

Mount Sinai South Nassau  
MEDICAL STAFF BYLAWS

June 16, 2025

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# **PART A – Medical Staff and Medical Board**

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## **Article 1 Medical Staff Purpose and Authority**

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### **1.1 Purpose**

The purpose of these Medical Staff Bylaws is to organize the activities of physicians, dentists, oral and maxillofacial surgeons, podiatrists, and certain other clinically privileged Practitioners who practice at the Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board of Trustees.

### **1.2 Authority**

Subject to the authority and approval of the Board of Trustees, the Medical Staff at Mount Sinai South Nassau will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws, the Medical Staff Rules & Regulations, Medical Staff Policies and Procedures, and the policies and procedures of the Hospital.

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## Article 2 Definitions

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**Active Staff** is defined in Section 4.2 of these Bylaws.

**Advanced Practice Provider (APP)** is an individual other than a physician, dentist, oral maxillofacial surgeon, or podiatrist, who, if qualified, may be Credentialed and Privileged to provide an advanced level of medical care and direct patient care services in the Hospital in a collaborative and/or supervisory relationship with a physician who has been granted Clinical Privileges at the Hospital, and includes the following disciplines:

- Advanced Practice Registered Nurse (APRN), further subdivided as:
  - Nurse Practitioner;
  - Certified Nurse Midwife;
  - Certified Registered Nurse Anesthetist; and
  - Clinical Nurse Specialist;
  - Registered Nurse First Assistants
- Certified Midwife (non-nurse);
- Physician Assistant;
- Optometrist;
- Clinical Psychologist;
- House Physician and;
- Other disciplines that the Board of Trustees may deem eligible for consideration for the grant of Clinical Privileges to provide an advanced level of medical care.

**Advanced Practice Provider Staff** means that group of Practitioners comprised of Advanced Practice Providers (APPs) who have been Credentialed and may be granted Clinical Privileges at the Hospital.

**Applicant** means an applicant for Membership on the Medical or Advanced Practice Provider Staff and/or for Clinical Privileges at the Hospital.

**Application** means the official documentation provided by an Applicant to the Hospital when seeking Membership and/or Privileges.

**Associate Staff** is defined in Section 4.3 of these Bylaws.

**Attending Physician** or **Attending Surgeon** means a fully-trained Practitioner who has been granted privileges to care for patients in the Hospital.

**Authorized Hospital Official** means a Hospital Department Chair, the Hospital Chief Medical Officer, the Hospital President, the Chief Executive Officer, and the President of the Medical Board.

**Authorized System Official** means a relevant System Chair (or Institute Director), the System Chief Medical Officer, and the System Chief Executive Officer.

**Board of Trustees** means the Board of Trustees of the Hospital.

**Bylaws** means these Medical Staff Bylaws, which cover the operations of the Medical Staff that have been adopted by the Medical Staff and approved by the Board of Trustees.

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**Category 1** is defined in Subsection 16.3.1 of these Bylaws and means an Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges that raises no concerns as enumerated in that Section.

**Category 2** is defined in Subsection 16.3.2 of these Bylaws and means an Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges that raises concerns as enumerated in that Section.

**Chief Executive Officer (CEO)** means the Chief Executive Officer of the Hospital. The CEO of the Hospital is also the CEO of the Health System

**Chief Medical Officer (CMO)** means the Hospital Chief Medical Officer, unless otherwise stated to mean the Chief Medical Officer of the System (“System CMO”). The Hospital CMO serves as the Medical Director under New York Hospital Code Section 405.4.

**Clinical Privileges** means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental and/or surgical services to patients of the Hospital.

**Complete Application** means an Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges that contains all materials that the Applicant is required to provide, and where all required credentialing elements have been verified as set forth in the Medical Staff Policies & Procedures.

**Credentials File** means the virtual and/or actual hard copy file containing the materials collected by the Department of Medical Staff Services for the evaluation of an Applicant or Reapplicant for Medical Staff Membership and/or Clinical Privileges.

**Days** means calendar days, unless otherwise stipulated in these Bylaws.

**Dean** means the Dean of the Icahn School of Medicine at Mount Sinai.

**Department** means a grouping of specialist practitioners reporting to a Department Chair as set forth in Section 6.1 of these Bylaws and further defined in Article VIII (*Organization and Functions of the Medical Staff*) of the Rules & Regulations.

**Division** means a grouping of sub-specialist Practitioners within a Department reporting to a Division Director as set forth in Section 6.1 of these Bylaws and further defined in Article VIII (*Organization and Functions of the Medical Staff*) of the Rules & Regulations.

**Good Standing** means having no pending internal investigations, no current restrictions to Medical Staff or Advanced Practice Provider Membership and/or Clinical Privileges, or no prior adverse corrective or disciplinary actions, as defined in Sections 12.2 and 12.3, which is deemed by an Authorized Hospital or System Official to be egregious or that demonstrates a pattern of clinical competence or professional conduct concerns.

**Hearing Committee** means the Committee appointed to conduct an evidentiary Hearing based on a disciplinary action against a Member of the Medical or Advanced Practice Provider Staff, in accordance with Section 13.3 of these Bylaws.

**Hospital** means Mount Sinai South Nassau

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**Hospital President** means the President of the Hospital as appointed by the Board of Trustees to be responsible to the Chief Executive Officer of the Hospital and the Board of Trustees, for the affairs and administration of the Hospital.

**Hospital Site** means a particular campus of the Hospital.

**Institute** means a grouping of related clinical specialties organized to provide a focused approach to clinical care, reporting to an institute director.

**Institute Director** means the individual who has responsibility for the activities of a system-based institute. For the purposes of the Medical Staff Bylaws, Rules & Regulations and Medical Staff Policies & Procedures, the term “Chair” throughout these documents shall be inclusive of the Institute Directors.

**Medical Board** means the Executive Committee of the Medical Staff provided for in Article 7 of these Bylaws.

**Medical Director** is a physician who is qualified for Membership on the Medical Staff, appointed by the Board of Trustees, and who shall be responsible for directing the Medical Staff organization in accordance with provisions of New York State Hospital Code Section 405.4. The Medical Director is the CMO.

**Medical Staff** means the organization of those individuals, who are either physicians, dentists, oral and maxillofacial surgeons, or podiatrists, who have obtained Membership status.

**Medical Staff Bylaws** (see Bylaws).

**Medical Staff Member** is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been appointed to the Medical Staff pursuant to the procedure set forth in these Bylaws.

**Medical Staff Rules & Regulations** (see Rules & Regulations)

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

**Practitioner** means a Physician, Dentist, Oral and Maxillofacial Surgeon, Podiatrist or Advanced Practice Provider.

**Prerogative** means the rights afforded a Practitioner to participate in Medical or Advanced Practice Provider Staff activities, as set forth in Subsections 4.2.2, 4.3.2, and 4.4.2 of these Bylaws, by virtue of Staff category or otherwise, granted to a Member of the Medical or Advanced Practice Provider Staff, and subject to the ultimate authority of the Board of Trustees and the conditions and limitations imposed in these Bylaws, the Medical Staff Rules & Regulations, Medical Staff Policies, and in other Hospital and System policies.

**Privileges** (see Clinical Privileges)

**Reapplicant** means an Applicant for renewed Membership on the Medical or Advanced Practice Provider Staff and/or for Clinical Privileges at the Hospital.

**Reapplication** means the official documentation provided by a Reapplicant to the Hospital when seeking Reappointment and/or renewal of Privileges.

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**Rules & Regulations** means the rules and regulations that cover the Medical Staff operations and that have been adopted by the Medical Board and approved by the Board of Trustees.

**School** means Icahn School of Medicine at Mount Sinai.

**Site Chair** means each local Department Chair at each of Hospital's campuses.

**System** means Mount Sinai Health System and includes all hospitals and other enterprises in Mount Sinai Health System.

**System Chair** means the individual who has responsibility for the activities of all corresponding hospital-based departments across Mount Sinai Health System.

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## **Article 3 Medical Staff Membership**

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### **3.1 Nature of Medical Staff Membership**

Membership on the Medical Staff of the Hospital is a privilege that may be extended only to allopathic and osteopathic physicians, dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff, the Hospital, and the System.

### **3.2 Qualifications for Membership**

The qualifications for Medical Staff Membership are delineated in Part C (*Credentialing & Privileging*) of these Bylaws.

### **3.3 Nondiscrimination**

The Hospital will not discriminate in granting Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges on the basis of national origin, age, race, ethnicity, gender, veteran status, gender identification, sexual orientation, marital status, religion, disability, or any other category protected by applicable law.

### **3.4 Conditions and Duration of Appointment**

The Board of Trustees has sole authority to make initial appointments and reappointments to the Medical Staff and to grant Clinical Privileges. The Board of Trustees shall act on appointments and reappointments, and shall grant and renew Privileges only after the process set forth in these Bylaws has been followed and the Medical Staff has had an opportunity to submit a recommendation from the Medical Board, except for requests for Temporary, Emergency, and Disaster Privileges, where such recommendation is not required. Appointment and reappointment to the Medical or Advanced Practice Provider Staff and duration of Privileges shall be for no more than three years.

### **3.5 Medical Staff Membership and Clinical Privileges**

An Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges will be processed only when the potential Applicant meets the current minimum qualifying criteria approved by the Board of Trustees. Membership and/or Clinical Privileges will be granted and administered as delineated in Part C (*Credentialing & Privileging*) of these Bylaws.

### **3.6 Responsibilities of Medical and Advanced Practice Provider Staff Members and Other Privileged Practitioners**

Each Medical and Advanced Practice Provider Staff Member and other Practitioners with Clinical Privileges:

- 3.6.1 Must provide appropriate, timely, and continuous care of their patients within the scope of their Privileges and at the level of quality and efficiency generally recognized as appropriate by professionals in the same or similar circumstances;
- 3.6.2 Must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions, including service on appropriate Medical Staff Committees, as may be required;
- 3.6.3 Must participate in the on-call coverage of the Emergency Department or in other Hospital coverage programs, consistent with their Clinical Privileges, as determined

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- by the relevant Department Chair and Medical Board, and as described in the Rules & Regulations;
- 3.6.4 Must abide by the Medical Staff Bylaws, Rules & Regulations, and all other rules, regulations, policies, procedures, and standards of the Medical Staff, Hospital and System, including, but not limited to, the System Code of Conduct;
- 3.6.5 Must maintain and provide evidence of continuous professional liability coverage of a type, and in an amount established by the Hospital. Each Medical and Advanced Practice Provider Staff Member and other Practitioners with Clinical Privileges shall notify the Chief Medical Officer or designee within twenty-four (24) hours of any and all lapses and/or limitations in professional liability insurance coverage;
- 3.6.6 Shall prepare and complete in a timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Practitioner provides care under the auspices of the Hospital;
- a. A medical history and physical examination shall be completed no more than thirty (30) days before and no more than twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician or other practitioner with the requisite professional credentials, in accordance with New York State law and Hospital policy.
  - b. When the medical history and physical examination are completed within thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician or other practitioner with the requisite professional credentials.
  - c. The content of a complete versus a focused medical history and physical examination, and the criteria for when each type is appropriate, are delineated in the Medical Staff Rules & Regulations.
- 3.6.7 Shall use Confidential Information, as defined below, only as necessary for treatment, payment, or healthcare operations, or to conduct authorized approved research, all in accordance with the Hospital and System policies, and with federal and state law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and Title 45 of the Code of Federal Regulations (CFR) Part 160, 162, and 164.
- a. Confidential Information refers to patient information, peer review information, information obtained as part of a quality investigation, and information pertaining to operations, financial matters, research, and any other information which is non-public, no matter what the means of conveyance, including verbal, written, printed or electronically transmitted.
- 3.6.8 Shall support the mission of the Hospital and the System;
- 3.6.9 Must promptly cooperate in any type of competency evaluation when determined necessary by an Authorized Hospital or System Official in order to assess the Practitioner's fitness for duty, competence to be on the Medical Staff, or ability to exercise their Clinical Privileges;

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- 3.6.10 Must notify the Department of Medical Staff Services and Hospital Chief Medical Officer of any of the following within the prescribed timeframes:
- a. Immediate notification, i.e., within twenty-four (24) hours, is required for any change in:
    - i. Professional licensure, including the imposition of warnings or sanctions by a licensing agency;
    - ii. Controlled Substance Registration (“DEA”) Certification;
    - iii. Medicare or Medicaid enrollment, including elective disenrollment or imposed exclusion;
    - iv. Professional liability insurance, including expiration, limitation or loss; and
    - v. Clinical Privileges and/or Appointment status at any healthcare facility, except when due to a not-for-cause termination of an exclusive contract for provision of professional services, or when imposed temporarily for failure to complete medical records timely.
  - b. Prompt notification, i.e., within five (5) calendar days, is required for:
    - i. Any change in the information that was required to be supplied for consideration for Clinical Privileges, Appointment, and/or Reappointment, no matter when the change occurred;
    - ii. Loss of staff Appointment at any healthcare facility;
    - iii. Filing of charges by a law enforcement agency;
    - iv. Notice to the Practitioner that they are under investigation by a healthcare-related or licensing entity, including, but not limited to, the New York State Department of Health, the New York State Department of Education, the Office of the Inspector General (OIG) of the Department of Health and Human Services, and the Office of the Medicaid Inspector General (OMIG) of any jurisdiction;
    - v. Exclusion from a managed care plan; and
    - vi. Expulsion from or censure by a professional society.
- 3.6.11 Shall maintain Hospital-determined proficiency in the use of the Electronic Health Records (EHR) and other technological systems and devices relevant to their practice; and
- 3.6.12 When requested to do so, will participate in consultations, including for pre-operative evaluations, as appropriate, for diagnostic or therapeutic issues requiring specialized medical expertise, and for patient or family requests for second opinions.

### **3.7 Medical Staff Member Right to Escalate Concerns**

- 3.7.1 If a Medical Staff Member reasonably believes that there is a matter that may adversely affect patient safety in the Hospital, they should bring it to the attention of their Department Chair, Chief Medical Officer, and/or the President of the Medical Board, for resolution. If the matter is not resolved to the Medical Staff Member’s satisfaction, they have the right to attend the next meeting of the Medical Board to bring the matter to the Medical Board’s attention. The Medical Staff Member must initiate the request to present the matter to the Medical Board by providing written notice to the President of the Medical Board specifying their concerns at least two (2) weeks in advance of a

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regular meeting, if possible. If such notice is not given, or there are extenuating circumstances, the President of the Medical Board has the prerogative to delay the discussion until the following meeting.

- 3.7.2 Subsection 3.7.1 of these Bylaws does not pertain to issues involving investigations into professional performance or conduct, corrective actions, denial of requests for Appointment and/or Clinical Privileges, or any other matter relating to individual Membership or Clinical Privileges. Such matters are governed by Part B of these Bylaws, which sets forth Medical Staff Members' rights to a Hearing and Appeal procedure.
- 3.7.3 As required by 10 NYCRR Section 405.4(c)(9), any Member of the Medical Staff who has informed a patient of their refusal to give advice with respect to, or to participate in, any induced termination of pregnancy, shall be exempt from liability by the Hospital.

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## **Article 4 Categories of the Medical Staff**

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### **4.1 Staff Categories**

- 4.1.1 There are two (2) categories of Medical Staff Membership:
- a. Active Staff
  - b. Associate Staff
- 4.1.2 All initial Members of the Medical Staff shall be appointed automatically to the Associate Staff and may request advancement to Active Staff at their first reappointment or earlier at the Chair’s discretion, if they meet all criteria.
- 4.1.3 Advanced Practice Providers are not eligible for Medical Staff Membership, but may be granted Clinical Privileges and, as such, are addressed as Members of the Advanced Practice Provider Staff.
- 4.1.4 Assignment to a staff category is determined by recommendation of the relevant Department Chair.

### **4.2 Active Staff**

#### **4.2.1 Distinctions**

Members of the Active Staff must satisfy one or more of the following distinctions:

- a. Engage in at least twelve (12) Hospital encounters per year, where a Hospital encounter means any of the following:
  - i. Unique inpatient admission, discharge, or consultation;
  - ii. Referral of a patient for admission to the Hospital by another Practitioner;
  - iii. Provision of care during any portion of an inpatient admission (for Practitioners who are not the admitting or discharging Practitioner, or who do not perform the consultation);
  - iv. Inpatient or ambulatory procedure performed at the Hospital on a patient for whom the Practitioner does not otherwise get credit for an encounter;
  - v. Defined teaching session of house staff or medical students at the Hospital;
  - vi. Hospitalist, intensivist, laborist, pathologist, radiologist, anesthesiologist, or emergency physician shift performed at the Hospital; OR
- b. Regularly (as defined by the Department Chair) serve on the Hospital’s on-call roster for urgent and emergency consultations and admissions; OR
- c. Provide regularly (as defined by the Department Chair) scheduled services in a Hospital provider-based clinic; OR
- d. Participate in at least twelve (12) official, Hospital-based meetings per year, including general Medical Staff; Department and/or Division; and/or Hospital or Medical Staff Committees.

By virtue of their appointment as a Department Chair, such individuals shall be considered Members of the Active Staff.

#### **4.2.2 Prerogatives**

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Members of the Active Staff may:

- a. Attend Medical Staff, Department and Division meetings and any open Medical Staff or open Hospital educational programs;
- b. Vote on all matters presented to the Medical Staff, relevant Department and/or Division, and Committee(s) on which the Medical Staff Member actively participates as an appointee; and
- c. As long as they have no conflict of interest that would prohibit them from doing so, hold office and sit on or be the chair of any Medical Staff Committee, in accordance with any qualifying criteria set forth in these Bylaws, the Medical Staff Rules & Regulations, or Medical Staff policies; and vote on matters that come before such Committees;
- d. Serve on Hospital Committees and vote on matters that come before such Committees, in accordance with any qualifying criteria set forth in Hospital policies; and
- e. Have access to the electronic health record (EHR), visit their patients in the hospital and consult with the attending of record.

### **4.2.3 Responsibilities**

Members of the Active Staff shall:

- a. At all times, meet the Qualifications for Membership delineated in Article 15 of these Bylaws;
- b. Contribute to the organizational and administrative affairs of the Medical Staff, including serving on Committees; and attending and participating in Medical Staff, Department and Division meetings;
- c. When requested, contribute to the operational, organizational and administrative affairs of the Hospital, including serving on Hospital Committees;
- d. Actively participate as requested or required in activities and functions of the Medical Staff, including, but not limited to, quality and performance improvement; peer review; credentialing and privileging; patient care, education and/or research; risk and utilization management; medical records completion; and in the discharge of other Staff functions as may be required; and
- e. Fulfill or comply with these Bylaws, the Medical Staff Rules & Regulations, and any applicable Medical Staff or Hospital policies or procedures.

## **4.3 Associate Staff**

### **4.3.1 Distinctions**

The Associate Staff is reserved for new Medical Staff Members or Members who do not meet the activity eligibility requirements to qualify for Membership on the Active Staff, listed in Subsection Part A4.2.1 of these Bylaws.

### **4.3.2 Prerogatives**

Members of the Associate Staff may:

- a. Attend Medical Staff, Department and Division meetings and any open Medical Staff or open Hospital educational programs;

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- b. Serve as a non-voting member on Hospital and Medical Staff Committees, other than the Medical Board, as long as they have no conflict of interest;
- c. Have access to the electronic health record (EHR), visit their patients in the hospital and consult with the attending of record;
- d. NOT vote on matters presented to the Medical Staff, Department or Division; and
- e. NOT be an Officer of the Medical Staff.

### **4.3.3 Responsibilities**

Members of the Associate Staff shall have the same responsibilities as Active Staff Members.

## **4.4 Advanced Practice Provider Staff**

### **4.4.1 Distinctions**

The Advanced Practice Provider Staff is comprised of Advanced Practice Providers as defined in Article 2, who have been Credentialed and may, when eligible, have been granted Clinical Privileges.

### **4.4.2 Prerogatives**

Members of the Advanced Practice Provider Staff may:

- a. Attend Medical Staff, Department and Division meetings and any open Medical Staff or open Hospital educational programs;
- b. Except for the Medical Board, serve on Hospital and Medical Staff Committees, such as the Advanced Practice Provider Credentials Committee, and vote on matters that come before such Committees;
- c. NOT vote on matters presented to the Medical Staff;
- d. NOT be an Officer of the Medical Staff; and
- e. Have access to the electronic health record (EHR), visit their patients in the hospital and consult with the attending of record.

### **4.4.3 Responsibilities**

Members of the Advanced Practice Provider Staff shall have the same responsibilities as Active Staff Members as outlined in Section 4.2.3 of these Bylaws.

## **4.5 Non-Members with Clinical Privileges**

### **4.5.1 Distinctions**

Non-Members are those Practitioners who have not applied for or do not qualify for Membership on the Medical Staff but have been granted Clinical Privileges. (Although this category, by definition, includes Advanced Practice Providers, they are covered in Section 4.4 of these Bylaws and are not addressed here.)

### **4.5.2 Prerogatives**

Non-Members with Clinical Privileges may:

- a. Attend Medical Staff, Department and Division meetings and any open Medical Staff or open Hospital educational programs;

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- b. NOT serve on Hospital and Medical Staff Committees, nor vote on matters that come before such Committees;
- c. NOT vote on matters presented to the Medical Staff, Department or Division; and
- d. NOT be an Officer of the Medical Staff.

### 4.5.3 Responsibilities

Non-Members with Clinical Privileges shall have the same responsibilities as Active Staff Members.

## **4.6 Emeritus Recognition**

### 4.6.1 Distinctions

Emeritus Recognition is not a Membership category. It is an honorific restricted to those individuals recommended for this designation by the Medical Board and approved by the Board of Trustees. This recognition is entirely discretionary and may be rescinded at any time. Medical and Advanced Practice Provider Staff Members recommended for Emeritus Recognition shall be those Members who are retiring or who have retired from active Hospital practice, who are of outstanding reputation, and have provided distinguished service to the Hospital.

### 4.6.2 Prerogatives

Practitioners designated as Emeritus may:

- a. Attend Medical Staff, Department and Division meetings and any open Medical Staff or open Hospital educational programs;
- b. Serve on Hospital and Medical Staff Committees, other than the Medical Board, and vote on matters that come before such Committees;
- c. NOT vote on matters presented to the Medical Staff; and
- d. NOT be an Officer of the Medical Staff; and
- e. NOT hold Clinical Privileges.

### 4.6.3 Responsibilities

Practitioners designated as Emeritus shall:

- a. NOT be required to maintain Medical or Advanced Practice Provider Staff Membership;
- b. At all times, be of upstanding moral character, and free from criminal charges, convictions, or other sanctions, including, but not limited to, any concerns related to moral turpitude that may impact the Hospital's or System's reputation;
- c. Support the mission of the Hospital and System; and
- d. Comply with the spirit of these Bylaws, the Medical Staff Rules & Regulations, and any applicable Medical Staff or Hospital policies and procedures, as they pertain to the Practitioner's circumstances.
- e. NOT be required to maintain professional liability coverage.

## **PART A – Medical Staff and Medical Board**

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### **Article 5 Officers and Meetings of the Medical Staff**

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#### **5.1 Officers of the Medical Staff**

The Officers of the Medical Board serve as Officers of the Medical Staff. They include the President, President-Elect, Secretary and Treasurer. Their qualifications, duties, and election are described in Article 8 of these Bylaws.

#### **5.2 Meetings of the Medical Staff**

##### **5.2.1 Annual Meetings**

Annual meeting of the Medical Staff will be held. Ad hoc meetings can be held at the discretion of the Medical Board President.

##### **5.2.2 Regular Meetings**

Regular meetings of the Medical Staff may be called at the discretion of the President of the Medical Staff, with two (2) weeks' notice.

##### **5.2.3 Special Meetings**

Special meetings may be called by the President of the Medical Staff, or on written request of fifteen (15) members of the Medical Staff. At least two (2) days' notice shall be given; and with it, the purpose of the meeting shall be stated. The business of the meeting shall be restricted to the subject(s) for which the meeting is called.

##### **5.2.4 Quorum**

Thirty (30) members shall constitute a quorum for all business.

# **PART A – Medical Staff and Medical Board**

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## **Article 6 Medical Staff Organization**

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### **6.1 Departments and Divisions of the Medical Staff**

- 6.1.1 The Medical Staff shall be organized into Departments. A list of Departments organized by the Medical Staff and recognized by the Medical Board and Board of Trustees is listed in Article VIII (*Organization and Functions of the Medical Staff*) of the Rules & Regulations.
- 6.1.2 An Authorized Hospital or System Official may propose the creation of new Medical Staff Departments or the dissolution of current Departments to promote quality improvement, patient safety, and effective credentialing and privileging. Such proposals must be approved by the Medical Board and the Board of Trustees.
- 6.1.3 A Department Chair, with the approval of the Hospital President, the System Chair, and the Medical Board, may create or dissolve Divisions within their Department to facilitate Medical Staff activities.
- 6.1.4 System-wide Institutes may be established or dissolved from time to time by an Authorized System Official to facilitate clinical integration, standardization, effectiveness and efficiency. The relationship between a System-wide Institute and the Hospital Departments is defined collaboratively between the Authorized System Official establishing the Institute, the System Chief Medical Officer, and the relevant System and Hospital Chairs. When an Institute practitioner holds an appointment in a Clinical Department, the Department Chair and Institute Chair shall collaborate on all quality, credentialing and peer review matters.

### **6.2 Qualifications, Selection, Term, and Removal of Department Chairs**

- 6.2.1 **Qualifications**

Department Chairs, Vice and/or Associate Chairs, and Division Directors must be leaders in their field, be actively involved in providing, supervising, teaching, and/or reviewing patient care, indicate a willingness and ability to serve, be in Good Standing, be in compliance with all relevant Hospital and System policies, and have Clinical Privileges, as warranted. Department Chairs must be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. By virtue of their appointment as a Department Chair, they shall be considered Members of the Active Staff.
- 6.2.2 **Selection Process**

Each Department Chair shall be appointed by the respective System Chair with approval of the Hospital President and the Board of Trustees.

Each System Chair shall be appointed by the Dean of the School with the approval of the CEO and the Board of Trustees.
- 6.2.3 **Term of Office**

Each Department Chair, if not the System Chair, shall serve at the discretion of the Hospital President and the System Chair.

Each System Chair shall serve at the discretion of the Dean, CEO and the Board of Trustees.
- 6.2.4 **Removal from Office**

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System Chairs can be removed by action of the Dean or CEO at any time. Department Chairs can be removed by action of the Hospital President and the System Chair at any time.

### **6.3 Responsibilities of the Department Chair**

6.3.1 The Department Chair shall have the following responsibilities:

- a. Oversee all clinically-related activities of the Department;
- b. Oversee all administratively-related activities of the Department, unless otherwise provided by the Hospital;
- c. Provide ongoing surveillance of the performance of each Practitioner granted Membership and/or Clinical Privileges in the Department;
- d. Address matters of substandard performance, professional competence and/or conduct, and other departures from acceptable standards, and to work with the Hospital Chief Medical Officer and the Medical Board to remediate such issues, including the possible imposition of corrective actions;
- e. Recommend to the Joint Credentials Committee and Medical Board the criteria for granting Clinical Privileges that are relevant to the care provided by the Department;
- f. Recommend Clinical Privileges for each Practitioner applying for and exercising Privileges that fall within the scope of services provided by the Department;
- g. Assess and recommend to the Medical Board and Hospital Administration off-site sources for needed patient care services, as well as external vendors providing services on-site, that are not provided by the Department, and the Hospital;
- h. Integrate the Department into the principal functions of the Hospital;
- i. Coordinate and integrate inter-service and intra-service functions and communication, including, but not limited to ensuring the effective provision of emergency on-call coverage by members of the Department;
- j. Develop and implement Department policies and procedures that guide and support the provision of patient care services delivered by the Department; and to review and update these in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;
- k. Support and enforce all Medical Staff and Hospital policies and procedures that relate to the provision of patient care services delivered by the Department; and to participate in their review and update to reflect required changes consistent with current practice, problem resolution, and standards changes;
- l. Recruit for and ensure the appointment of sufficient numbers of qualified and competent persons to provide the necessary patient care and services that fall within the scope of services considered the responsibility of the Department;
- m. Continually assess and improve the quality of patient care, treatment, and services provided by the Department and the Hospital;
- n. Implement and maintain effective comprehensive quality improvement programs, as appropriate;
- o. Orient and regularly assess the educational needs of all persons in the Department and to provide education to fulfill those needs;

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- p. Take recommendations to the Medical Board and the Hospital Administration for adequate space and other resources needed by the Department to provide patient care services;
- q. Assist in the preparation of such reports, annually or otherwise, including budgetary planning pertaining to the Department, as may be required by the Medical Board, Hospital Administration, the System, the School, and the Board of Trustees, including, but not limited to, facilities, equipment, procedures, personnel, quality assurance, clinical activity, educational activity, scholarly activity, wellness, and other matters affecting the patient care provided by and the persons in the Department;
- r. Be responsible for the planning and conducting of Departmental educational conferences, Departmental and Divisional grand rounds, and Departmental administrative meetings;
- s. Be responsible for the directing and operation of all residency and fellowship training programs conducted within the Department, including, but not limited to, their successful maintenance of accreditation;
- t. Recommend and oversee the activities of Division leaders, if applicable; and
- u. Perform such other responsibilities and duties as may be assigned to them by the Hospital President, Chief Medical Officer, System Chair, and Board of Trustees.

### **6.4 Assignment to Department**

Each Medical Staff Member and Advanced Practice Provider will be assigned to a primary Department, based upon clinical practice, specific expertise, training, credential, or other criteria. Practitioners may be granted Privileges in more than one Department, in which case, their clinical activities will be overseen by each of those Departments.

# **PART A – Medical Staff and Medical Board**

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## **Article 7 Medical Board**

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### **7.1 Purpose**

- 7.1.1 The purpose of the Medical Board, as delegated by the Medical Staff, shall be to perform the following functions:
- a. Represent the interests of the Medical Staff to Hospital Administration and the Board of Trustees;
  - b. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws;
  - c. Provide oversight over all Medical Staff functions;
  - d. Ensure the implementation of policies adopted by the Board of Trustees as they relate to the activities of the Medical Staff;
  - e. Submit recommendations to the Board of Trustees concerning all matters relating to appointment, reappointment, Staff categories, Department assignments, Clinical Privileges, and corrective and disciplinary actions;
  - f. Report to the Board of Trustees and to the Medical Staff concerning the overall quality of patient care services provided by individuals with Clinical Privileges, and coordinate the participation of the Medical Staff in organizational performance improvement activities;
  - g. Working with the Department Chairs, take steps to encourage and monitor professional and ethical conduct and competent clinical performance on the part of Members of the Medical and Advanced Practice Provider Staffs, as warranted;
  - h. Make recommendations to the Board of Trustees on medical and relevant administrative matters that fall within the purview of the Medical Staff;
  - i. Participate in identifying community health needs and implementing Hospital and Medical Staff programs to meet those needs;
  - j. Require, review, and act on reports from Medical Staff Committees and Departments;
  - k. Formulate and recommend to the Medical Staff and Board of Trustees amendments to these Bylaws;
  - l. Formulate and communicate to the Medical Staff amendments to the Rules & Regulations, and Policies and Procedures.
  - m. Formulate, recommend to the Board of Trustees, and adopt amendments to the Medical Staff Rules & Regulations;
  - n. Formulate, recommend to the Board of Trustees, and adopt amendments to Medical Staff policies and procedures;
  - o. Consult with Hospital Administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital and ensure that there is an acceptable quality assurance program in place to monitor those contracted services;
  - p. Support and participate in the corporate compliance program as it pertains to the Medical and Advanced Practice Provider Staffs; and

## **PART A – Medical Staff and Medical Board**

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- q. Hold Medical Staff leaders, Committees, and Departments accountable for appropriately fulfilling their duties and responsibilities.

7.1.2 The Medical Board is empowered to act for the Medical Staff between meetings of the Medical Staff, or when meetings of the Medical Staff are not convened. This delegated authority is granted or removed via the Medical Staff Bylaws amendment process set forth in Article 11 of these Bylaws.

### **7.2 Medical Board Composition**

#### 7.2.1 – Composition

- The President of the Medical Staff (with vote)
- The Vice-President of the Medical Staff (President Elect) (with vote)
- The Secretary of the Medical Staff (with vote)
- The Treasurer of the Medical Staff (with vote)
- The Immediate, Past President of the Medical Staff (with vote)
- Members elected at Large (with vote)
- Clinical Chairpersons of the following Departments (with vote)
  - Anesthesiology
  - Cardiology
  - Cardiovascular Surgery
  - Emergency Medicine
  - Family Medicine
  - Internal Medicine
  - Obstetrics and Gynecology
  - Pathology
  - Pediatrics
  - Psychiatry
  - Radiology
  - Surgery
- The Chief Executive Officer/President (with vote if member of the Medical Staff)
- The Chief Medical Officer (with vote)

#### 7.2.2 At-Large Members

There shall be six (6) members at large.

### **7.3 Removal from the Medical Board**

A Medical Staff Officer or Department Chair who is removed from their position in accordance with Section 8.3 or Subsection 6.2.4, respectively, will automatically lose their membership on the Medical Board. A Medical Board member who is subject to disciplinary action as defined in Section 12.3 of these Bylaws will automatically lose their membership on the Medical Board. A Medical Board member who engages in an activity that creates a significant conflict of interest with the Hospital and/or the Medical Staff may be considered for removal from the Medical Board.

A Medical Board member who ceases to be a Member of the Active Staff shall automatically lose their membership on the Medical Board. A Medical Board member who takes a leave of absence shall relinquish their Medical Board membership for the duration of the leave and a designee appointed.

## **PART A – Medical Staff and Medical Board**

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The membership on the Medical Board of an ex-officio member shall terminate automatically upon loss of the applicable status.

### **7.4 Meetings of the Medical Board**

The Medical Board shall meet at least eight (8) times per year and more often as needed to perform its assigned functions. Meetings are generally conducted in-person with an option to participate virtually, if approved by the President of the Medical Board.

### **7.5 Meeting Quorum**

A quorum of the Medical Board will exist when fifty percent (50%) of the voting members are present.

### **7.6 Attendance Requirement**

Medical Board members are expected to attend at least two-thirds (2/3) of the meetings held on an annual basis (e.g., no less than seven (7) meetings if ten (10) are conducted over the course of the year), commencing with the Medical Staff Year. Failure to meet the attendance requirement will result in replacement. This replacement will be automatic, with replacement of the member proceeding in the same manner as initial appointment to the Medical Board.

Department Chairs may appoint a designee to attend Medical Board meetings on their behalf. Such designee must be approved in advance by the Medical Board President and the Hospital Chief Medical Officer, and shall be permitted to attend meetings and to vote in accordance with Section 7.10 of these Bylaws.

### **7.7 Participation of Authorized Hospital and System Officials**

Authorized Hospital and System Officials or their designees may attend any Medical Board, Medical Staff, or Medical Staff Committee meeting as an ex officio member, without vote.

### **7.8 Parliamentary Procedure**

Medical Board meetings shall be run in a manner determined by the President of the Medical Board. When parliamentary procedure is needed, as determined by the President of the Medical Board or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall be used.

### **7.9 Conduct of Confidential Peer Review Discussions**

Sensitive, confidential peer review discussions shall be conducted in executive session, attended solely by individuals authorized to participate in such activities in accordance with Section 7.14 of these Bylaws. As with all Medical Staff Committees, in accordance with Section 9.11 of these Bylaws, the Medical Board may call itself into executive session at any time during a regular or special meeting. Separate minutes shall be kept of any executive session.

### **7.10 Voting**

Voting on matters brought before the Medical Board is by open ballot, unless a request is made to the President of the Medical Board at the time of the vote for a secret ballot. In which case, the President of the Medical Board may, at their discretion, authorize a secret ballot. Motions carry by a simple majority of the members voting. Members who cannot attend a meeting may notify the President of the Medical Board in advance of the meeting of a request to vote by proxy and indicate their proxy vote to the President of the Medical Board. On occasion, when the Medical Board cannot meet in person to conduct its business, asynchronous electronic voting (e.g., by email) may be permissible if authorized by the President of the Medical Board.

## **PART A – Medical Staff and Medical Board**

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### **7.11 Notice of Meetings**

Regular meetings of the Medical Board are scheduled according to a yearly calendar that is distributed to all members. Each regular meeting's agenda will be distributed not less than seven (7) days before the meeting. Electronic notice stating the place, day, and hour of Special Meetings, i.e., those not regularly scheduled, shall be sent to each Medical Board member not less than seven (7) days before the date of such meeting by the person or persons calling the meeting indicating the reason for the meeting.

### **7.12 Special Meetings**

To conduct special, urgent business, the Medical Board will meet upon the request of the President of the Medical Board or the President of the Hospital, or when at least 25% of the Medical Board's members sign a petition indicating the reason for meeting, addressed to the President of the Medical Board, requesting such a meeting. Special Meetings have a single agenda item.

### **7.13 Minutes**

Minutes of each regular and special meeting of the Medical Board shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The Medical Board shall authenticate the minutes, and make them available to the Medical Board and Members of the Medical Staff. A permanent file of the minutes of each meeting shall be maintained. Minutes of the Medical Board shall be forwarded to the Board of Trustees.

### **7.14 Executive Session of the Medical Board**

Sensitive, confidential peer review, credentialing and quality-related discussions will be conducted in an executive session of the Medical Board and attended solely by individuals authorized to participate in such activities. Separate minutes shall be kept of any executive session and only members of the executive session are authorized to view the peer review materials, which includes all provider credentialing data. A quorum of the executive session of the Medical Board will exist when fifty percent (50%) of the voting members are present.

#### **7.14.1 Executive Session of the Medical Board Composition**

- President of the Medical Board, as Chair (with vote)
- Vice President of the Medical Board (with vote)
- Secretary of the Medical Board (with vote)
- Immediate Past President of the Medical Board (with vote)
- The Chief Medical Officer (with vote)

# **PART A – Medical Staff and Medical Board**

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## **Article 8      Officers of the Medical Board**

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### **8.1      The Officers of the Medical Board**

8.1.1      The Officers of the Medical Board also serve as the officers of the Medical Staff, respectively. Refer to Section 5.1 of these Bylaws.

#### 8.1.2      Qualifications

The Officers must be Members of the Active Staff, in Good Standing, indicate a willingness and ability to serve, and be in compliance with the policies of the Hospital and the System.

#### 8.1.3      Election of Officers

- a. Elections for Officers occur at the Annual Meeting of the Medical Board, which is the meeting held immediately preceding the commencement of the Medical Staff Year.
- b. The Nominating Committee composition is defined in Article IX (*Medical Staff and Hospital Committees*) of the Rules & Regulations.
- c. The Nominating Committee shall develop a slate of Candidates for the positions of President, President-Elect, Secretary and Treasurer of the Medical Board.
- d. The list of nominees shall be announced to the Medical Board at least four (4) weeks in advance of the election. Nominations may also be made by petition, signed by at least five (5) voting members of the Medical Board, submitted to the Nominating Committee at least two (2) weeks in advance of the election. The Nominating Committee must determine if the Candidate meets the qualifications in Subsection 8.1.2, above, before the Candidate can be placed on the ballot.
- e. Provided that a quorum is present, voting shall occur by secret ballot of those present at the meeting, with the President of the Medical Board withholding their vote. The Candidate who receives a majority of the votes cast shall be elected as the Medical Staff Officer. In the event of a lack of majority, the two Candidates receiving the most votes will be placed into a run-off election. If a quorum is not achieved, the vote will be delayed until the following meeting.

#### 8.1.4      Term of Office

All Officers serve a term of two (2) years and take office after the start of the Medical Staff Year. An incumbent Officer may run and, if elected, serve for one (1) additional consecutive two (2) year term in that same office. Each Officer shall serve in office until a successor is appointed/elected, unless the Officer resigns sooner or is removed from office.

#### 8.1.5      Vacancy of Office

The Medical Board shall fill, by off-cycle election, vacancies of the Offices of President-Elect, Secretary and Treasurer of the Medical Board that occur during the Medical Staff Year. If there is a vacancy in the office of the President of the Medical Board, the Vice President of the Medical Board shall serve the remainder of the term as President of the Medical Board, which does not count as a term.

## **PART A – Medical Staff and Medical Board**

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### **8.2 Duties of Officers**

#### **8.2.1 President of the Medical Board**

- a. The President of the Medical Board is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board of Trustees and Hospital Administration. Specific responsibilities and authority include the following:
- b. Call and preside at all regular and special meetings of the Medical Board;
- c. Serve as Chair of the Medical Board with vote, as ex officio member of all other Medical Staff and Medical Board Committees without vote, and participate as invited by the Hospital President or the Board of Trustees on Hospital or Board of Trustees Committees;
- d. Enforce Medical Staff Bylaws, Rules & Regulations, and Policies and Procedures, as well as all Hospital and System policies and procedures as they relate to the Medical and Advanced Practice Provider Staffs;
- e. Except as stated otherwise, appoint Medical Staff Committee Chairs and all Medical Staff Standing and Ad Hoc Committee members; in consultation with Hospital Administration, appoint Medical Staff Members and privileged Advanced Practice Providers to Hospital Committees or to serve as advisors or liaisons to carry out specific functions; in consultation with the Chair of the Board of Trustees, appoint Medical Staff Members to Board of Trustee Committees, as appropriate;
- f. Support and encourage Medical Staff leadership and participation in interdisciplinary clinical performance improvement activities;
- g. Report to the Board of Trustees the Medical Board's recommendations concerning appointment, reappointment, delineation of Clinical Privileges or specified services, and corrective actions with respect to Practitioners who are applying for appointment or Privileges, or who are granted Privileges or providing services in the hospital;
- h. Review and enforce compliance with standards of ethical conduct and professional demeanor among Medical Staff Members and all privileged Practitioners in their relations with each other, Hospital Administration and Staff, Board of Trustees, other professional and support personnel, and the community that the Hospital serves;
- i. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting Hospital operations to Hospital Administration, the Medical Board, and the Board of Trustees;
- j. Attend Board of Trustees meetings and Board of Trustees Committee meetings as invited by the Board of Trustees;
- k. Ensure that the decisions of the Board of Trustees are communicated to and carried out by the Medical Staff; and
- l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

#### **8.2.2 President-Elect of the Medical Board**

## **PART A – Medical Staff and Medical Board**

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In the absence of the President of the Medical Board, the President-Elect of the Medical Board shall assume all the duties and have the authority of the President of the Medical Board. The President-Elect of the Medical Board shall serve on the Medical Board and perform such duties to assist the President of the Medical Board as the President of the Medical Board may request from time to time.

### **8.2.3 Secretary of the Medical Board**

Medical Board shall collaborate with the Department of Medical Staff Services, assure maintenance of Medical Board minutes, attend to Medical Board correspondence, and coordinate communication to and within the Medical Staff. The Secretary of the Medical Board shall perform such further duties to assist the President of the Medical Board as the President of the Medical Board may request from time to time.

### **8.2.4 Treasurer of the Medical Board**

The Treasurer of the Medical Board shall collaborate with the Department of Medical Staff Services, attend to applicable Medical Board correspondence, and act as Medical Staff treasurer. The Treasurer of the Medical Board shall perform such further duties to assist the President of the Medical Board as the President of the Medical Board may request from time to time.

## **8.3 Removal and Resignation from Office**

### **8.3.1 Removal by Vote**

Officers may be removed by vote for failure to meet the responsibilities set forth in these Bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the Hospital, the System, their goals, or their programs. The Medical Board may initiate the removal of any officer if at least twenty percent (20%) of the Medical Board members sign a petition advocating for such action. Notification must be made to the Chief Medical Officer at least ten (10) days in advance of the meeting at which the vote is to be held. Removal shall become effective upon an affirmative vote by two-thirds (2/3) of those Medical Board members casting in-person ballot votes at a meeting where a quorum is met.

### **8.3.2 Automatic Removal**

Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer set forth in Subsection 8.1.2 of these Bylaws.

### **8.3.3 Resignation**

Elected officers wishing to resign must give written notice to the Medical Board. Such resignation shall take effect on the date specified in the notice.

# **PART A – Medical Staff and Medical Board**

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## **Article 9 Medical Staff Committees**

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### **9.1 Medical Board Responsibility for Medical Staff Committees**

To execute its responsibilities under these Bylaws, the Medical Board may establish standing and ad hoc Committees of the Medical Staff, which are enumerated in Article IX (*Medical Staff and Hospital Committees*) of the Rules & Regulations. Such Medical Staff Committees may hold regular and/or special meetings. The activities of these Committees shall be reported to the Medical Board and resolutions affecting the Medical Staff shall be subject to the approval of the Medical Board, as determined by the President of the Medical Board in consultation with the Hospital Chief Medical Officer. For any Medical Staff Committees that are combined into a System Committee, each site's representative(s) shall be responsible for reporting System Committee actions to the Medical Board at an interval at the discretion of the Medical Board President.

### **9.2 Regular Meetings of Medical Staff Committees**

Medical Staff Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Otherwise, Committees shall meet as needed, unless otherwise stipulated in these Bylaws and/or the Rules & Regulations of the Medical Staff.

### **9.3 Special Meetings of Medical Staff Committees**

A special meeting of any Committee may be called by the Committee Chair or by the President of the Medical Board.

### **9.4 Notice of Meetings of Medical Staff Committees**

Notice of Committee meetings will generally be given during the Committee's preceding meeting. Electronic notice stating the place, day, and hour of meetings rescheduled or cancelled shall be sent to each Committee member not less than seven (7) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

### **9.5 Membership of Medical Staff Committees**

Except as stated otherwise, the Medical Board President appoints all Medical Staff Committee Chairs. Medical Staff standing and ad hoc Committee members are appointed by the Medical Board President in consultation with the relevant Committee Chair. Chief Nursing Officers may vote on Medical Staff Committees at the discretion of the Committee Chair.

### **9.6 Rights of Ex Officio Members of Medical Staff Committees**

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

### **9.7 Attendance Requirements for Members of Medical Staff Committees**

#### **9.7.1 Joint Credentials Committee**

Members of the Joint Credentials Committee are expected to attend at least two-thirds (2/3rds) of the meetings held on an annual basis (e.g., no less than seven (7) meetings if ten (10) are conducted over the course of the year), commencing with the Medical Staff Year. Failure to meet the attendance requirement will result in replacement. This replacement will be automatic, with replacement of the member proceeding in the same manner as initial appointment to the Medical Board.

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### **9.7.2 All Other Medical Staff Committees**

Members of these Medical Staff Committees or Departments are encouraged to attend their meetings. At the discretion of the Chair, regular absences will result in replacement on the Committee. This replacement will be automatic, with substitution of the Member proceeding in the same manner as the initial appointment to the Committee.

### **9.8 Quorum for Medical Staff Committee Meetings**

The quorum for each Medical Staff Committee is defined as fifty percent (50%) of the voting members and no official action can be taken without a quorum.

### **9.9 Parliamentary Procedure**

Committee meetings will be run in a manner determined by the Committee Chair. When parliamentary procedure is needed, as determined by the Committee Chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order or a parliamentary procedure book approved by the Medical Board, as noted in the Rules & Regulations, shall determine procedure.

### **9.10 Actions of Medical Staff Committees**

The recommendation of a majority of its members present at a meeting at which a quorum is present, excluding the Committee Chair, shall be the action of the Committee. Only items noted on the agenda may be voted on at the meeting, unless an item raised is a matter of legal, regulatory, or accreditation compliance. In the event of a tie, the Committee Chair shall cast the deciding vote. Committee actions will be forwarded to the Medical Board for action.

### **9.11 Executive Session**

Any committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group, and other individuals who have a legitimate reason to be present, may remain during such session. Separate minutes shall be kept of any executive session.

### **9.12 Minutes of Medical Staff Committee Meetings**

Minutes of each regular and special meeting of a Medical Staff Committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The Committee shall authenticate the minutes and make them available to the Medical Board. A permanent file of the minutes of each meeting shall be maintained.

# **PART A – Medical Staff and Medical Board**

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## **Article 10 Conflict Resolution**

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### **10.1 Conflicts Between the Medical Board and the Board of Trustees**

10.1.1 In the event the Board of Trustees disagrees with a recommendation by the Medical Board, it will return the matter back to the Medical Board for reconsideration. If after reconsideration the Medical Board maintains its original position, it may request that an ad hoc Joint Conference Committee be convened. The Joint Conference Committee, composed of the officers of the Medical Board and an equal number of members of the Board of Trustees selected by the Chair of the Board of Trustees, will review the matter and make a recommendation to the full the Board of Trustees at its next regularly scheduled meeting. The decision of the Board of Trustees will be final.

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

### **10.2 Conflicts Between the Medical Staff and the Medical Board, Board of Trustees or the Hospital President**

10.2.1 The President of the Medical Board must call a special meeting of the Medical Board in response to a petition signed by a majority of the members of the Medical Board or a petition signed by twenty percent (20%) of the Members of the Active Staff. Such petition shall state the purpose of the meeting.

10.2.2 The President of the Medical Board may call a special meeting of the Medical Staff at any time. The President of the Medical Board must call a special meeting of the Medical Staff in response to a petition signed by twenty percent (20%) of the Members of the Active Staff. Such petition shall state the purpose of the meeting.

10.2.3 The President of the Medical Board shall designate the date, time and place of any special meeting, and electronic notice stating the date, time, place, and purposes of any special meeting shall be sent to each member of the respective body, at least seven (7) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting. If a resolution at a special meeting of the Medical Staff is proposed, only Members of the Active Staff may vote. No quorum is required for meetings of the Medical Staff related to Section 10.2.

10.2.4 If a resolution is passed by majority vote of the Members of the Active Staff at a special meeting of the Medical Staff, or, alternatively, by the members of the Medical Board at a special meeting of the Medical Board, the matter may be submitted to a Joint Conference Committee composed of the Officers of the Medical Board, an equal number of Members of the respective body requesting the special meeting who are proponents of the resolution, and an equal number of members of the Board of Trustees, for review and recommendation to the full Board of Trustees. The Committee will submit its recommendation to the Board of Trustees at its next regularly scheduled meeting. The decision of the Board of Trustees will be final.

# **PART A – Medical Staff and Medical Board**

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## **Article 11 Amending the Medical Staff Bylaws and Rules & Regulations**

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### **11.1 Methods of Adoption and Amendment to these Bylaws**

- 11.1.1 Proposed amendments to these Bylaws may be originated by any Authorized Hospital Official, the Medical Board, or by a petition signed by twenty percent (20%) of the Members of the Active Staff pursuant to the procedure set forth in Section 10.2 of these Bylaws. Once such proposed amendments are submitted, the Medical Board oversees the process for their consideration.
- 11.1.2 Each Member of the Active Staff will be eligible to vote on the proposed amendment, which will be conducted by electronic ballot. Ballots must be returned within fourteen (14) days of the ballot being sent, except that the President of the Medical Board may impose a shorter time period if the amendment must be made for regulatory or other urgent reasons. The amendment shall be considered approved by the Medical Staff if two-thirds (2/3rds) of the ballots received during the designated voting period are in the affirmative.
- 11.1.3 Bylaws amendments so adopted shall be effective when approved by the Board of Trustees. Following approval, the Medical Board shall immediately inform the Medical Staff.
- 11.1.4 Notwithstanding the foregoing, the Medical Board may adopt such amendments to these Bylaws that are, in the Medical Board’s judgment, technical modifications or clarifications. Such modifications may include reorganization or renumbering, or correcting punctuation, spelling, or other errors of grammar or expression. These shall be effective when approved by the Board of Trustees.
- 11.1.5 Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws in a substantive way.
- 11.1.6 In cases of a documented need for an urgent amendment to the Medical Staff Bylaws necessary to comply with law or regulation, the Medical Board may provisionally adopt and the Board of Trustees may provisionally approve such urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Board shall immediately inform the Medical Staff. The Active Medical Staff shall be given 14 calendar days to retrospectively review and comment on the provisional amendment. If there is no conflict between the Active Medical Staff and the Medical Board, the provisional amendment stands and shall be communicated to all Members of the Medical Staff. If the Active Medical Staff wishes to challenge the amendment, it may do so by following the conflict resolution procedure set forth in Section 10.2 of these Bylaws.
- 11.1.7 If at any time it is determined that the Medical Staff Bylaws are in conflict with the Hospital’s Corporate Bylaws, the parties will promptly work to resolve the conflict.

### **11.2 Methods of Adoption and Amendment to Medical Staff Rules & Regulations, Policies and Procedures**

- 11.2.1 The Medical Staff may amend and adopt rules, regulations, policies and procedures as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules & Regulations document and/or Policies & Procedures manual may be used to organize these documents.

## **PART A – Medical Staff and Medical Board**

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- 11.2.2 The Medical Board shall vote on the Medical Staff Rules & Regulations and Policies and Procedures and any revisions thereto at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by simple majority, Rules & Regulations and Policies and Procedures may be adopted, amended, or repealed, in whole or in part, and such changes shall be effective upon approval of the Board of Trustees. Following approval, the Medical Board shall immediately inform the Medical Staff.
- 11.2.3 In addition to the process described in Subsection 11.2.2 of these Bylaws, the Active Medical Staff, itself, may recommend directly to the Board of Trustees the adoption, amendment or repeal of any rule, regulation, or policy and procedure by submitting a petition indicating the reason for its existence to the Medical Board signed by twenty percent (20%) of the Members of the Active Staff. If the Medical Board does not vote to approve and forward it to the Board of Trustees, the dispute resolution process set forth in Section 10.2 of these Bylaws will be followed.
- 11.2.4 When amendment, adoption or repeal of Rules & Regulations is proposed, the proposing party (either the Medical Board or the Active Medical Staff) will communicate the proposal to the other party at least seven (7) days prior to the Medical Board meeting at which it will be voted upon.
- 11.2.5 In cases of a documented need for an urgent amendment to the Medical Staff Rules & Regulations necessary to comply with law or regulation, the Medical Board may provisionally adopt and the Board of Trustees may provisionally approve such urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Board shall immediately inform the Active Medical Staff. The Active Medical Staff shall be given 14 calendar days to retrospectively review and comment on the provisional amendment. If there is no conflict between the Active Medical Staff and the Medical Board, the provisional amendment stands and shall be communicated to all Members of the Medical Staff. If the Active Medical Staff wishes to challenge the amendment, it may do so by following the conflict resolution procedure set forth in Section 10.2 of these Bylaws.
- 11.2.6 Notwithstanding the foregoing, the Medical Board may adopt such amendments to the Medical Staff Rules & Regulations that are, in the Medical Board's judgment, technical modifications or clarifications. Such modifications may include reorganization or renumbering, or correcting punctuation, spelling, or other errors of grammar or expression. These shall be effective when approved by the Board of Trustees.
- 11.2.7 Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Rules & Regulations in a substantive way.

# **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

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## **Article 12 Corrective and Disciplinary Action**

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### **12.1 Grounds for Action**

An Authorized Hospital or System Official may initiate corrective and/or disciplinary action, as defined in Sections Part B 12.2 and 12.3 of these Bylaws, against any Practitioner who:

- a. Fails to demonstrate an acceptable level of professionalism, professional competence, or clinical judgment;
- b. Commits an act that constitutes professional misconduct under the New York State Education Law or engages in unprofessional or unethical behavior;
- c. Fails to abide by the System Code of Conduct, these Bylaws, the Rules & Regulations of the Medical Staff, or any other policies or rules of the Medical Staff, the Hospital, or the System;
- d. Fails at any time to meet a qualification for appointment, or makes a material misstatement on their Application or Reapplication for Medical Staff Membership and/or Privileges;
- e. Engages in any activity that is a threat to the welfare or safety of anyone, including patients, visitors, employees, other personnel, other Practitioners, the Hospital, and/or the System;
- f. Is terminated for cause by the School;
- g. Is subject to corrective or disciplinary action by another hospital or healthcare facility, a licensing agency, a medical or professional society, or a health plan or third-party payer;
- h. Fails to cooperate and/or comply timely with a request for an interview or to present documents during an investigation of their conduct;
- i. Fails to cooperate and/or comply timely with a request to participate in a quality, peer review and/or risk management, or any other hospital investigation, whether or not the Practitioner is the subject of the investigation; or
- j. Fails to cooperate and/or comply with, and satisfy, all remedial actions required by the Medical Board, or an Authorized Hospital or System Official, including, but not limited to, further clinical training, study and/or education; referral for and engagement in behavioral intervention(s); referral to and evaluation by the Physician Wellness Committee and/or Employee Health Services; referral to and engagement with the Committee for Physician Health of the Medical Society of the State of New York (if a Physician, a Physician Assistant, or a Specialist Assistant) or the Professional Assistance Program of the New York State Office of the Professions (for all other Practitioners); and/or referral for medical and/or psychiatric consultation, evaluation, and treatment by a healthcare provider who has been deemed acceptable to the Hospital Chief Medical Officer and Employee Health Services.

### **12.2 Corrective Action**

12.2.1 The following are “Corrective” Actions, the imposition of which do not restrict or curtail Privileges, that an Authorized Hospital or System Official may take against a Practitioner:

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

- a. Written warning;
  - b. Letter of admonition; or
  - c. Letter of reprimand.
- 12.2.2 The Practitioner shall have the right to submit a written response within thirty (30) calendar days following receipt of the warning, admonition or reprimand, and the response shall be maintained in the Practitioner's Credentials File.
- 12.2.3 Corrective Action, as described above, is not considered Disciplinary Action and shall not be treated as such. The Practitioner shall have no right to a Hearing on any such Corrective Action under these Bylaws.

### **12.3 Disciplinary Action**

- 12.3.1 The following are "Disciplinary" Actions that may be taken against a Practitioner:
- a. A period of enhanced monitoring of clinical activity and/or workplace behavior, along with feedback and counseling, that restricts or curtails Clinical Privileges, or that limits independent practice;
  - b. A time-limited term of probation (which should not initially be longer than one (1) year), involving intensive monitoring of the Practitioner, that may be extended, modified and/or result in different corrective or disciplinary action(s) based on events occurring during the period of probation or on new information obtained during the period of probation;
  - c. A requirement for clinical supervision, and/or prospective or concurrent consultation, with respect to care, or categories of care, when coupled with a written statement identifying this action as a disciplinary action under these Bylaws;
  - d. Except as provided in Section 12.4 (d) of these Bylaws, reduction, restriction, suspension, or termination of some or all Clinical Privileges, unless this action is applied to all staff in the Department or Division, in which case a separate determination must be made as to whether the action is intended to be disciplinary;
  - e. Restriction, suspension or termination of Medical Staff Membership;
  - f. Continuation or expansion of the scope of a previously imposed disciplinary action; or
  - g. Such other action as may be appropriate.
- 12.3.2 Notice of Request for Disciplinary Action
- The Authorized Hospital or System Official who initiates the request for disciplinary action must send a written notice to the Practitioner that sets forth the following:
- a. Proposed disciplinary action;
  - b. Reason for the request for the action;
  - c. If the Practitioner is a Member of the Medical Staff, their right to request a Hearing, in the manner provided by Section 13.2 of these Bylaws, within thirty (30) days of receipt of notice of the request for the action;
  - d. If the Practitioner is a Member of the Advanced Practice Provider Staff, their right to request an Advanced Practice Provider Staff Review, in the manner provided by

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

Subsection 13.11.4 of these Bylaws, within ten (10) days of receipt of notice of the request for the action;

- e. Practitioner’s rights under Article 12 and Article 13 of these Bylaws; and
- f. Access to the Medical Staff Bylaws.

12.3.3 Disciplinary action shall not become final until either:

- a. The time to request a Hearing, Advanced Practice Provider Staff Review, or Appeal regarding such action has expired and no such request has been received;
- b. All Hearing, Advanced Practice Provider Staff Review and Appeal procedures provided in Article 13 of these Bylaws are resolved; or
- c. The Practitioner has waived the right to a Hearing or an Appeal, as set forth in Article 13 of these Bylaws.

### **12.4 Summary Action**

12.4.1 An Authorized Hospital or System Official, in prompt consultation with another Authorized Hospital or System Official, may summarily restrict or suspend some or all of the Clinical Privileges and/or Medical Staff Membership of any Practitioner:

- a. Where the failure to take such action may, in the opinion of the individual(s) taking the action, result in imminent danger to the health or safety of any individual and/or imminent reputational or other harm to the Hospital or System;
- b. Where the Practitioner failed to cooperate fully with any quality assurance, Physician Wellness Committee, risk management, peer review or compliance investigation;
- c. If the Practitioner is under investigation for, charged with, pleads guilty to, or is found guilty of a felony, or other legal offense involving moral turpitude, in any jurisdiction, that affects the Practitioner’s ability to exercise their privileges; has an adverse effect on their reputation, or that of the Hospital, System, and/or School; or is related to their Hospital responsibilities; or
- d. Specifically for the purposes of conducting an investigation to determine if there is a need for corrective or disciplinary action, on the understanding that such restriction or suspension is for evaluative purposes only, is not itself corrective or disciplinary action, and, accordingly, is not subject to the hearing procedures set forth in Article 13 of these Bylaws or the reporting obligations of federal and state law, and will last up to fourteen (14) calendar days.

12.4.2 Notice of Summary Action

Except in the case of immediate automatic termination or suspension imposed pursuant to Section 12.4.1 (d) or 12.5 of these Bylaws, the Authorized Hospital or System Official imposing the summary action must send the Practitioner notice in writing of the:

- a. Summary action being imposed;
- b. Reason for the summary action;
- c. Practitioner’s rights under Article 13 of these Bylaws, including that the Practitioner has the right to request a Hearing on the decision in the manner provided by Subsection 13.2 of these Bylaws within thirty (30) days of the Practitioner’s receipt of notice of the summary action; and

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

- d. Online address at which these Bylaws can be located.

### **12.5 Automatic Termination or Suspension**

#### **12.5.1 Licensure Interruption**

A Practitioner whose license to practice their medical profession in New York State has expired, or has been revoked or suspended, shall immediately notify in writing the Department of Medical Staff Services, consistent with Subsections 3.6.10 and 16.2.9 of these Bylaws, and be subject to automatic termination or suspension as follows:

- a. Revocation

A Practitioner's Membership on the Medical or Advanced Practice Provider Staff and Clinical Privileges shall be automatically and immediately terminated upon revocation of the Practitioner's license.

- b. Probation or Restriction

A Practitioner's Membership on the Medical or Advanced Practice Provider Staff and Clinical Privileges shall be automatically and immediately suspended upon imposition of probation or a restriction of their license; and the Practitioner shall undergo an immediate investigation to determine whether further action is needed.

- c. Expiration of Registration

A Practitioner's Membership on the Medical or Advanced Practice Provider Staff and Clinical Privileges shall be automatically and immediately suspended upon expiration of registration of the Practitioner's license, provided that the suspension shall conclude, and that the Practitioner shall be reinstated in Good Standing status, immediately upon confirmation of the renewal of the Practitioner's registration. Failure to renew the registration within thirty (30) days shall be deemed a voluntary resignation of Medical/Advanced Practice Provider Staff Membership and voluntary relinquishment of Clinical Privileges, as per Subsection 12.5.8 of these Bylaws.

- d. Suspension

A Practitioner's Membership on the Medical or Advanced Practice Provider Staff and Clinical Privileges shall be automatically and immediately suspended upon suspension of their license for any reason other than expiration of registration. In addition to providing notification of the suspension, the Practitioner shall provide in writing all known facts and circumstances giving rise to the suspension and shall undergo an immediate investigation to determine whether further action is needed. A Practitioner whose license is reinstated following a period of suspension shall be responsible for providing written notice of the reinstatement to the aforementioned individuals and for requesting that their Medical Staff Membership and/or Clinical Privileges be reinstated. Depending on the outcome of the investigation, the Practitioner may be reinstated within five (5) days of receipt of the request, unless the Practitioner is subject to Summary Action, pursuant to Section 12.4 exclusive of Subsection 12.4.1d, in which case the Practitioner shall be entitled to the notice required by Subsection 12.4.2.

Automatic termination or suspension in accordance with this Subsection 12.5.1 of these Bylaws shall not be subject to the hearing procedures set forth in Article 13 of these Bylaws.

#### **12.5.2 Faculty Termination**

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Where a Practitioner whose appointment to the Faculty of the School has been terminated, whether with or without cause (“Faculty Termination”), and the Faculty appointment was a prerequisite to Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges, the Practitioner’s Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges shall be automatically terminated. If any Practitioner’s Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges is/are terminated because of the Practitioner’s loss of appointment to the Faculty of the School, and if the Practitioner elects to contest the Faculty Termination under the process described in the Faculty Handbook, then the automatic termination of the Practitioner’s Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges shall not be subject to an additional Hearing under Article 13 of these Bylaws.

### 12.5.3 Medicare or Medicaid Exclusion

A Practitioner who is excluded from participating in Medicare or Medicaid by the Center for Medicare and Medicaid Services (CMS), i.e., does not electively opt-out of participating, shall be automatically terminated from the Medical Staff. In accordance with Subsection 3.6.10a of these Bylaws, a Practitioner shall immediately notify, in writing, the Department of Medical Staff Services of a determination to exclude them from Medicare and/or Medicaid. Automatic termination in accordance with this Subsection shall not be subject to the hearing procedures set forth in Article 13 of these Bylaws.

### 12.5.4 Professional Liability Insurance Interruption

A Practitioner whose professional liability insurance coverage is cancelled or non-renewed shall immediately notify, in writing, the Department of Medical Staff Services and be automatically suspended from the Medical Staff for at least the period until the coverage is reinstated. Automatic suspension in accordance with this Subsection shall not be subject to the hearing procedures set forth in Article 13 of these Bylaws. Failure to reinstate the professional liability insurance coverage within thirty (30) days shall be deemed a voluntary resignation of Medical/Advanced Practice Provider Staff Membership and voluntary relinquishment of Clinical Privileges, as per Subsection 12.5.8 of these Bylaws.

### 12.5.5 DEA Certificate Interruption

For Practitioners who are required to maintain an active Controlled Substance Registration (“DEA”) Certificate in accordance with Subsection 15.2.1e of these Bylaws:

- a. If the DEA Certificate expires, the Practitioner shall automatically be divested of the right to prescribe medications covered by such DEA Certificate interruption until the DEA Certificate is reinstated. Failure to reinstate the DEA Certificate within thirty (30) days shall be deemed a voluntary resignation of Clinical Privileges, as per Subsection 12.5.8 of these Bylaws; however, they may maintain Medical or APP Staff Membership.
- b. If the DEA Certificate is restricted, suspended, or revoked, the Practitioner shall immediately notify the Department of Medical Staff Services, in writing, of the action and of all known facts and circumstances giving rise to it, and automatically be divested of the right to prescribe medications covered by such DEA Certificate interruption. An Authorized Hospital or System Official may summarily impose additional limitations on the Practitioner’s Clinical Privileges in light of the

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

Practitioner’s prescribing restriction. Additionally, restriction, suspension or revocation of a Practitioner’s DEA Certificate may trigger an investigation and further corrective and/or disciplinary action. Automatic restriction or suspension of prescribing privileges in accordance with this Subsection shall not be subject to the hearing procedures set forth in Article 13 of these Bylaws.

### **12.5.6 Extension of Corrective and Disciplinary Actions across the Health System**

If a Practitioner is subject to corrective or disciplinary action at a Mount Sinai Health System Site, the action will apply across all Sites. The communication shall come from the Site that is taking the corrective or disciplinary action with notice to the other Sites.

#### **Regulatory and Administrative Mandates**

A Practitioner who fails to comply with the following administrative or regulatory requirements shall have their Membership on the Medical/Advanced Practice Provider Staff and Clinical Privileges automatically suspended until the issue is cured:

- a. After receiving advance warning, fails to complete medical records on a timely basis, in accordance with the rules established from time to time by the Medical Board and/or Hospital;
- b. Fails to provide documentation of current compliance with completion of the Infection Control Course mandated by New York State;
- c. After receiving advance warning, fails to comply with requirements of the Employee Health Service, e.g., annual health screening, periodic respiratory fit-testing, required immunizations, tuberculin testing, etc.;
- d. Fails to demonstrate ongoing competence in using the electronic medical record(s) and other technology relevant to the Practitioner’s scope of practice;
- e. After receiving advance warning, fails to complete continuing professional education, regulatory compliance modules, and/or other training and education that are mandated from time to time by the Medical Board, the Hospital, and/or regulatory agencies;
- f. Fails to execute releases and/or provide requested documents for consideration of an Application or Reapplication; or
- g. Fails to pay dues, assessments and/or Application fees, as may be reasonably imposed from time-to-time by the Medical Board and/or Hospital.

Failure to cure any of these requirements within thirty (30) days shall be deemed a voluntary resignation of Medical/Advanced Practice Provider Staff Membership and voluntary relinquishment of Clinical Privileges, as per Subsection 12.5.8 of these Bylaws.

### **12.5.7 An automatic action imposed under Subsections 12.5.1c, 12.5.4 and 12.5.5a and 12.5.7 of these Bylaws shall not be longer than thirty (30) days. Failure of the Practitioner, without good cause, to renew their registration, reinstate their malpractice insurance, or cure any of the other causes of automatic action covered in Subsection 12.5.7 of these Bylaws within the thirty (30) day timeframe will be deemed a voluntary resignation of Medical/Advanced Practice Provider Staff Membership and voluntary relinquishment of Clinical Privileges with no right of appeal.**

### **12.5.8 Automatic suspension or limitation of privileges in accordance with this Section 12.5 of these Bylaws shall be in addition to, not in lieu of, any disciplinary, corrective, or**

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

summary action that may be imposed pursuant to the other provisions of this Article 12 of these Bylaws.

# **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

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## **Article 13      Hearing and Appeal Process**

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### **13.1      Right to a Hearing**

- 13.1.1      Except as otherwise provided in these Bylaws, any Applicant to, or Member of, the Medical Staff (“Applicant/Medical Staff Member”), i.e., not the Advanced Practice Provider Staff (see Section 13.11), who has received notice of:
- a.      Rejection of their Application for initial Appointment or Reappointment to the Medical Staff on grounds other than failure to meet the Basic Eligibility Criteria for Membership;
  - b.      Denial of any request for any Clinical Privilege;
  - c.      Disciplinary action pursuant to Section 12.3 of these Bylaws; or
  - d.      Summary action pursuant to Section 12.4, excluding Subsection 12.4.1d,
- is entitled to a Hearing pursuant to the procedure set forth in Article 13 of these Bylaws.
- 13.1.2      When an Applicant/Medical Staff Member is subject to an action that entitles them to a Hearing, as defined in Subsection 13.1.1, and action is requested at other hospitals within the System based upon the same underlying issue(s), there will be a single hearing panel and that hearing panel will be the final decision for hospital.
- 13.1.3      An Applicant/Medical Staff Member employed by, or seeking to become employed by, the Hospital or the School, may not invoke the Hearing and Appeals procedures set forth in Article 13 of these Bylaws with respect to decisions regarding their employment.
- 13.1.4      There is no right to a Hearing for any matter relating to termination of a professional service agreement, or termination of an independent contractor or consulting arrangement.
- 13.1.5      References in this Article 13 to “Applicant/Medical Staff Member” are interpreted to exclude:
- a.      Practitioners serving in a locum tenens capacity;
  - b.      Practitioners functioning as trainees in a re-entry program;
  - c.      Practitioners only providing telemedicine services where the Distant Site is not part of the Health System; and
  - d.      Fellows (i.e., current trainees who have previously completed a qualifying primary residency) who are serving as part-time, Hospital-based, Attending Physicians.
- Such Practitioners are not eligible for a Hearing.
- 13.1.6      Privilege actions pertaining to the Advanced Practice Provider Staff are addressed in Section 13.11 of these Bylaws.

### **13.2      Request for a Hearing**

- 13.2.1      A request for a Hearing must be sent in writing to the President of the Medical Board by overnight mail, return-receipt requested, and by e-mail, within thirty (30) days after the Applicant/Medical Staff Member first receives notice of the adverse action.
- 13.2.2      If no such request is made, the adverse action shall become final, in accordance with these Bylaws.

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- 13.2.3 Where the Hearing is requested in connection with a summary action, the Medical Staff Member may request an expedited Hearing as defined in Section 13.4 (b) of these Bylaws.

### **13.3 Hearing Committee**

- 13.3.1 Within fourteen (14) days of receipt of a request for a Hearing, the President of the Medical Board, in consultation with the Hospital President, shall designate a Hearing Committee.

#### **13.3.2 Composition**

- a. The Hearing Committee shall consist of five (5) Members of the Medical Staff, at least two (2) of whom shall be members of the Medical Board, and up to two (2) of whom do not primarily receive their compensation from the Hospital, System or School. If the Medical Staff Member primarily practices at a specific Hospital Site, as confirmed by the relevant Department Chair, at the Medical Staff Member's request, two (2) members of the Hearing Committee shall be Members of the Medical Staff who practice primarily at that Site.
- b. When an Applicant/Medical Staff Member is subject to disciplinary action at multiple hospitals within the System arising from the same underlying issue(s), pursuant to Subsection 13.1.2, the Hearing shall be conducted by the hospital where the issue(s) giving rise to the action occurred. If the issue(s) did not specifically occur at one particular hospital, the Applicant's/Medical Staff Member's primary hospital as indicated in the credentials file shall conduct the Hearing. If no primary hospital is identified, or relevant, the hospital of the Applicant's/Medical Staff Member's choosing, with which they have a relationship, will conduct the Hearing.
- c. No Member of the Medical Staff who has actively participated in the initiation of the action or the decision that is the subject of the Hearing, or whose medical practice is in direct economic competition with the Applicant/Medical Staff Member, shall serve as a member of the Hearing Committee.
- d. The President of the Medical Board shall appoint a member of the Hearing Committee to serve as its Chair.
- e. The Hearing Committee may, in its sole discretion, arrange for legal counsel through the System's Legal Department to advise it on legal and procedural matters.

- 13.3.3 Within seven (7) days of receipt of the Notice of Hearing (Section 13.4 of these Bylaws), the Applicant/Medical Staff Member may challenge, for cause, the inclusion on the Hearing Committee of any member who, in the opinion of the Applicant/Medical Staff Member, would be unable to render an impartial decision. It shall be at the sole discretion of the Hearing Committee Chair whether to replace any member of the Hearing Committee so challenged, provided that the Hearing Committee Chair shall replace any member whose practice is found to be in direct economic competition with that of the Applicant/Medical Staff Member.

### **13.4 Notice of Hearing**

Upon designation of the Hearing Committee, the Applicant/Medical Staff Member will be given notice, in writing, setting forth:

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

- a. The place, time, and date of the Hearing, which date, unless otherwise agreed to by the Parties, shall be at least thirty (30) days from the date of the Notice;
- b. However, where the Medical Staff Member has made a proper request for an expedited Hearing, the Hearing date shall be no later than fifteen (15) days from the date of the Notice.
- c. The names of the Hearing Committee Chair and the other members of the Hearing Committee; and
- d. The names of the witnesses whom the Party taking the action plans to call to testify at the Hearing.

### **13.5 Witness Lists**

- 13.5.1 Within 14 (fourteen) days of receipt of the Notice of Hearing required by Section 13.4 of these Bylaws, or such other time as may be determined by the Hearing Committee Chair, the Applicant/Medical Staff Member shall submit to the Hearing Committee Chair and the Party taking the action a list of the names of the witnesses whom the Applicant/Medical Staff Member will call to testify at the Hearing.
- 13.5.2 Additional witnesses for the Party taking the action and the Applicant/Medical Staff Member may be permitted at the Hearing in the discretion of the Hearing Committee.

### **13.6 Written Submissions**

If requested by the Chair of the Hearing Committee, each Party shall submit to the Chair, no later than ten (10) days prior to the scheduled date of the hearing, or such other time as may be determined by the Chair, at least eight (8) copies of:

- a. All documents the Party wishes to be considered by the Hearing Committee;
- b. A written statement setting forth the Party's position; and
- c. Copies of the curriculum vitae and report of any witness being called as an expert.

As required by the Health Insurance Portability and Accountability Act (HIPAA), all protected health information (PHI) shall be redacted. The Chair may require the parties to exchange copies of their submissions.

### **13.7 Special Considerations Regarding Patients and/or Their Advocates as Witnesses**

- 13.7.1 No adverse inference shall be drawn from the failure of either Party to call a patient, a patient's family member, or a patient's surrogate as a witness in a Hearing.
- 13.7.2 To preserve the integrity and confidentiality of patients, their families and their advocates, neither the Party taking the action nor the Applicant/Medical Staff Member may call a patient, a patient's family member, or a patient's advocate as a witness in a Hearing. In the event that the Party taking the action or the Applicant/Medical Staff Member believes that such testimony is critical to its case, they may make a special application to the Hearing Committee Chair or their designee for an in-camera interview. The Chair shall have discretion to grant this request and then interview the witness, prior to the Hearing, if possible. The Party taking the action and the Applicant/Medical Staff Member shall provide the Chair with written questions for such an interview. The Chair shall provide a summary or a transcript of the interview to both Parties.

### **13.8 Hearing Procedures**

- 13.8.1 Purpose of the Hearing

## **PART B – Corrective and Disciplinary Action, Hearing and Appeal**

The Applicant/Medical Staff Member shall have the burden of establishing that the proposed adverse action is arbitrary or capricious. The purpose of the Hearing shall be limited to determining whether the Applicant/Medical Staff Member has met this burden. The Hearing Committee shall make any decisions and rules, in addition to those set forth in this Article 13, that it deems necessary to assure a fair and expeditious handling of the matter.

### 13.8.2

#### Rules of Evidence

The rules of evidence shall not apply to the Hearing.

### 13.8.3

#### Transcript

All testimony at the Hearing shall be under oath and a transcript of the Hearing shall be prepared. Each Party may request copies of the transcript, which shall be prepared at that Party's expense.

### 13.8.4

#### Arguments

The Parties will be permitted to make opening and closing statements at the Hearing, to present and to refer to documentary evidence, to examine their own witnesses, and to cross-examine the witnesses called by the other Party. Unless otherwise directed by the Chair of the Hearing Committee, the Party taking the action shall present its case first, followed by the Applicant/Medical Staff Member. The Hearing Committee will have the right to limit the introduction of any evidence or line of inquiry that it deems duplicative, irrelevant, or designed to harass or embarrass. The Hearing Committee, itself, may examine the witnesses brought by either Party. At the request of either Party, the Hearing Committee will permit the Parties to provide to the Hearing Committee, and to exchange with each other, post-Hearing written submissions in lieu of, or in addition to, closing statements. The Hearing Committee shall have authority to decide all matters arising during the Hearing.

### 13.8.5

#### Applicant's/Medical Staff Member's Participation in the Hearing

The Applicant's/Medical Staff Member's attendance at the Hearing shall be mandatory. If the Applicant/Medical Staff Member does not call himself as a witness, they may be called and examined as if under cross-examination.

### 13.8.6

#### Failure to Appear

The right to a Hearing will be forfeited if the Staff Member fails, without good cause, to appear. Requests for postponement without good cause, as determined by the Hearing Committee, shall be denied.

### 13.8.7

#### Obligation of Medical and Advanced Practice Provider Staff Members to Participate in a Hearing

The Hearing Committee may, in its discretion, require that any Member of the Medical or Advanced Practice Provider Staffs be called as a witness, and refusal by that individual to testify may itself be ground for disciplinary action pursuant to Section 12.1 of these Bylaws. No retaliation or harassing conduct shall be taken against a witness for testifying at a Hearing in accordance with the policies of the Hospital.

### 13.8.8

#### Representation

Each Party may be represented at the Hearing by an attorney; in lieu of an attorney, the Applicant/Medical Staff Member may appoint a non-attorney to be their representative. The role of such representation shall be limited to providing advice and

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counsel to the Party and to addressing the Hearing Committee on the Party's behalf. The representative shall not be permitted to present evidence or to examine or to cross-examine witnesses. However, the Hearing Committee may, in its discretion, further define, expand or limit the role of the Parties' appointed representatives.

The Hearing Committee may request counsel to advise it.

### **13.8.9 Hearing Committee Determination**

Upon conclusion of the Hearing, the evidence and arguments presented shall be considered by the Hearing Committee in closed session. The Hearing Committee shall be entitled to consider the Applicant's/Medical Staff Member's entire credentials and quality/peer review files in its deliberations. By a majority vote, the Hearing Committee shall render a decision to confirm, modify, or reverse the adverse action. The Hearing Committee will prepare a written decision setting forth the basis of the Hearing Committee's determination. If any of the Hearing Committee's members dissent from the determination, the written decision shall note the number of dissenters and will provide an explanation for their dissent; the written decision shall not, however, identify the Hearing Committee members who dissented and those in the majority. The Parties, the President of the Medical Board, and the President of the Hospital will receive a copy of the written decision.

## **13.9 Appeal to the Board of Trustees**

### **13.9.1 The Parties**

Any one or more of the following individuals (which constitute "the Parties") may appeal the decision of the Hearing Committee to the Board of Trustees:

- a. Applicant/Medical Staff Member
- b. The Party that originally requested the action;
- c. Hospital Chief Medical Officer; or
- d. President of the Hospital.

### **13.9.2 Appeal Request**

A request for an Appeal shall be sent in writing to the Chair of the Board of Trustees by overnight mail, return-receipt requested, and with copy by e-mail, read-receipt requested, no later than fifteen (15) days after receipt of the decision of the Hearing Committee. A copy of the request shall be sent to the other Parties, as relevant, amongst those listed in Subsection 13.9.1 of these Bylaws.

### **13.9.3 Appellate Review Materials**

The Party requesting the appeal shall enclose a copy of the following materials (the "Hearing Record") with the request to the Chair of the Board of the Trustees:

- a. Copy of the Hearing Committee's written decision;
- b. Transcript of the proceedings before the Hearing Committee, if then available;
- c. Copy of all documents presented to the Hearing Committee, whether during, prior to, or following the Hearing;
- d. Copy of each Party's post-Hearing written submissions, if any; and
- e. Any other material that the Hearing Committee considered in rendering its decision.

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If the transcript of the Hearing is not available when the request for an appeal is made, the Party requesting the appeal shall forward a copy of the transcript to the Chair of the Board of Trustees as soon as it becomes available.

### 13.9.4 Appellate Review Committee

The Chair of the Board of Trustees may, at their discretion, refer the Appellate Review to the entire Board of Trustees, a standing committee thereof, or an ad hoc committee thereof, provided any such body consists of at least three (3) members of the Board of Trustees appointed for such purpose (in each case, the “Appellate Review Committee”) and that no Appellate Review Committee member be in economic competition with the Applicant/Medical Staff Member. The Chair of the Board of Trustees shall arrange for copies of the Hearing Record to be made available to the Appellate Review Committee. The Appellate Review Committee shall make any rules, in addition to those set forth in this Section 13.9 of the Medical Staff Bylaws, that it deems necessary to assure a fair and expeditious handling of the matter.

### 13.9.5 Appellate Review Procedures

- a. Within a reasonable timeframe, the Appellate Review Committee will schedule a hearing (the “Appellate Hearing”) to be attended by both Parties and the individual who originally requested the action, if not a Party to the Appellate Hearing.
- b. The Appellate Review Committee may, in its discretion, request that a member or members of the Hearing Committee attend the Appellate Hearing. The member(s) of the Hearing Committee invited to attend the Appellate Hearing may provide an oral statement concerning the basis of the Hearing Committee’s decision.
- c. The affected Applicant/Medical Staff Member may bring a representative to the Appellate Hearing, as described in Subsection 13.8.8 of these Bylaws.
- d. Each Party, as well as the individual who originally requested the action, if not a Party to the Appellate Hearing, shall be entitled to submit, no later than three (3) business days prior to the Appellate Hearing, a written statement setting forth its position concerning the merits of the appeal and to make an oral statement at the Appellate Hearing of such position.
- e. Unless permitted by the Appellate Review Committee in its discretion, the Hearing Record shall not be supplemented with additional documentary material.
- f. The Appellate Review Committee may ask questions of those in attendance at the Appellate Hearing.
- g. The Appellate Review Committee may request legal counsel to advise it.

### 13.9.6 Appellate Review Determination

The Appellate Review Committee shall determine whether there is a reasonable basis on the record as a whole to support the findings and conclusions of the Hearing Committee. Within sixty (60) days of the Appellate Hearing, the Appellate Review Committee shall send notice of its decision and a statement of the basis for its decision to the Parties, the Chair of the Hearing Committee, the CEO, and the Chair of the Board of Trustees. The decision of the Appellate Review Committee shall be final and the action under consideration implemented upon its approval by the Board of Trustees.

### 13.9.7 Failure to Appear

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The right to an appeal will be forfeited if the appealing Party fails, without good cause, to appear at the Appellate Hearing. Requests for postponement without good cause, as determined by the Appellate Review Committee, may be denied.

### **13.10 Interpretation of Rules**

The procedures of this Article 13 are intended to establish fair and reasonable guidelines to be followed by the Medical Board, the Board of Trustees, and their respective committees. Breaches of such rules shall be grounds for new proceedings only if the breach is of a substantial and material nature.

### **13.11 Review of Privileges Actions for Advanced Practice Providers**

- 13.11.1 Advanced Practice Providers are not entitled to the hearing and appeals procedures set forth in Sections 13.1 through 13.10 of these Bylaws, for any reason, including denial of an initial request for privileges and/or an action to reduce, restrict, suspend, or terminate some or all Clinical Privileges.
- 13.11.2 Employed Advanced Practice Providers shall be deferred to Labor Relations for any issues that require review.
  - a. Labor Relations shall work in collaboration with the Medical Staff, including but not limited to the Department Chair or designee that recommended the Clinical Privileges, for any concerns or actions that impact Clinical Competence or Professional Conduct.
  - b. Any actions or restrictions of one's employment recommended by Labor Relations shall be applied equally to the Practitioner's Advanced Practice Provider Membership and/or Clinical Privileges.
- 13.11.3 Non-Employed Advanced Practice Providers may meet with an "Advanced Practice Provider Staff Review Committee," comprised of two physician Members of the Medical Staff and a peer, assigned by the Chair of the Committee on Professional Enhancement, in consultation with the Hospital Chief Medical Officer. The Advanced Practice Provider may elect to be accompanied by their Supervising/Collaborating Physician, if applicable, who may participate in the proceedings at the discretion of the Advanced Practice Provider.
- 13.11.4 The Advanced Practice Provider must submit a written request for such a meeting to the President of the Medical Board within ten (10) calendar days from the date of receipt of the adverse action notice, or they shall have waived the right to such a meeting.
- 13.11.5 At the meeting, the Advanced Practice Provider is entitled to discuss, explain, or refute the adverse action. The Advanced Practice Provider may submit a written statement, along with written statements from other Practitioners, within five (5) calendar days of the meeting.
- 13.11.6 Failure of the Advanced Practice Provider to appear, without good cause, shall be deemed a withdrawal of the request for the meeting. The person(s) seeking to impose the adverse action also must attend.
- 13.11.7 The decision of the Advanced Practice Provider Staff Review Committee shall be communicated in writing to the Advanced Practice Provider the person seeking to impose the adverse action, the Medical Board, and the Board of Trustees.
- 13.11.8 In the event that the Advanced Practice Provider does not prevail, they may submit a written request for an Appeal to the CEO within ten (10) calendar days of receipt of

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the findings of the Advanced Practice Provider Staff Review Committee. Two (2) members of the Board of Trustees (“Advanced Practice Provider Staff Appeal Committee”), assigned by the Chair of the Board of Trustees, shall hear the Appeal. The Advanced Practice Provider may elect to be accompanied by their Supervising/Collaborating Physician, if applicable, who may participate in the proceedings at the discretion of the Advanced Practice Provider. A representative from the Medical Staff leadership may be present. The recommendation of the Advanced Practice Provider Staff Appeal Committee will be forwarded to the Board of Trustees for final decision. The Advanced Practice Provider will be notified within ten (10) calendar days of the final decision of the Board of Trustees.

- 13.11.9 Advanced Practice Providers are not entitled to the review and appeal rights set forth in this Section 13.11, if their Clinical Privileges are terminated solely because of:
- a. Termination of employment for reasons other than clinical conduct or lack of professionalism;
  - b. Termination of a professional service agreement; or
  - c. Termination of an independent contractor or consulting agreement.

# **PART C – Credentialing & Privileging**

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## **Article 14 Medical Staff Joint Credentials Committee**

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### **14.1 Composition**

- 14.1.1 There shall be a Joint Credentials Committee consisting of Members from each of the System hospitals. The Joint Credentials Committee will consist of eighteen (18) Members of the Active Staff appointed by the respective President of the Medical Staff: five (5) from Mount Sinai Hospital/Mount Sinai Queens, five (5) from Mount Sinai Beth Israel/Mount Sinai Brooklyn, five (5) from Mount Sinai Morningside/Mount Sinai West, and three (3) from New York Eye and Ear Infirmary of Mount Sinai. Plus, there will be a Committee Chair appointed by the System Chief Medical Officer.
- 14.1.2 Each hospital's appointments to the Committee should be made in collaboration with the Committee Chair, the Hospital Chief Medical Officers and the Presidents of the other Medical Staffs to foster diverse representation on the Committee.
- 14.1.3 Members will be appointed for three (3) year terms, with the initial terms staggered such that approximately one third (1/3) of the Members will be appointed each year. Terms may be extended at the discretion of the Chair and Members may be reappointed to successive terms.
- 14.1.4 The Chair(s) of the Advanced Practice Providers Credentials Subcommittee shall attend as ex officio, non-voting members.
- 14.1.5 Authorized Hospital and System Officials, Department of Medical Staff Services personnel, and representatives from Risk Management and the Legal Department may attend without vote.

### **14.2 Meetings**

The Joint Credentials Committee shall meet at least ten (10) times per year, and may have special meetings, if called by the Chair or by an Authorized Hospital or System Official.

- a. Quorum is defined as fifty percent (50%) of the voting members and no official action can be taken without a quorum.
- b. The Committee shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations to the Medical Board.
- c. Meetings may be conducted electronically and asynchronously, as needed, at the direction of the Chair.

### **14.3 Responsibilities**

The Joint Credentials Committee has the following responsibilities:

- a. To review and recommend action on all Applications and Reapplications for Membership on the Medical and Advanced Practice Provider Staffs, including assignments of Medical Staff category and department;
- b. To review and recommend action on all requests regarding Clinical Privileges from eligible Practitioners;
- c. To recommend Basic Eligibility Criteria (Section 15.1), as well as General and Profession-Specific Qualifications (Sections 15.2 and 15.3, respectively), for the granting of Medical and Advanced Practice Provider Staff Membership;

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- d. To recommend all clinical competence criteria, including but not limited to, education, training, experience, certification, and oversight criteria, as set forth in Clinical Privileges delineations;
- e. To act on behalf of the Medical Staff in overseeing the initial focused professional practice evaluation programs implemented by the Departments;
- f. To develop, recommend, and consistently implement appropriate and compliant policies and procedures for all credentialing and privileging activities;
- g. To review and, where appropriate, take action on reports that are referred to the Committee from the Medical Board, other Medical Staff Committees, the Medical Staff, or Authorized Hospital and System Officials;
- h. To share credentialing, privileging, and peer review information between the various System hospitals for the purposes of credentialing and privileging and other peer review activities; and
- i. To perform such other functions as requested by the Medical Board and Authorized Hospital and System Officials.

### **14.4 Confidentiality and Access to Credentials Files**

The Joint Credentials Committee shall function as a peer review committee, consistent with federal and state law. All Members of the Committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all materials and information obtained by virtue of membership on the Committee.

- 14.4.1 Credentials Files (defined in Article 2) are the property of the Hospital and will be maintained securely and with strict confidence. The files will be maintained in a locked office suite and/or in secure electronic format. Files may be accessed only by approved Hospital and System personnel, who require them for Hospital peer review or institutional functions and to comply with accreditation and regulatory requirements.
- 14.4.2 Practitioners may review their Credentials File only upon written request to the Department of Medical Staff Services. Review of such files will only be conducted in the presence of Department of Medical Staff Services personnel or a designee of Hospital or System Administration. Confidential letters of reference and items obtained under the Practitioner's signed waiver may not be reviewed and will be sequestered prior to the Practitioner's review of the file. The Practitioner may not remove anything from the file. Only items supplied by the Practitioner or directly addressed to the Practitioner may be provided to the Practitioner. A record will be made and placed in the file indicating the dates and circumstances of the review, and any items that were copied and released to the Practitioner. The Practitioner may prepare a signed and dated memorandum to be included in the file, which may be reviewed by an Authorized Hospital and/or System Official.

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### **Article 15 Eligibility and Qualifications for Membership and/or Clinical Privileges**

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#### **15.1 Basic Eligibility Criteria**

15.1.1 No Practitioner shall be entitled to Membership on the Medical or Advanced Practice Provider Staff and no Practitioner shall be entitled to be granted Clinical Privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

No Practitioner shall be eligible for Membership on the Medical or Advanced Practice Provider Staff and no Practitioner shall be eligible for Clinical Privileges if they do not meet the following Basic Eligibility Criteria:

- a. Has successfully graduated from an approved school and recognized course of training in a clinical profession approved by the Board of Trustees for the grant of Clinical Privileges, as applicable, and further defined below;
- b. Has a current state or federal license and, if applicable, required professional registration or certification (i.e., not board certification) applicable to their profession, providing authorization to practice in the State of New York, or other licensure that is compliant with New York State law to permit practice;
- c. Demonstrates evidence of professional liability insurance coverage of a type and in an amount required by the Hospital.

Failure to meet all of the Basic Eligibility Criteria may preclude release of an Application for Medical Staff Membership and/or Clinical Privileges.

#### **15.2 General Qualifications**

15.2.1 The following qualifications must be met and continuously maintained by all Applicants and Reapplicants for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges.

- a. Not currently on the Office of the Inspector General (OIG) List of Excluded Individuals/Entities or System for Award Management (SAM). Any prior history or exclusions, or any OIG Corporate Integrity Agreements, shall be considered on a case by case basis by the Joint Credentials Committee;
- b. Has no history of criminal conviction, guilty plea, or plea of no contest to any crime related to controlled substances, illegal drugs, fraud, or abuse (physical, sexual, child or elder), excluding non-violent minor misdemeanor convictions. The Joint Credentials Committee has the option to evaluate these matters on a case by case basis;
- c. Meets requirements for experience, training, current competence, medical knowledge, technical skill, and ability to perform the Clinical Privileges requested;
- d. Meets requirements for professionalism, ethics, character, integrity, collegiality, and citizenship;
- e. Possesses a current and valid Controlled Substance Registration (“DEA”) Certificate, with a New York State address, if applicable to the Practitioner’s profession and specialty as determined by the relevant Department Chair; any

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waiver requests or restrictions to a DEA will be reviewed on a case-by-case basis. For Members that do not hold Clinical Privileges, a DEA is not required.

- f. Possesses a valid individual National Provider Identifier (NPI) number;
- g. Provides evidence of a recent physical examination, including a medical history, and participate in annual health screenings, all of sufficient scope to ensure that the Practitioner is free from a health condition which could pose a potential risk to patients or other personnel, or which might interfere with the performance of the Practitioner’s duties and/or exercise of Clinical Privileges;
- h. If granted privileges, demonstrates the capability to provide continuous and timely patient care to the satisfaction of the relevant Department Chair, Medical Board and Board of Trustees;
- i. Demonstrates recent clinical performance within the last twenty-four (24) months with an active clinical practice in the discipline in which Clinical Privileges are sought, adequate to meet current clinical competence criteria, or consider participating in Practitioner Re-Entry as defined in Section 19.4 of these Bylaws;
- j. Requests only Clinical Privileges that are offered at the Hospital;
- k. For a Fellow-in-Training that is seeking to serve as a part-time, Hospital-based, Attending Physician, requests only Clinical Privileges for which the Practitioner is qualified by virtue of having completed a qualifying primary residency and, if applicable, other fellowship(s), but may not request Clinical Privileges in the current fellowship sub-specialty area; and
- l. Provides a description of the Practitioner’s intended practice plan(s), indicating how the Applicant/Reapplicant intends to affiliate with the Hospital and integrate with the Medical Staff. All Members of the Medical Staff must contribute to the Hospital and its patients as set forth in Article 4. With respect to new applicants for Membership and/or Clinical Privileges, the further need for Practitioners with these qualifications, and/or the availability of more qualified candidates for appointment shall be determined by the applicable System and/or Site Chair.

Failure to meet one or more of the General Qualifications listed above does not preclude release of an application for Medical Staff Membership and/or Clinical Privileges, but may result in denial of Membership and/or Clinical Privileges.

### 15.3 Profession-Specific Qualifications

The following qualifications for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges must be met and continuously maintained by the specific Applicant and Reapplicant types listed.

#### 15.3.1 A **Physician** Applicant (MD or DO) must have:

- a. Successfully graduated from a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA); **OR**
- b. Successfully graduated from a medical school recognized by the World Directory of Medical Schools and been certified by the Education Commission for Foreign Medical Graduates (ECFMG);

**AND** completed an allopathic or osteopathic residency program approved by the Accreditation Council for Graduate Medical Education (ACGME), the American

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Osteopathic Association (AOA), or the United Council for Neurologic Subspecialties (UCNS), respectively, or a training program of similar scope and rigor that is acceptable to the Chair of the Department, the Joint Credentials Committee, and the Medical Board, and approved by the Board of Trustees.

- 15.3.2 For each of the specialties and subspecialties in which they intend to exercise privileges as set forth on the requested delineation of privileges, a **Physician** Applicant must be currently board-certified or, if not currently board-certified, must be currently board-admissible and then become board-certified within five (5) years of having completed formal training in that respective discipline, as defined by the appropriate specialty board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association, the Royal College of Physicians and Surgeons in Canada and the United Kingdom, and the Australian Medical Council; or demonstrate equivalent professional competence as deemed acceptable by their Department Chair, the Joint Credentials Committee, and the Medical Board, and approved by the Board of Trustees. Any Physician Applicant boarded by another country's certifying body (other than those listed above) must submit documentation to deem such certification as substantially equivalent to ABMS requirements.
- 15.3.3 Regarding board certification, the following shall also apply:
- a. Current Members of the Medical Staff who fail to gain their initial specialty and/or subspecialty board certification(s) within five (5) years of completing formal training, or fail to renew their board certification shall be evaluated by the Clinical Department and the Joint Credentials Committee to determine eligibility for a waiver.
  - b. Current Members of the Medical Staff who hold membership and/or Clinical Privileges as of January 1, 2006 and who have met prior qualifications for Membership and/or Clinical Privileges shall be exempt from board certification requirements. These Practitioners are considered Legacy Medical Staff Members.
  - c. Members of the Medical Staff must participate in maintenance of certification as applicable to all required board certifications as set forth in their specialty-specific delineation of privileges, or be granted a waiver of such under Section 15.4 of these Bylaws. Members of the Medical Staff who do not hold Clinical Privileges or are deemed Legacy status are not required to participate in MOC; however, they will be required to do so if they request clinical privileges in the future.
- 15.3.4 A **Dentist** Applicant must have graduated from an American Dental Association-approved school of dentistry, accredited by the Commission of Dental Accreditation.
- 15.3.5 An **Oral and Maxillofacial Surgeon** Applicant must have graduated from an American Dental Association-approved school of dentistry that is accredited by the Commission of Dental Accreditation, must have successfully completed an American Dental Association-approved residency program, and must be board-certified, or, if not board-certified, must be board-admissible and become board-certified within five (5) years of having completed formal training, as defined by the American Board of Oral and Maxillofacial Surgery, in accordance with the relevant portions of Subsection 15.3.3.
- 15.3.6 A **Podiatrist** Applicant must have graduated from a school of podiatric medicine accredited by the Council on Podiatric Medical Education; must have successfully completed a three (3) year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American

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Podiatric Medical Association (APMA); and must be board-certified, or, if not board-certified, must be board-admissible and become board-certified within five (5) years of having completed formal training, as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine, in accordance with the relevant portions of Subsection 15.3.3.

15.3.7 **Advanced Practice Provider** Applicants must meet the qualifications set forth in the applicable delineation of privileges and Medical Staff Policies and Procedures.

### **15.4 Waiver of Qualification Requirements**

The Board of Trustees may, after considering the recommendations of the Medical Board, Joint Credentials Committee, and any appropriate Department Chair, waive any of the General and Profession-Specific Qualifications (Sections 15.2 and 15.3 of these Bylaws, respectively) for Membership on the Medical or Advanced Practice Provider Staff and Clinical Privileges established pursuant to these Bylaws, the Medical Staff Rules & Regulations, or any Medical Staff or Hospital policy for good cause shown, if the Board of Trustees determines that such waiver is reasonable and necessary to meet the needs of the patients and the Hospital. There is no obligation to grant any such waiver and Practitioners have no right to have such waivers considered or granted. The refusal of the Board of Trustees to waive any Qualification shall not entitle any practitioner to a Hearing or any other rights of review.

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### **Article 16 Initial Appointment Procedure**

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#### **16.1 Completion of Application for Initial Appointment**

- 16.1.1 All requests for release of an Application for initial Appointment to the Medical or Advanced Practice Provider Staff and/or initial Clinical Privileges must be approved by the relevant Department Chair(s) and forwarded to the Department of Medical Staff Services. Upon receipt of the approved request, the Department of Medical Staff Services will provide the Applicant with an Application package, which will include access to the Medical Staff Bylaws and Rules & Regulations. This package will enumerate the Basic Eligibility Requirements and Qualifications for Medical and Advanced Practice Provider Staff Membership and/or Clinical Privileges.
- 16.1.2 An Application shall be deemed complete (“Complete Application”) when it includes, at a minimum:
- a. A fully completed, signed, and dated Application form;
  - b. If seeking Clinical Privileges, a detailed, properly executed, delineation of privilege form(s) and required supporting documentation;
  - c. Suitable copies of all requested documents and information necessary to confirm that the Applicant meets criteria for Membership and/or Privileges and to establish current competency;
  - d. All applicable fees;
  - e. Verification of identity by real-time check of an original, current picture identification card issued by a state or federal agency (e.g. driver’s license or passport);
  - f. When available, relevant recent Applicant-specific performance data, including, but not limited to, morbidity and mortality data, with comparisons to aggregate cohort data;
  - g. Any additional information that the Department Chair, Joint Credentials Committee, Medical Board and Board of Trustees may require from the Applicant to conduct a thorough evaluation;
  - h. A completed Intended Practice Plan, as described in Subsection 15.2.11; and
  - i. Verification of all credentialing and competency criteria set forth in these Bylaws and associated Medical Staff Policies and Procedures.
- 16.1.3 An Application shall be deemed incomplete (“Incomplete Application”) if any of the items listed in Subsection 16.1.2 are missing or if the need arises for new, additional, or clarifying information that has yet to be provided. An Incomplete Application will be deemed to have been abandoned and will not be processed if it remains incomplete for greater than thirty (30) days, in which case the Applicant will not be entitled to the Hearing procedures set forth in Article 13 of these Bylaws.
- 16.1.4 If at any time during the credentialing process it becomes apparent that an Applicant does not meet all Basic Eligibility Criteria for Membership and/or Privileges, as defined in Section 15.11 of these Bylaws, the credentialing process will be terminated and no further action taken on the Application, in which case the Applicant will not be entitled to the Hearing procedures set forth in Article 13 of these Bylaws.

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- 16.1.5 The burden is on the Applicant to provide all required information.
- a. Individuals seeking Membership and/or Clinical Privileges shall have the burden of producing information deemed necessary and adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
  - b. It is the Applicant's responsibility to ensure that the Department of Medical Staff Services receives all required supporting documents timely, verifying the information on the Application, and to provide sufficient evidence, as required in the sole discretion of the Hospital, that the Applicant meets the requirements for Medical or Advanced Practice Provider Staff Membership and/or the Clinical Privileges requested.

### **16.2 Applicant's Attestation, Authorization, and Acknowledgement**

The Applicant must sign the Application form. By signing the Application, the Applicant:

- 16.2.1 Attests to the accuracy and completeness of all information on the Application and all accompanying documents provided by the Applicant, and agrees that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the Application process, and disqualification from Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges, and/or employment;
- 16.2.2 Consents to appear timely for any requested interviews in regard to their Application;
- 16.2.3 Authorizes Hospital representatives to consult with prior and current associates of the Applicant and others who may have information bearing on the Applicant's professional competence, ability to perform the Clinical Privileges requested, character, integrity, collegiality, ethical behavior, ability to work cooperatively with others, and other qualifications for Membership and/or the Clinical Privileges requested;
- 16.2.4 Consents to Hospital representatives' inspection of all records and documents that may be material to an evaluation of:
- a. Professional qualifications and competence to exercise the Clinical Privileges requested;
  - b. Professionalism, character, integrity, collegiality, and ethical behavior;
  - c. Professional liability actions, including past closed and currently pending claims, involving the Applicant; and
  - d. Any other issue relevant to establishing the Applicant's suitability for Medical or Advanced Practice Provider Staff Membership and/or Privileges;
- 16.2.5 Authorizes the Hospital to release any and all credentialing and peer review information to other hospitals and healthcare entities, licensing boards, and appropriate government bodies, or to engage in any valid discussion relating to the past and present evaluation of the Applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the Applicant's overall qualifications;
- 16.2.6 Agrees to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against the Hospital and any Medical or Advanced Practice Provider Staff Member, or Hospital representative, regarding any action described in this Article 16, and agrees further, that all such representatives shall have

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the full benefit of this release and absolute waiver, as well as any legal protections afforded under the law, provided they have acted in good faith;

- 16.2.7 Releases from liability and promises not to sue all individuals and entities that provide information to the Hospital or the Medical Staff, including otherwise legally privileged, protected or confidential information, concerning the Applicant's experience, competence, professional ethics, character, utilization practice patterns, and other qualifications for Medical or Advanced Practice Provider Staff Membership and Clinical Privileges;
- 16.2.8 Acknowledges that the Applicant has had access to the Medical Staff Bylaws and Rules & Regulations of the Medical Staff, and agrees to abide by their provisions; and
- 16.2.9 Agrees to provide accurate and complete answers to the questions on the Application Attestation Form and any further inquiries related to the Application, and agrees to immediately notify the Hospital in writing, as defined in Section 3.6.10 of these Bylaws, should any of the information regarding these items change during processing of this Application or while the Practitioner has been granted Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges, and agrees that failure to do so is grounds for disciplinary action, up to and including termination of Membership and/or Clinical Privileges.

### **16.3 Credentialing Process**

All Applications for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges will be designated "Category 1" or "Category 2," as follows:

- 16.3.1 Category 1 Application: Refers to a Complete Application that does not raise concerns, as characterized by the criteria for Category 2 Applications defined in the Medical Staff Policies and Procedures and Section 16.3.2 of these Bylaws.
- 16.3.2 Category 2 Application: Refers to a Complete Application that raises a concern by meeting one or more of the criteria set forth in the Medical Staff Policies and Procedures related to credentialing red flags.
- 16.3.3 The Department of Medical Staff Services shall complete all credentialing procedures set forth in the Medical Staff Policies and Procedures prior to deeming an Application complete and ready for review by the Department Chair, as set forth in Section 16.5 of these Bylaws, and make the initial categorization.

### **16.4 Applicant Interview**

- 16.4.1 All Applicants for initial Appointment to the Medical or Advanced Practice Provider Staff and/or for the initial granting of Clinical Privileges may be required to participate in an interview, at the discretion of the Chief Medical Officer, the applicable Department Chair or designee, Joint Credentials Committee, Medical Board, or Board of Trustees. The interview may take place in person or by remote communication, at the discretion of the interviewing party. The interview may be used to solicit information required to complete the Credentials File or clarify information previously provided. The interview may also be used to communicate performance expectations related to Medical or Advanced Practice Provider Staff Membership and/or the exercise of Clinical Privileges.
- 16.4.2 The Applicant will be notified if an interview is required and must cooperate with scheduling a timely appointment.

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- 16.4.3 Failure of the Applicant to appear for a scheduled interview without good cause shown may be deemed a withdrawal of the Application, in which case the Applicant will be informed of such determination and shall not be eligible for the Hearing procedures set forth in Article 13 of these Bylaws.

### **16.5 Department Chair Action**

- 16.5.1 The Complete Application will be presented to the relevant Department Chair or designee for review and recommendation. The Department Chair or designee will review the Application to ensure that the Applicant fulfills the requirements for Membership, as set forth in Article 15 of these Bylaws, the Medical Staff Policies and Procedures, and any established Hospital and Department standards for Clinical Privileges.
- 16.5.2 The Department Chair or designee in consultation with the Chair of the Joint Credentials Committee, if requested, will confirm the initial categorization and then determine whether the Application will be forwarded to the Joint Credentials Committee as Category 1 or a Category 2, as defined in Section 16.3 of these Bylaws.
- 16.5.3 The Department Chair or designee will forward to the Department of Medical Staff Services and the Joint Credentials Committee recommendations on each of the following:
- a. Whether the Joint Credentials Committee should act on the Application as Category 1 or Category 2;
  - b. Whether to approve or deny the Applicant's request for Membership, and/or to approve, deny or modify the request for Clinical Privileges;
  - c. Whether there are any issues which require enhanced focused professional practice evaluation (FPPE), in accordance with Section 19.1 of these Bylaws, upon initial grant of Clinical Privileges and the details of such enhanced FPPE, and
  - d. Explanations of these recommendations, as needed.
- 16.5.4 Additionally, if the Application is deemed Category 2, the Department Chair or designee will:
- a. Provide a detailed description of the concern(s) that caused such categorization;
  - b. Provide a detailed description of the investigation or evaluation that was conducted to vet the concern(s); and
  - c. Provide the rationale for the Chair's recommendation(s) for or against the granting of Membership and/or Privileges in sufficient detail so as to enable the Joint Credentials Committee to make its own determination.
- 16.5.5 Evaluating Applications of Department Chairs
- a. For System Chairs: The System Chief Medical Officer, with the assistance of a senior member of the relevant Department, shall evaluate the Application of a System Chair, and recommend appropriate action to the Joint Credentials Committee.
  - b. For Site Chairs (excluding individuals serving as System Chairs): The System Chair, in collaboration with the Hospital Chief Medical Officer, shall evaluate the Application of a Site Chair, and recommend appropriate action to the Joint Credentials Committee.

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### **16.6 Joint Credentials Committee Action**

- 16.6.1 The Joint Credentials Committee will review each Application to ensure that it fulfills the Membership criteria set forth in Article 15 of these Bylaws, as well as the established standards for Clinical Privileges for the Hospital, and it will review the recommendations of the Department Chair or designee, including any explanations. The Joint Credentials Committee then will forward the Application to the Board of Trustees, along with:
- a. A recommendation as to whether the Application should be acted on as Category 1 or Category 2;
  - b. A recommendation of whether to approve or deny the Applicant's request for Membership, and/or to approve, deny or modify the request for Privileges; and
  - c. A recommendation as to whether there are any issues which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges, and
  - d. Explanations of these recommendations, as needed.
- 16.6.2 The Joint Credentials Committee may request that the relevant Department Chair(s) or designee(s) directly address the Committee regarding their recommendation and/or that relevant subject matter experts evaluate selected Applications.

### **16.7 Medical Board Action**

- 16.7.1 The Medical Board will review each Application to ensure that it fulfills the Membership criteria set forth in Article 15 of these Bylaws, as well as the established standards for Clinical Privileges for the Hospital, and the recommendations of the Department Chair or designee and the Joint Credentials Committee.
- 16.7.2 If the Application had been designated Category 1, the President of the Medical Board may elect to send the it to the voting members of the Medical Board electronically for approval, which would require 50% of the members to participate. Category 2 Applications may only be considered at a regular meeting of the Medical Board.
- 16.7.3 The Medical Board will forward the Application to the Board of Trustees, along with:
- a. A recommendation of whether to approve or deny the Applicant's request for Membership, and/or to approve, deny or modify the request for Privileges;
  - b. A recommendation as to whether there are any issues which require monitoring and evaluation of clinical performance after the initial grant of Clinical Privileges; and
  - c. Explanations of these recommendations, as needed.
- 16.7.4 Whenever the Medical Board makes an adverse recommendation to the Board of Trustees, a special notice explaining the reason(s) for the adverse recommendation shall be sent to the Applicant by the President of the Medical Board by certified mail, return-receipt requested, or hand-delivered with signature-receipt; along with a notice to the Practitioner of their rights under Article 13 of these Bylaws, including that the Practitioner has the right to request a Hearing concerning the adverse recommendation in the manner provided by Section 13.2 of these Bylaws by making a written request to the President of the Medical Board within thirty (30) days of the Practitioner's receipt of the notice. The notice shall also provide the online address at which these Bylaws can be located.

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### **16.8 Board of Trustees Action**

The Board of Trustees will review the Application and adopt or reject in whole or in part the recommendation of the Medical Board, or send the Application back to the Medical Board for further consideration, stating the reasons for such action, and setting a time limit within which a subsequent recommendation must be made. If the Board of Trustees concurs with the Applicant's request for Membership and/or Clinical Privileges, it will grant the appropriate Membership and/or Clinical Privileges for a period not to exceed three (3) years.

### **16.9 Notice of Final Decision**

Notice of the Board of Trustees' final decision will be given by the Chair of the Board of Trustees to the President of the Medical Board, the Chair of each Department concerned, and the Department of Medical Staff Services. In addition,

- a. If the Board of Trustees has granted the Applicant Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges, a notice shall be sent to the Practitioner that includes, as applicable, the Medical Staff category or other designation to which the Practitioner has been appointed, the Department(s) to which the Practitioner is assigned, the Clinical Privileges that the Practitioner may exercise, the timeframe of the Appointment, and any special conditions attached to the Appointment.
- b. If the Board of Trustees has not granted the Applicant Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges, as had been requested, the Chair of the Board of Trustees shall provide a notice to the President of the Medical Board providing the rationale for the adverse recommendation. A notice explaining the reason(s) for the adverse recommendation shall be sent to the Applicant by the President of the Medical Board by certified mail, return-receipt requested, or hand-delivered with signature-receipt; along with a notice to the Practitioner of their rights under Article 13 of these Bylaws, including that the Practitioner has the right to request a Hearing concerning the adverse recommendation in the manner provided by Section 13.2 of these Bylaws.

### **16.10 Time Period for Processing an Initial Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges**

All those involved in the credentialing and privileging process shall act on an Application for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges in a timely and good faith manner, and, except for good cause, Applications will be processed within 180 (one-hundred-and-eighty) calendar days. This timeframe is a guideline only, and failure to meet it does not give an Applicant a right to a Hearing and Appeal.

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## **Article 17 Reappointment**

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### **17.1 Criteria for Reappointment**

The Hospital only reappoints and/or renews Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges for those Practitioners who have continuously met the qualifications and criteria for initial and ongoing Membership, and/or Clinical Privileges, as relevant, that were in effect during the period of Membership and the holding of Clinical Privileges; as well as all current qualifications and criteria described in Article 15 of these Bylaws; and who have provided care that is consistent with the Hospital's quality and performance standards.

### **17.2 Information Collection and Verification**

17.2.1 On or before five (5) months prior to the date of expiration of a Medical or Advanced Practice Provider Staff Membership or grant of Clinical Privileges, the Department of Medical Staff Services will notify the Practitioner of the date of expiration and provide a Reapplication for Membership on the Medical or Advanced Practice Provider Staff and/or renewal of Clinical Privileges.

17.2.2 The Practitioner must timely return the following to the Department of Medical Staff Services:

- a. A fully completed Reapplication form, which includes all information required to update the Practitioner's existing file for items contained in the original Application, subsequent Reapplications, and any required new, additional, or clarifying information;
- b. If seeking Clinical Privileges, a detailed, properly executed, delineation of the Clinical Privileges being requested, taking into consideration the range of Clinical Privileges exercised by the Reapplicant during the current Appointment/Privileging period, in a format provided by the Department of Medical Staff Services;
- c. Documentation of having satisfied the required hours of continuing professional education activity, which can be demonstrated by verification of participation in a professional board Maintenance of Certification (MOC) program as applicable to the relevant specialty or subspecialty board or by attesting to having met the continuing medical education criteria mandated by the State of New York for renewal of licensure;
- d. Information regarding all new, and updates regarding all previous pending, professional liability activity since providing such information on the prior Application or Reapplication;
- e. Any required fees or dues; and
- f. A dated signature on the Reapplication form by which the Practitioner agrees to the same terms as identified in Section 16.2 of these Bylaws.

Failure, without good cause, to provide all subsequently requested information at least three (3) months prior to the expiration of their current Membership and/or Clinical Privileges, may result in cessation of processing of the Reapplication and automatic expiration of their Membership and/or Clinical Privileges when the current Appointment/Privileging period concludes.

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17.2.3 The Department of Medical Staff Services will collect and verify information regarding the Practitioner’s activities to include those items listed on the attestation form of the Reapplication. The Credentialing Process as set forth in Section 16.3 of these Bylaws shall also apply to Reappointments.

17.2.4 In the event there is undue delay in obtaining all required information from third parties, the Department of Medical Staff Services may request assistance from the Reapplicant. Failure of a Reapplicant to adequately respond to a request for assistance within thirty (30) calendar days may be deemed a withdrawal of the Reapplication.

### **17.3 Evaluation of Application for Reappointment of Membership and/or Renewal of Privileges**

17.3.1 Reapplications for Membership and/or renewal of Clinical Privileges will be categorized as described in Subsections 16.3.1 and 16.3.2 of these Bylaws.

17.3.2 The Reapplication will be reviewed and acted upon as described in Sections 16.5 through 16.9 of these Bylaws.

17.3.3 In evaluating the Reapplication, the Department Chair or designee shall consider the Reapplicant’s range and volume of clinical activity during the current Appointment/Privileging period and, if the volume or range is limited, may advise the Reapplicant to curtail their list of requested Clinical Privileges to correlate with their actual activity. Relinquishing Clinical Privileges under this circumstance is not considered a result of corrective or disciplinary action and does not require reporting to licensing and regulatory agencies.

17.3.4 Evaluating Reapplications of Department Chairs:

- a. For System Chairs: The System Chief Medical Officer, or designee, with the assistance of a senior member of the relevant Department, shall evaluate the Reapplication of a System Chair, and recommend appropriate action to the Joint Credentials Committee.
- b. For Site Chairs (excluding individuals serving as System Chairs): The System Chair, in collaboration with the Hospital Chief Medical Officer, shall evaluate the Reapplication of a Site Chair, and recommend appropriate action to the Joint Credentials Committee.

17.3.5 For the purpose of renewal of a Practitioner’s Membership and/or Clinical Privileges, an “adverse recommendation” by the Board of Trustees, as that term is used in Section 16.9b of these Bylaws, means a recommendation or action to deny Reappointment, or to deny or restrict requested Clinical Privileges, or any other action which would entitle the Reapplicant to a Hearing under these Bylaws.

17.3.6 All Reappointments and renewals of Clinical Privileges will be for a period not to exceed three (3) years.

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### **Article 18 Clinical Privileges**

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#### **18.1 Exercise of Clinical Privileges**

18.1.1 A Practitioner providing clinical services at the Hospital may exercise only those Clinical Privileges granted to them by the Board of Trustees; or Temporary, Emergency or Disaster Privileges as described herein.

#### 18.1.2 Clinical Privileges for Non-Members of the Medical Staff

Clinical Privileges may be granted by the Board of Trustees, upon recommendation of the Medical Board, to Practitioners who are not Members of the Medical Staff. In addition to Advanced Practice Providers, such individuals include Practitioners serving only in a locum tenens role; certain Practitioners providing telemedicine services; House Physicians; Fellows (i.e., current trainees who have previously completed a primary residency) who are serving as part-time, Hospital-based, Attending Physicians in their primary specialty; and others deemed appropriate by the Medical Board and Board of Trustees. Prerogatives are described in Section 4.5

#### **18.2 Requests for Clinical Privileges**

When seeking Clinical Privileges, Applicants and Reapplicants must submit a request for the specific Clinical Privileges desired. Requests for Temporary Privileges, as well as for additional Clinical Privileges or modifications to existing Clinical Privileges during the period between reappointments, must also indicate the specific Clinical Privileges being sought and/or modified.

#### **18.3 Basis for Clinical Privileges Determination**

18.3.1 Requests for Clinical Privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Hospital in its Board-approved criteria for Clinical Privileges. The volume based criteria set forth on the delineation of privilege form is meant to establish the expected recent experience applicants should demonstrate for initial grant or renewal of Clinical Privileges. If the volume criteria has not been met, the Department Chair or designee shall review the totality of information when making their recommendation for a focused professional practice evaluation, conditional privileges, or renewal of privileges to confirm competency.

18.3.2 Requests for Clinical Privileges will be consistently evaluated on the basis of prior and continuing education, training, and experience; utilization practice patterns; current ability to perform the Clinical Privileges requested; demonstrated current competence, ability, and judgment; documented clinical performance of the Practitioner; patient care needs and the Hospital's need and capability to support the type of Clinical Privileges being requested; the continuous availability of qualified coverage in the Practitioner's absence; and, as applicable, results of the Practitioner's ongoing professional practice evaluations and performance improvement program activities. As needed, information relevant to Clinical Privileges will be obtained from peers and/or staff from other institutions and healthcare settings where the Practitioner exercises Clinical Privileges.

18.3.3 Clinical Privileges that are new to the Hospital and/or for which no credentialing and/or privileging criteria have been established will be addressed by the Novel Procedures Oversight Committee established in accordance with the Medical Staff Rules & Regulations, Section 9.10.

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18.3.4 The procedures by which requests for Clinical Privileges are processed are as outlined in Article 16 and Article 17 of these Bylaws.

### **18.4 Special Conditions for Dental Privileges**

All patients being admitted to or undergoing an ambulatory procedure by a Dentist will receive a medical evaluation (i.e., history and physical examination) performed by a Physician privileged by the Hospital to perform such an evaluation, which will be recorded in the medical record in compliance with Subsection 3.6.6 of these Bylaws.

### **18.5 Special Conditions for Oral and Maxillofacial Surgical Privileges**

To qualify for the Privilege to perform a history and physical examination, Oral and Maxillofacial Surgeons must provide documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence to perform such an evaluation. In the absence of such documentation and evidence of current competence, all patients being admitted to or undergoing an ambulatory procedure by an Oral and Maxillofacial Surgeon will receive a medical evaluation (i.e., history and physical examination) by a Physician privileged by the Hospital to perform such an evaluation, which will be recorded in the medical record in compliance with Subsection 3.6.6 of these Bylaws.

### **18.6 Special Conditions for Podiatric Privileges**

To qualify for the Privilege to perform a history and physical examination, podiatrists must provide documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence to perform such an evaluation. In the absence of such documentation and evidence of current competence, all patients being admitted to or undergoing ambulatory surgery by a Podiatrist will receive a medical evaluation (i.e., history and physical examination) by a Physician privileged by the Hospital to perform such an evaluation, which will be recorded in the medical record in compliance with Subsection 3.6.6 of these Bylaws.

### **18.7 Special Conditions for Advanced Practice Providers**

Advanced Practice Providers may practice independently within the scope of their granted Clinical Privileges, if authorized to do so by their state licensing board and the Board of Trustees.

### **18.8 Special Conditions for Residents- or Fellows-in-Training**

18.8.1 Residents- or Fellows-in-Training in the Hospital are not Members of the Medical Staff and are not granted specific independent Clinical Privileges. Rather, they function in accordance with the documented training protocols developed by the Graduate Medical Education Committee in conjunction with the applicable residency/fellowship training program.

18.8.2 The Graduate Medical Education Committee will communicate periodically with the Medical Board and the Board of Trustees about the performance of its residents and fellows, patient safety issues, and quality of patient care, and must work with the Medical Board to ensure that all supervising Practitioners possess Clinical Privileges commensurate with their supervisory activities.

18.8.3 Outside of their training activities at the Hospital, Fellows may apply for Clinical Privileges, which are commensurate with their competency gained from having previously completed a qualifying primary residency (and other fellowships, when so completed). In such circumstances, they could be granted Clinical Privileges, but would not qualify for Medical Staff Membership, as stated in Subsection 18.1.2 of these Bylaws.

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### **18.9 Telemedicine Privileges**

18.9.1 Requests for Telemedicine Privileges at the Hospital will be processed through one of the following mechanisms:

- a. The Hospital fully initially credentials and privileges, and subsequently reappoints, the Practitioner in accordance with Article 16 and Article 17 of these Bylaws; **OR**
- b. The Hospital initially privileges and re-privileges the Practitioner, following the process described in Sections 16.5 through 16.9 of these Bylaws, using credentialing information provided by a “distant site” facility (i.e., the site where the Practitioner generally practices and is fully credentialed and privileged), provided that the distant site facility is a Joint Commission-accredited hospital or ambulatory care organization and the Practitioner has a current unrestricted license and registration that is recognized by the state in which the patient is located; **OR**
- c. The Hospital initially privileges and re-privileges the Practitioner, following the process described in Sections 16.8 and 16.9, using the credentialing and privileging decision from the “distant site” facility (i.e., the site where the Practitioner generally practices and is fully credentialed and privileged), provided that all of the following requirements are met:
  - i. The “distant site” facility is a Joint Commission-accredited hospital or ambulatory care organization;
  - ii. The Practitioner is privileged at the “distant site” for those services to be provided at the Hospital; and
  - iii. The Hospital has evidence of an internal review of the Practitioner’s performance of these Clinical Privileges and sends to the “distant site” facility information that is useful to assess the Practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided, and complaints about the Practitioner from patients, Medical Staff Members, or staff at the Hospital.

### **18.10 Temporary Privileges**

18.10.1 Circumstances

The Hospital President or designee based on the recommendation of the President of the Medical Staff or designee may grant Temporary Privileges for up to one-hundred-and-twenty (120) days. Temporary Privileges may only be granted in the following circumstances, as further outlined in the Medical Staff Policies and Procedures:

- a. To fulfill an important patient care, treatment, or service need; or
- b. When an Application for Clinical Privileges that raises no concerns is awaiting Medical Board and Board of Trustees approval and has received a positive recommendation from the Department Chair.

18.10.2 Special Requirements

Special requirements of consultation and/or reporting may be imposed as part of the granting of Temporary Privileges. Except in unusual circumstances, Temporary Privileges will not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, Rules & Regulations, and policies and procedures of the Medical Staff,

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Hospital and Health System in all matters relating to the Practitioner’s Temporary Privileges. Whether or not such written agreement is obtained, these Bylaws, the Rules & Regulations, and policies and procedures control all matters relating to the exercise of Clinical Privileges.

### **18.10.3 Termination of Temporary Privileges**

The Hospital President or designee may terminate any or all of a Practitioner’s Temporary Privileges based upon the discovery of any information, or the occurrence of any event, that is of a nature that raises questions about continuing the Temporary Privileges.

### **18.10.4 Rights of a Practitioner with Temporary Privileges**

A Practitioner who has only been granted Temporary Privileges is not considered a Member of the Medical or Advanced Practice Provider Staff. A Practitioner with only Temporary Privileges is not entitled to the procedural rights afforded in Part B of these Bylaws (Investigation, Corrective/Disciplinary Action, Hearing and Appeal) in the event that the Practitioner’s request for Temporary Privileges is refused or because all or any part of the Practitioner’s Temporary Privileges are restricted, terminated or suspended.

## **18.11 Emergency Privileges**

In the case of a perceived medical emergency, any Practitioner is authorized to do everything possible to save a patient’s life or to save a patient from serious harm, to the degree permitted by the Practitioner’s license, regardless of Departmental affiliation, Medical Staff category, or Clinical Privileges. A Practitioner exercising Emergency Privileges must summon all consultative assistance and arrange for appropriate hand-off and follow-up, as soon as possible.

## **18.12 Disaster Privileges**

18.12.1 If the Hospital’s Disaster Plan has been activated and the Hospital is unable to meet immediate patient care needs, or if other area facilities are unable to meet patient care needs, the President (and other individuals, as identified in the Hospital’s Disaster Plan, with similar authority) may, on a case-by-case basis, consistent with professional licensing and other relevant state statutes, grant Disaster Privileges to selected Volunteer Practitioners and assign them to Medical Staff Departments consistent with their clinical expertise. Volunteer Practitioners from outside of the Hospital granted Disaster Privileges are not considered Members of the Medical or Advanced Practice Provider Staff.

18.12.2 The credentialing process for Volunteer Practitioners granted Disaster Privileges is set forth in the Medical Staff Policies and Procedures.

18.12.3 The oversight of all Volunteer Practitioners granted Disaster Privileges is defined by the relevant Department Chair or designee as appropriate to the type of disaster and clinical needs of the Department. Monitoring may include, but not be limited to, escorted rounds, direct observation or concurrent review, and/or retrospective medical record review.

18.12.4 Once the situation that prompted activation of the Hospital’s Disaster Plan has passed and such determination has been formally made, consistent with the Disaster Plan, the Practitioner’s Disaster Privileges will terminate as soon as a smooth transition of responsibility for ongoing care can be effected.

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- 18.12.5 Any individual identified in the Hospital's Disaster Plan with the authority to grant Disaster Privileges shall also have the authority to terminate Disaster Privileges.
- 18.12.6 Authority to grant or rescind Disaster Privileges may be exercised in the sole discretion of the Hospital and will not give rise to Hearing or Appeal rights.

### **18.13 Privileges for Organ Procurement**

Practitioners from an Organ Procurement Organization, as designated by the Secretary, U.S. Department of Health and Human Services, who are engaged at the Hospital solely in the harvesting of tissues and/or other body parts for transplantation, therapy, research, or educational purposes, pursuant to the Federal Anatomical Gift Act, are exempt from the requirement to obtain Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges.

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## **Article 19 Clinical Competency Evaluation**

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### **19.1 Focused Professional Practice Evaluation (FPPE)**

All Practitioners initially granted Clinical Privileges and subsequently granted additional Clinical Privileges will undergo an FPPE to assess their performance. The Department Chair, with the approval of the Joint Credentials Committee, defines the circumstances and duration of monitoring and evaluation of each Practitioner’s performance following their initial grant of Clinical Privileges at the Hospital. Such monitoring and evaluation may utilize prospective, concurrent, or retrospective evaluation, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, direct observation, morbidity and mortality reviews, and discussion with other healthcare professionals involved in the care of the Practitioner’s patients, as well as Hospital support staff. FPPEs may be standardized or tailored to meet specific concerns at the discretion of the Department Chair.

The Department Chair, with Joint Credentials Committee approval, will also establish triggers that indicate the need for ad hoc performance evaluation, monitoring, and/or remediation, as described in Section 19.3 of these Bylaws.

### **19.2 Ongoing Professional Practice Evaluation (OPPE)**

All Practitioners granted Clinical Privileges will undergo serial OPPEs to identify professional practice trends that may affect quality of care and patient safety. Information from these evaluations will be factored into the decision to maintain existing Clinical Privileges, to revise existing Clinical Privileges, or to revoke or restrict one or more existing Clinical Privileges prior to or at the time of Reappointment. OPPEs shall be undertaken at the frequency set forth in the OPPE Policy and Procedure as part of the Medical Staff’s responsibility to continually evaluate, measure, and improve each Practitioner’s current clinical competency in terms of patient care and technical skill; medical knowledge; professionalism; interpersonal communication; practice-based learning and improvement; and systems-based practice.

### **19.3 Triggered Focused Professional Practice Evaluation**

Each Practitioner with Clinical Privileges may at any time be subject to a triggered FPPE when issues affecting the provision of safe, high quality patient care are identified through the routine OPPE process or from other sources, including, but not limited to, patient or staff complaints, and acute concerns regarding patient care and technical skill; medical knowledge; professionalism; interpersonal communication; practice-based learning and improvement; and systems-based practice. Decisions to assign a period of performance monitoring or evaluation to further assess current competence will be determined through the process set forth in the Professional Enhancement Policy and will be based on the evaluation of an individual’s current clinical competence, practice behavior, and ability to perform specific Clinical Privileges.

### **19.4 Practitioner Re-Entry**

19.4.1 Since Practitioners requesting Clinical Privileges at the Hospital must have current clinical competence, they must be recently engaged in clinical practice. If a Practitioner requesting Clinical Privileges at the Hospital has not provided clinical care related to the Clinical Privileges requested within the past twenty-four (24) months, or as set forth on the delineation of privilege form for their specialty area, the Clinical Privileges may be granted on a conditional basis as set forth in the Conditional Privileging Policy which may include a clinical refresher or additional training with a qualified preceptor or proctor.

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- 19.4.2 If a Practitioner requesting Clinical Privileges at the Hospital has not provided any clinical care within the past five (5) years, the Practitioner may be required to complete a formal re-entry process through an ACGME- or AOA-accredited residency program or other formal process to assess and confirm clinical competence.
- 19.4.3 The Practitioner assumes full responsibility for any financial costs required to fulfill these requirements.
- 19.4.4 A description of the preceptorship or training program, including details of monitoring and consultation, must be submitted in writing for approval by the Department Chair, Joint Credentials Committee, Medical Board, and Board of Trustees before commencing. At a minimum, the preceptorship or training program description must include the following:
- a. A detailed description of the scope and intensity of the preceptorship’s or training program’s required activities; and
  - b. The requirement for submission of a written report from the preceptor or training program director, prior to its termination, assessing, at a minimum, the Practitioner’s demonstrated clinical competence in regard to patient care and technical skill; medical knowledge; professionalism; interpersonal communication; practice-based learning and improvement; and systems-based practice; as well as the Practitioner’s ability to get along with others; the quality and timeliness of medical records documentation; ability to perform the Clinical Privileges requested; and professional ethics and conduct.
- 19.4.5 Upon satisfactory completion of the preceptorship or training program, as determined by the preceptor or training program director, the report referenced above will be incorporated into the Practitioner’s Application and used to evaluate the Practitioner’s request for Clinical Privileges, in accordance with Article 16 of these Bylaws.
- 19.4.6 Any such preceptorship and monitoring for re-entry are separate and apart from that which may be required by other agencies that are involved with the Practitioner, e.g., the Office of Professional Medical Conduct (OPMC) of the New York State Department of Health, the Office of Professional Discipline (OPD) of the New York State Department of Education, or the Committee for Physician Health (CPH) of the Medical Society of the State of New York.

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### **Article 20      Reconsideration After Adverse Action; Modification of Staff Relationship and Clinical Privileges; Leave of Absence**

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#### **20.1      Reconsideration for Membership and/or Privileges After Adverse Action**

Except as otherwise determined by the Medical Board and Board of Trustees, a Practitioner who has received a final adverse decision resulting in termination of Membership and/or Clinical Privileges, or who has resigned in lieu of or to avoid such an adverse action, or who has withdrawn a Reapplication for Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges while under investigation or to avoid an investigation, is not eligible to be reconsidered for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges.

#### **20.2      Request for Modification of Staff Category or Department Assignment**

A Practitioner, either in connection with Reappointment or at any other time, may request modification of Medical Staff category or Department assignment by submitting a written request, through the Department of Medical Staff Services, to the relevant Department Chair. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request.

#### **20.3      Request for Additional Privileges**

All requests for additional Clinical Privileges must be accompanied by a revised delineation of privileges request form and information demonstrating education, training, and current clinical competence for the specific Clinical Privilege(s) being requested. A request for additional Clinical Privileges is granted in the same manner as a Reapplication, as outlined in Article 17 of these Bylaws.

#### **20.4      Request for Voluntary Relinquishment of Specific Clinical Privileges**

A Practitioner who wishes to relinquish or limit the exercise of particular Clinical Privileges shall send a written request to the relevant Department Chair, which will be included in their Credentials File. The Department Chair will determine if such Privilege reduction is acceptable and, if so, recommend its consideration by the Joint Credentials Committee, Medical Board, and Board of Trustees. If the Chair's determination is that the request is unacceptable, the Practitioner may escalate the request to the Site Chief Medical Officer, and ultimately to the Joint Credentials Committee.

#### **20.5      Resignation of Staff Appointment and/or Clinical Privileges**

A Practitioner who wishes to resign their Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges shall send a written request to the relevant Department Chair/Clinical Department at least thirty (30) calendar days prior to the anticipated effective date, except when circumstances prohibit such advance notice as affirmed by the Medical Board. The notice shall specify the anticipated effective date. A Practitioner who resigns their Medical or Advanced Practice Provider Staff Appointment and/or Clinical Privileges must fully, accurately, and promptly satisfy all professional obligations to the Medical Staff and Hospital, including completion of all portions of all medical records for which the Practitioner is responsible, prior to the effective date of resignation. Additionally, the Practitioner must ensure smooth transition of care for all of their Hospital patients to another appropriately privileged Practitioner. Failure to comply with these requirements shall result in an entry in the Practitioner's Peer Review File acknowledging the resignation and indicating that it became effective under unfavorable circumstances and that the

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Practitioner was not in Good Standing at the time of separation. Depending on the circumstances, reporting to regulatory agencies may also be required.

### **20.6 Leave of Absence**

#### **20.6.1 Leave Request**

- a. A Practitioner who wishes to take a leave of absence from the Medical or Advanced Practice Provider Staff (i.e., Membership) and/or patient care responsibilities (i.e., Clinical Privileges) shall send a written request to the relevant Department Chair stating the reason for the leave, including whether the request is related to the Practitioner's physical or mental health, or ability to care for patients safely and competently. The Department Chair has discretion in granting the leave. The Department shall immediately notify Medical Staff Services when a leave is granted.
- b. A planned leave of absence of longer than ninety (90) days must be requested at least thirty (30) days in advance, unless circumstances prohibit such notice.
- c. The Hospital Chief Medical Officer, in consultation with the relevant Department Chair and President of the Medical Board, may trigger an automatic Medical Leave of Absence in cases of urgent need.

#### **20.6.2 Leave Duration**

The request must provide the approximate anticipated duration of the leave, which may not exceed one (1) year, except for military service or with express permission from the Medical Board. If the leave of absence will extend beyond the duration originally requested, the Practitioner shall send a written request for an extension to the relevant Department Chair. Such request will be handled following the same process as for the initial request.

#### **20.6.3 Activities During a Leave**

While on a leave of absence, a Practitioner may not exercise Clinical Privileges or Prerogatives at any Hospital location and has no obligation to fulfill Medical or Advanced Practice Provider Staff responsibilities, aside from completion of medical records. While on a leave of absence, a Practitioner must continue to comply with all ongoing requirements for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges, including the maintenance of professional liability insurance for Practitioner's who have a claims-made policy, (occurrence-based policy holders are not required to maintain their coverage while on a leave of absence). For those with Clinical Privileges that require a life support certification, the certification must be up to date prior to reinstatement.

#### **20.6.4 Lapse of Appointment During a Leave of Absence**

If a Practitioner's Membership on the Medical or Advanced Practice Provider Staff and/or Clinical Privileges are anticipated to expire while on a leave of absence, the Practitioner must timely submit a Reapplication and actively engage, as needed, in the Reapplication process so as not to have the Appointment lapse. Lapse of an Appointment is considered a voluntary resignation and reinstatement of Medical or Advanced Practice Provider Staff Membership and/or Privileges shall require a wholly new Application.

#### **20.6.5 Leave of Absence Is a Courtesy**

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Leaves of absence are matters of courtesy, not of right. In the event that a Practitioner has not demonstrated good cause for a leave, or where a request for leave or extension of leave is not granted, if the Practitioner is perceived to take a leave, the Practitioner will be deemed to have resigned and such determination shall be final, with no recourse to a Hearing and Appeal.

### **20.6.6 Termination of Leave and Reinstatement**

- a. No less than thirty (30) calendar days prior to the anticipated or early termination of a leave of absence, the Practitioner shall request reinstatement by written request to the relevant Department Chair. The request shall include a summary of all activities in which the Practitioner engaged during the leave of absence that could have a material impact on the decision to reinstate the Practitioner.
- b. A Practitioner returning from a leave that was taken for health reasons must undergo an evaluation by Employee Health Services and provide a written report from the Practitioner's physician that answers any questions that the Department Chair or Medical Board may have in considering the request for reinstatement.
- c. A request for reinstatement must be approved by the Department Chair before the Practitioner can resume clinical activities. The Department shall submit the appropriate reinstatement paperwork to Medical Staff Services in order for the Practitioner to be reinstated.

### **20.6.7 Failure to Request Reinstatement After a Leave of Absence**

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation and shall result in automatic termination of Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges. A Practitioner whose Membership and/or Clinical Privileges is automatically terminated shall not be entitled to the procedural rights provided in Part B of these Bylaws. A request for Medical or Advanced Practice Provider Staff Membership and/or Clinical Privileges subsequently received from a Practitioner so terminated shall be submitted and processed in the manner specified for Applications for initial Appointments as described in Article 16 of these Bylaws.

## **20.7 Reporting Requirements**

The Hospital President or designee shall be responsible for ensuring that the Hospital satisfies its obligations under New York State and federal law. Whenever a Practitioner's Privileges are limited, revoked, or in any way constrained, the Hospital shall, in accordance with state and federal laws and/or regulations, report those constraints to the appropriate state and federal authorities, registries, and/or databases, such as the National Practitioner Data Bank.

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### **Article 21 Contracted Services**

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#### **21.1 Telemedicine Privileges**

When the Hospital contracts for care services with Practitioners who provide interpretations of images, tracings, or specimens through a telemedicine mechanism, all such Practitioners who will be providing those services under contract will be permitted to do so only after being granted Clinical Privileges at the Hospital through the mechanisms established in these Bylaws.

#### **21.2 Exclusivity Policy**

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

#### **21.3 Qualifications**

A Practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of the Practitioner's appointment category as any other Applicant or Appointee.

The terms of the Medical Staff Bylaws will govern disciplinary actions, and Practitioners who are removed from providing services at the Hospital by a third-party employer, for cause, will still be subject to reporting as if they had voluntarily resigned or withdrawn.

#### **21.4 Effect of Contract or Employment Expiration or Termination**

The effect of expiration or other termination of a contract upon a Practitioner's Medical Staff Membership and/or Clinical Privileges will be coterminous.