plan and Rules and Regulations, shall be adopted at any regular or special meeting of the Active Professional Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Hospital Board.