Erie County Medical Center Corporation

Medical Dental Staff Bylaws

- Collegial Intervention, Peer Review, Fair Hearing and Appellate Review
- Rules and Regulations Part I and II
- Credentials Procedure Manual

January 2023

Medical Dental Staff Bylaws

Part I

BYLAWS OF THE MEDICAL/DENTAL STAFF
ERIE COUNTY MEDICAL CENTER CORPORATION

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ERIE COUNTY MEDICAL CENTER CORPORATION
BUFFALO, NEW YORK

MEDICAL/DENTAL STAFF BYLAWS

PART I

DEFINITIONS

1. **ALLIED HEALTH PROFESSIONALS (AHP)** means an individual, other than a duly licensed physician, dentist, oral surgeon or podiatrist, who as a result of providing evidence of academic and clinical training, current licensure/certification, professional competence, satisfactory physical and mental health status, is qualified and who is authorized to render specified patient care services within his area of professional competence. AHPs shall include, but are not limited to: clinical psychologists, certified nurse midwives, chiropractors, nurse practitioners, physician assistants, certified registered nurse anesthetists, and surgical first assists.
NOTE: Some organizations, accrediting and regulatory bodies use the nomenclature of *"Advanced Practice Providers (APPs)"* for this practitioner group.

2. **BOARD CERTIFIED** or **BOARD CERTIFICATION** means having been certified by the appropriate specialty board as recognized by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada, the American Osteopathic Association, or the American Dental Association, American Board of Podiatric Surgery, American Board of Podiatric Orthopedic and Primary Podiatric Medicine in an individual's stated area of specialized medical, dental, podiatric or surgical training or any other nationally or internationally recognized board certification entity approved by the Medical Executive Committee.

3. **BOARD OF DIRECTORS or BOARD** means the governing body of the Erie County Medical Center Corporation.

4. **CHIEF EXECUTIVE OFFICER, (CEO)** shall mean the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.

5. **CHIEF MEDICAL OFFICER (CMO)** shall mean the licensed physician designated by the Medical Center to exercise general supervision over the provision of health care services to patients at the Medical Center's facilities and to assist the Medical/Dental Staff President and other Medical/Dental Staff Officers in overseeing the care provided to patients, the Medical/Dental Staff's credentialing and privileging process and performance improvement activities.

6. **CHIEF OF SERVICE (COS)** means the licensed physician appointed by the Board of Directors and accountable to the Medical Executive Committee for all professional, administrative, clinically related and quality review functions within his clinical department. For the purposes of job descriptions and titles, this position was previously known as "Clinical Director".

7. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted by the Board of Directors to render specified diagnostic, therapeutic, clinical or surgical services.

8. **DENTIST** means an individual who has been awarded the degree of Doctor of Dentistry (DDS) or Doctor of Dental Medicine (DMD) by an accredited institution recognized by the Medical Center.

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

10. **GOOD STANDING** refers to a Staff member or practitioner with clinical privileges who is not in arrears in fees payment and is not under suspension or other restriction applicable to his appointment or admitting and/or clinical privileges. Members in good standing shall have the prerogatives and rights provided by these Bylaws. Active Staff members in good standing shall have the right to vote, be nominated for and hold Staff office or to serve as a member of the Medical Executive Committee or as a department officer or committee chair or member.

11. **INITIAL APPLICANT** means an individual who meets the minimum eligibility criteria as defined in these Medical/Dental Staff Bylaws or related policies and procedures.

12. **MEDICAL CENTER** means the Erie County Medical Center Corporation.

13. **MEDICAL/DENTAL STAFF or STAFF MEMBER** means all medical and osteopathic physicians and all dentists, oral surgeons, podiatrists and allied health professionals licensed to practice in the State of New York who are privileged to attend to patients at the Medical Center.

14. **MEDICAL/DENTAL STAFF BYLAWS** means the Bylaws of the Medical/Dental Staff.

15. **MEDICAL/DENTAL STAFF YEAR** means the period from January 1 through December 31.

16. **MEDICAL EXECUTIVE COMMITTEE or MEC** means the Executive Committee of the Medical/Dental Staff.

17. **ORGANIZED MEDICAL STAFF** refers to the self-governing entity accountable to the governing body that operates under a set of bylaws, rules and regulations and policies developed and adopted by the voting members of the Medical/Dental Staff and approved by the governing body.

18. **PERFORMANCE IMPROVEMENT** is an approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and others; ongoing activities designed to objectively and systematically evaluate the quality of patient care and services, pursue opportunities to improve patient care and services and resolve identified problems. Standards are applied to evaluate the quality of a Medical Center's performance in conducting performance improvement activities. Includes, but is not limited to, peer review and/or Practice Improvement activities of the Medical/Dental Staff.

19. **PHYSICIAN** means an individual who has been awarded the degree of Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) by an accredited institution recognized by the Medical Center.

20. **PODIATRIST shall mean doctor of podiatric medicine who is a licensed healthcare professional who diagnoses, treats, operates and prescribes for any disease, injury, deformity, or other condition of the foot.**

21. **PRACTITIONER** means any duly licensed physician, dentist, oral surgeon, podiatrist, or licensed independent or dependent practitioner exercising, or applying for clinical privileges at the Medical Center.

22. **PRESIDENT** means President of the Medical/Dental Staff.

23. **QUALITY OF CARE** means the degree to which patient care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge.

24. **SPECIAL NOTICE** means written notification sent certified or registered mail, return receipt requested.

25. **UNIVERSITY** shall mean the State University of New York at Buffalo

ARTICLE I
PURPOSES AND RESPONSIBILITIES

1.1 PURPOSE

The purpose of the Medical/Dental Staff is:

(a) To ensure that all patients admitted to or treated in the Medical Center receive optimal, achievable quality patient care and treatment;

(b) To serve as a primary means of accountability to the Board;

(c) To ensure an optimal level of professional performance of all members of the Medical/Dental Staff and practitioners authorized to practice in the Medical Center and its facilities and through on-going monitoring and evaluation of clinical skills and technical performance of each Staff member;

(d) To provide accountability through the reporting of outcomes to the Board on patient care evaluations, continuous monitoring and other quality improvement activities in accordance with the Performance Improvement Plan;

(e) To provide an appropriate educational setting that will assist in maintaining patient care standards and that will lead to continuous advancement in professional knowledge and skill;

(f) To initiate and maintain Bylaws, Rules and Regulations, Policies and Procedures for the proper functioning of the Medical/Dental Staff organization; and

(g) To provide a means whereby issues concerning the Medical/Dental Staff and Medical Center may be discussed by the Medical/Dental Staff with the Board and the CEO, and thereby provide a means through which the Staff may participate in the Medical Center's policy-making and planning process.

1.2 RESPONSIBILITIES

The responsibilities of the Medical/Dental Staff are to account for the safety, quality and appropriateness of patient care rendered by all members of the Medical/Dental Staff and other practitioners authorized to practice in the Medical Center through the following measures:

(a) Evaluation of the quality of patient care and the reporting of results to the Board no less than on a quarterly basis;

(b) A continuing medical education program based on the needs demonstrated through the Performance Improvement Program;

(c) A utilization review program based on the requirements of the Medical Center's utilization review plan;

(d) An organizational structure that allows continuous monitoring of patient care practices and outcomes;

(e) A credentials procedure, including mechanisms for appointment, proctoring, reappointment and the delineation of clinical privileges;

(f) Corrective action with respect to Medical/Dental Staff members and individuals granted clinical privileges or authority to practice, when warranted;

(g) Enforcement of compliance with these Bylaws, Rules and Regulations of the Staff and other related current Medical/Dental Staff or Medical Center Policies;

(h) Planning to satisfy community health needs and in setting appropriate institutional goals and implementing programs to meet those needs; and

(i) Exercising the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities; and

(j) Medical history and physical examinations are completed and documented by a physician, oral maxillofacial surgeon or other qualified licensed individual in accordance with state and federal law and as outlined in the Medical Staff Rules and Regulations, Part I, Section IV C (1). Minimum content for the Hx and Px is defined in HIM -030, "Hybrid Medical Record Requirements".

ARTICLE II
MEMBERSHIP

2.1 NATURE OF MEDICAL/DENTAL STAFF MEMBERSHIP

Membership on the Medical/Dental Staff of Erie County Medical Center Corporation is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws, associated rules and other related current policies and procedures of the Medical/Dental Staff and the Medical Center.

2.2 QUALIFICATIONS FOR MEMBERSHIP WITH PRIVILEGES

2.2.1 MEDICAL AND OSTEOPATHIC PHYSICIANS, ORAL SURGEONS, DENTISTS AND PODIATRISTS

It is Erie County Medical Center Corporation's policy to provide applications for appointment to the Medical/Dental Staff and requests for privileges only for individuals who meet the following criteria by providing evidence of:

(a) Current licensure in the state of New York OR Limited Permit necessary to achieve or pending full licensure;

(b) A current certificate of insurance, documenting appropriate professional liability insurance coverage of a type and with such limits as recommended by state law or regulations and/or the MEC and approved by the Board of Directors or documented proof of medical liability protection or coverage for activity at the Medical Center by an appropriate administrative official;

(c) For medical and osteopathic physicians, oral surgeons, dentists and podiatrists: successful completion of a residency/training program accredited by the ACGME, AOA, ADA or Council on Podiatric Medical Education; or an acceptable equivalent accrediting body as determined by the MEC;

(d) Except with respect to those applying for privileges in general dentistry or Allied Health Professionals, current specialty board certification by boards approved by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada, the Osteopathic Boards of the American Osteopathic Association and/or the American Dental Association, American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedic and Primary Podiatric Medicine (ABPOPPM) or any other nationally or internationally recognized board certification entity approved by the Medical Executive Committee ** **OR**

(e) Is in process of achieving board certification as documented by the specialty board **AND**

(f) Achievement of specialty board certification within four (4) years of date of appointment to the Medical/Dental Staff**;

**Medical/Dental Staff members who were appointed and/or privileged prior to December 2006 and Podiatrist members appointed and/or privileged prior to June 2010 are exempt from the requirement outlined in paragraphs (d), (e) and (f) above. In addition, upon request, limited exceptions to paragraphs (c) through (g) of this requirement may be made on a case-by-case basis by the MEC provided each such exception is in the best interests of the Medical/Dental Staff and patient care at ECMCC, as determined by the MEC and as approved by the Board.

In the event that the appointee has failed to achieve board certification as outlined in Section 2.2.1. (f) of these medical-dental staff bylaws or has failed to maintain such board certification, the appointee will be granted a onetime 4 year grace period to remediate. The appointee will be notified of such in writing by the Chair of the Credentials Committee and the President of the Medical-Dental Staff. If the appointee fails to achieve board (re)certification during this time frame, he/she may apply to the Medical Executive Committee for an exception as described in Section 2.2.1 (f) of these medical-dental staff bylaws.

(g) Recent active practice of medicine, dentistry or podiatry (at least twelve (12) months of the last twenty four (24) months) [residency or fellowship training is applicable] unless there are mitigating, extenuating circumstances as determined by the Credentials Committee;

(h) Requesting to provide only services capable of being supported by available Medical Center facilities and resources;

(i) The ability and willingness to work harmoniously with colleagues, hospital staff and management in the delivery of services including using due care and diligence regarding the economic utilization of Medical Center facilities and supplies;

(j) The ability to perform safely and competently, the duties of Medical/Dental Staff membership (In accordance with applicable Medical Center and Medical/Dental Staff policies); and

(k) Intentions regarding inpatient and Emergency Department coverage in compliance with Medical/Dental Staff requirements as outlined in the Rules and Regulations; scope of privileges desired including trauma privileges, if applicable, and general plans for practicing at the Medical Center and its licensed facilities.

2.2.2 ALLIED HEALTH PROFESSIONALS

It is Erie County Medical Center Corporation's policy to provide applications for appointment to the Medical/Dental Staff and requests for privileges only for individuals who meet the following criteria by providing evidence of:

(a) Professional licensure in the state of New York

(b) A professional role which includes patient care and contact

(c) Provision of services as defined by New York State for their respective scopes of practice

(d) Except with respect to those exempted by Federal or State law, current specialty board certification by the nationally recognized certifying agency (obtained within six months of appointment), such as The American Nurses Credentialing Center (ANCC), The American Association of Nurse Practitioners (AANP), The National Commission on Certification of Physician Assistants (NCCPA), National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA), American midwifery Certification Board (AMCB), American Board of Professional Psychology (ABCP) or any other nationally recognized board certification entity approved by the Medical Executive Committee.

Level of supervision for AHPs is divided into three categories:

1) Independent
   - Doctor of Chiropractic
   - Clinical Ph.D.
   - Research PhD

2) Independent/Collaboration
   - Nurse Practitioner
   - Nurse Midwife

3) Dependent/Supervision
   - Physician Assistant
   - Certified Registered Nurse Anesthetist
   - RN First Assist (RNFA)

2.3 NONDISCRIMINATION

No aspect of Medical/Dental Staff membership or particular clinical privileges shall be denied on the basis of race, color, creed, sex, sexual orientation, age, religion, national origin, membership in a protected class, gender, gender orientation or expression, marital status or the presence of a medical condition, or on the basis of any other criteria, all of which are unrelated to the delivery of quality care in the Medical Center setting or to professional qualifications for the Medical Center's purposes, needs and capabilities.

2.4 MEDICAL/DENTAL STAFF MEMBER RIGHTS

(a) Each member of the Medical/Dental Staff has the right to an audience with the Medical Executive Committee. In the event such practitioner is unable to resolve a difficulty working with his respective Chief of Service, that practitioner may, upon presentation of a written notice to the President, meet with the Medical Executive Committee to discuss the issue.

(b) Any active Staff member may call a general Staff meeting upon presentation of a petition signed by 5% of the members of the Active Staff, the Medical Executive Committee shall schedule a general Staff meeting for the specific purpose addressed by the petitioners. No business other than that detailed in the petition may be transacted.

(c) Any Active Staff member may raise a challenge to any rule or policy established by the Medical Executive Committee by submitting a petition signed by 10% of the Active Staff members. When such petition has been received by the Medical Executive Committee, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

(d) Any group may request a department meeting when a majority of the members of that department believe that the department has not acted in an appropriate manner.

(e) The above sections (a-d) do not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging sections. Procedures for Collegial Intervention, Peer Review, (Practice Improvement), Fair Hearing and Appellate Review provide recourse in these matters.

(f) Any Medical/Dental Staff member has a right to a hearing/appeal pursuant to the actions listed in the Procedures for Collegial Intervention, Peer Review (Practice Improvement), Fair Hearing and Appellate Review Manual.

2.5 NO ENTITLEMENT TO APPOINTMENT

No individual shall be entitled to appointment to the Medical/Dental Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that such individual:

(a) is licensed to practice a profession in this or any other state;
(b) is a member of any particular professional organization;
(c) is certified by a specialty certification board;
(d) has had in the past, or currently has, medical staff appointment or privileges at any medical center or health care facility;
(e) resides in the geographic service area of the Medical Center, or
(f) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

ARTICLE III
CATEGORIES OF THE MEDICAL/DENTAL STAFF

3.1 CATEGORIES

Categories of the Medical/Dental Staff shall include Active, Associate, Courtesy Refer and Follow, Emeritus, and Allied Health Professional.

3.2 ACTIVE STAFF

3.2.1 QUALIFICATIONS

(a) Meets the qualifications stated in these Bylaws

(b) Demonstrates an interest in and commitment to the Medical Center through patient care activities, providing his primary practice at the Medical Center and/or

provision of services to the Medical Center and Medical/Dental Staff activities and functions and performs such other obligations and duties as are assigned to him by the President of the Medical/Dental Staff, the MEC or his Chief of Service

(c) Actively participates in Performance Improvement/Risk Management activities at the Medical Center

(d) Contributes to the organizational and administrative activities of the Medical/Dental Staff, including Department or Committee duties as elected or appointed.

(e) Fulfills obligation of monitoring, proctoring, on-call Emergency care and back-up coverage

3.2.2. PREROGATIVES OF ACTIVE STAFF

(a) Admits patients to the Medical Center if the practitioner's delineation of privileges includes admitting privileges.

(b) Exercises such clinical privileges as are granted pursuant to the Bylaws

(c) Votes on all matters presented at general and special meetings of the Staff and the Clinical Services and committees to which they are appointed; and

(d) Except as otherwise provided in the Bylaws, holds Staff office

3.2.3. RESPONSIBILITIES AND OBLIGATIONS

(a) Assume and carry out responsibility within his area of professional competence for the daily care and supervision of each patient in the Medical Center for whom he/she is providing services. Each active Staff member is responsible for completion of all necessary medical records in a timely fashion, and arrangement for a suitable alternative appointee (on the Medical/Dental Staff) to provide such care and supervision during any absence or unavailability.

(b) Assume reasonable service for: emergency care (in accordance with applicable laws and regulations, including federal Emergency Medical Treatment and Active Labor Act), Medical/Dental Staff committees and departmental responsibilities at the discretion of the Chief of Service. Not withstanding contractual limitations, each member of the Active Staff may periodically be required to be "on-call" as evidenced by an on-call list maintained electronically and posted in the emergency department of the Medical Center. Members who are on-call must respond to the emergency department within a reasonable period of time after being notified to examine and treat patients with emergency medical conditions.

(c) Actively participate in recognized functions of the Staff appointment including quality/performance improvement, risk management and monitoring activities including monitoring of new appointees during Focused Professional Performance Evaluation (FPPE) in accordance with the Professional Practice Evaluation Policy and in discharging other Staff functions as may be required from time to time.

(d) Pay fees and/or dues in an amount established by the Medical Executive Committee.

3.3 ASSOCIATE STAFF

3.3.1 QUALIFICATIONS

(a) Meets the qualifications stated in these Bylaws

(b) Has his primary professional activity at another facility or office, who occasionally admits or consults to the Medical Center (not more than 20 patient interactions per year), attends or contributes to the care of patients in the Medical Center, outpatient departments or emergency department. Patient interactions include admissions, consults, inpatient procedures, outpatient procedures and same day procedures. It is expected that an Associate Staff member will, over the course of an appointment period, provide some direct and/or indirect patient care services at the Medical Center. The provider's volume and practice patterns will be reviewed during the Professional Practice Evaluation Process. At the time of reappointment, the staff member may be re-assigned to the appropriate staff category.

3.3.2 PREROGATIVES

(a) Admits and/or contributes to the care of patients within the limitations stated in these Bylaws

(b) Exercises such clinical privileges as are granted to him pursuant to the Bylaws

(c) Attends meetings of the Medical/Dental Staff, but is not eligible to vote on matters presented at general or special meetings of the Staff or hold office

(d) Attends meetings of the department of which he/she is a member, any Staff or Medical Center education programs and any committees to which he/she is assigned. He/She may serve as a voting member on designated departmental, Medical/Dental Staff or Medical Center committees on which he/she participates.

3.3.3 RESPONSIBILITIES AND OBLIGATIONS

(a) Assume and carry out responsibility within his area of professional competence for the daily care and supervision of each patient in the Medical Center for whom he/she is providing services including completion of all necessary medical records in a timely fashion, and arrange for a suitable alternative appointee (on the Medical/Dental Staff) to provide such care and supervision during any absence or unavailability

(b) Assume reasonable service for: emergency care, as requested, (in accordance with applicable laws and regulations, including federal Emergency Medical Treatment and Active Labor Act), Medical/Dental Staff committees and departmental responsibilities at the discretion of the Chief of Service

(c) Actively participate in recognized functions of the Staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during Focused Professional Practice Evaluation (FPPE) in accordance with the Professional Practice Evaluation Policy and in discharging other Staff functions as may be required from time to time

(d) Pay fees and/or dues in an amount established by the Medical Executive Committee

3.4 COURTESY, REFER AND FOLLOW STAFF

3.4.1 QUALIFICATIONS

Practitioners who are qualified for membership on the Staff pursuant to the Bylaws, and who wish to maintain a relationship with the Medical Center and Medical/Dental Staff. No clinical privileges may be granted to these individuals. Courtesy Refer and Follow practitioners may not document in the medical record.

3.4.2 PREROGATIVES

(a) Refers patients to the Medical Center for care and treatment

(b) Follows their referred patients

(c) Attends meetings of the Medical/Dental Staff, but is not eligible to vote on matters presented at general or special meetings of the Staff or hold office

(d) Attends meetings of the department of which he/she is a member, any Staff or Medical Center education programs and any committees to which he/she is assigned

(e) Access to medical records of referred patients, having completed appropriate patient confidentiality statements and medical records orientations

(f) Where appropriate, confers with attending/admitting physician, patient's family

3.4.3. RESPONSIBILITIES AND OBLIGATIONS

Pays fees and/or dues in the amount established by the Medical Executive Committee.

3.5 EMERITUS STAFF

3.5.1 QUALIFICATIONS

Membership status conferred by the Board to Members of the Medical/Dental Staff recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences or their previous long-standing service to the Staff. No clinical privileges may be granted to these individuals.

3.5.2 PREROGATIVES

(a) Not eligible to admit to or attend to patients in the Medical Center.

(b) Attends meetings of the Medical/Dental Staff, but is not eligible to vote on matters presented at general or special meetings of the Staff or hold office

(c) Attends meetings of the department of which he/she is a member, any Staff or Medical Center education programs and any committees to which he/she is assigned. He/She may serve as a voting member on designated departmental, Medical/Dental Staff or Medical Center committees on which he/she participates

(d) Does not pay dues

(e) Not required to apply for re-appointment. Emeritus Staff status shall continue until the resignation or death of the individual

3.6 ALLIED HEALTH PROFESSIONALS

3.6.1 QUALIFICATIONS

(a) Meets the qualifications stated in these Bylaws

(b) Demonstrates an interest in and commitment to the Medical Center through patient care activities

3.6.2 PREROGATIVES

(a) Contributes to the care of patients within the limitations stated in these Bylaws

(b) Exercises such clinical privileges as are granted to him/her pursuant to the Bylaws

(c) Attends meetings of the Medical/Dental Staff, votes on all matters presented at general and/or special meetings or the Staff, but may not hold office

(d) Attends meetings of the department of which he/she is a member, any Staff or Medical Center education programs and any committees to which he/she is assigned. He/She may serve as a voting member on designated departmental, Medical/Dental Staff or Medical Center committees on which he/she participates

3.6.3 RESPONSIBILITIES AND OBLIGATIONS

(a) May not admit patients to the Medical Center

(b) Actively participates in recognized functions of the Staff appointment including quality/performance improvement, risk management and monitoring activities including monitoring of new appointees during Focused Professional Performance Evaluation (FPPE) in accordance with the Professional Practice Evaluation Policy and in discharging other Staff functions as may be required from time to time.

(c) Assumes and carries out responsibility within his area of professional competence for the daily care of each patient in the Medical Center for whom he/she is providing services including completion of all necessary medical records in a timely fashion

(d) Pays fees and/or dues in an amount established by the Medical Executive Committee

ARTICLE IV
APPOINTMENT AND REAPPOINTMENT PROCESS

4.1 PROCESS

This process shall apply to all: (a) applications for appointment and reappointment to the staff; (b) requests for reinstatement after a leave of absence from the staff; and (c) requests for privileges.

4.2 APPLICATION FOR INTIAL APPOINTMENT AND REAPPOINTMENT

Each application for appointment or reappointment to the Medical/Dental Staff shall be in writing and submitted on the prescribed form as established by the Medical Executive Committee and approved by the Board of Directors. Procedures associated with the appointment and re-appointment process are detailed in the Credentials Procedures Manual.

4.3 APPLICATION PROCESS

4.3.1 APPLICANT'S BURDEN

Each applicant will have the burden of producing adequate information for complete evaluation of his or her application and proving that the applicant meets the qualifications for membership under Section 2.2 of the Bylaws

4.3.2 VERIFICATION OF INFORMATION

The applicant will deliver a completed application to the Medical/Dental Staff Office. Medical/Dental Staff office will, in timely fashion, seek to verify information from the primary source(s), whenever feasible and required, and will conduct relevant database profile searches from the National Practitioner Data Bank and other professional sources. The Medical/Dental Staff Office will promptly notify an applicant of any problems in obtaining required information. When the collection and verification process is complete, the Medical/Dental Staff Office shall submit the application and supporting materials to the appropriate Chief of Service for review and recommendation.

4.3.3 CHIEF OF SERVICE ACTION

The appropriate Chief of Service shall submit his or her written recommendation and the reasons for that recommendation to the Credentials Committee.

4.3.4 CREDENTIALS COMMITTEE ACTION

The Credentials Committee will review the application, supporting documentation, Chief of Service recommendation, and any other relevant information. The Credentials Committee will then submit a written recommendation, assignment to an appropriate service, privileges and any special conditions to the Medical Executive Committee.

4.3.5 MEDICAL EXECUTIVE COMMITTEE ACTION

The MEC will consider the Credentials Committee's recommendation including any related information and forward its recommendation to the Board.

4.3.6 ACTION BY THE BOARD OF DIRECTORS

The Board of Directors shall consider the Medical Executive Committee's favorable recommendation and take such action as it deems appropriate. If the Board approves the MEC recommendation, the application is approved and requested membership and/or privileges are granted. Written notice of the final decision of the Board of Directors regarding assignment to an appropriate Clinical Service, delineation of privileges granted, and any special conditions attached to the appointment shall be forwarded to the applicant. If the Board action is unfavorable as defined in Part II, Section M of these Bylaws, a Notice of Reasonable Cause shall be sent to the applicant in accordance with the Fair Hearing Procedure.

4.4 TIME PERIODS FOR PROCESSING APPLICATION

Upon receipt of a completed application, the review and appointment process shall not exceed 180 days, except for good cause.

4.5 LENGTH OF APPOINTMENT/REAPPOINTMENT

Initial appointment will be for up to two years. Reappointment will be for no more than two years.

4.6 EMERGENCY PRIVILEGES

In the case of an emergency, any practitioner, to the degree permitted by his or her license and regardless of Clinical Service or staff status or privileges, will be permitted to do, and will be assisted by hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. For the purposes of this section, an emergency is defined as a condition in which serious or permanent harm could result to a patient, or in which the life of a

patient is in immediate danger and any delay in administering treatment could add harm or danger.

4.7 TEMPORARY PRIVILEGES

Temporary privileges may be granted upon receipt of a request by an appropriately licensed practitioner for privileges for the care of one or more specific patients to fulfill an important patient care, treatment and/or service need. Such privileges will be granted upon the written concurrence of the appropriate Chief of Service, the President of the Medical/Dental Staff and the Chief Medical Officer (as designee of the CEO), who shall review and consider the clinical competency of the applicant. The applicant shall also be required to submit satisfactory evidence of licensure and current registration and adequate professional liability insurance coverage.

Temporary privileges may also be granted when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the Medical Executive Committee and/or the Board of Directors.

The grant of temporary privileges does not confer any rights or privileges of Membership on the Medical/Dental Staff. A denial of a request for temporary clinical privileges or the revocation or termination of limited privileges shall not give the applicant any procedural or substantive rights to a hearing or review under the Fair Hearing Procedure. Temporary Privileges may not be granted for longer than 120 days in a 12-month period.

4.8 TELEMEDICINE

4.8.1 CREDENTIALING AND PRIVILEGING TELEMEDICINE PRACITIONERS

The originating site has the responsibility to credential and privilege telemedicine practitioners through one of the approved methods as governed by CMS regulation and delineated in the ECMCC Credentials Procedure Manual.

4.9 DISASTER PRIVILEGES

4.9.1 CONDITIONS

Disaster privileges may be granted to volunteers eligible to be licensed independent practitioners by the President of the Medical/Dental Staff, the Chief Medical Officer or their designee (s) when ECMCC Emergency Preparedness Management Plan has been activated and ECMCC is unable to handle the immediate patient care needs. The process for activation of Disaster Privileges can be found in Section L of the ECMCC Credentials Procedures Manual.

ARTICLE V
MEDICAL/DENTAL STAFF LEADERS AND DEPARTMENTS

5.1 OFFICERS OF THE STAFF

5.1.1 IDENTIFICATION

The officers of the Staff shall be:

(a) President
(b) President-Elect
(c) Treasurer
(d) Secretary
(e) Immediate Past President

5.1.2 QUALIFICATIONS OF OFFICERS, CHIEFS OF SERVICE, ASSOCIATE CHIEFS OF SERVICE, MEDICAL EXECUTIVE COMMITTEE AND COMMITTEE CHAIRPERSONS

Only those active Staff appointees who satisfy the following criteria shall be eligible to serve as Medical/Dental Staff officers, Chiefs of Service or associate chiefs of service, and Medical Executive Committee members:

(a) be appointed in good standing to the Medical/Dental Staff and continue so during their term of office;

(b) have no pending adverse recommendations concerning Staff appointment or clinical privileges; and
(c) not be presently serving as a Medical/Dental Staff or corporate officer at another healthcare system or be employed full-time by another healthcare system and shall not serve during the term of office.

All Medical/Dental Staff Officers, Chiefs of Service and associate chiefs of service, and Medical Executive Committee members must possess at least the above qualifications and maintain such qualifications during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

5.1.3 NOMINATIONS

(a) **By Nominating Committee**: The Nominating Committee shall convene at least ninety (90) days prior to the Annual Meeting of the Medical/Dental Staff and shall submit to the President of the Medical/Dental Staff a list of one or more qualified nominees for each office and at–large members to the Medical Executive Committee. The names of such nominees shall be made available to all voting Medical/Dental Staff members at least thirty (30) days prior to the Annual Meeting;

(b) **By Petition**: Nominations may also be made by petition signed by at least twenty (20) members of the Active Staff with voting rights, to which is attached a statement signed by the nominee attesting to his willingness to stand for election to the office, and filed with the President of the Staff at least seven (7) days prior to the Annual Meeting. As soon after filing of a petition as is reasonably possible, the name(s) of these additional nominee(s) shall be made available to all voting Medical/Dental Staff members;

5.1.4 ELECTION

Officers shall be elected at the annual meeting of the Medical/Dental Staff. Only Active Staff members shall be eligible to vote. Voting shall be by voice, show of hands, or if there are two or more nominees for any office, by secret written ballot. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes.

Absentee ballots may be requested if a member is unable to attend the meeting. The Secretary will determine sufficient reason. The Secretary will provide the member with such ballot via the Medical/Dental Staff Office and the member shall return the completed ballot in a sealed envelope to the Secretary prior to the annual meeting to be tabulated at the time of the vote.

Any Member with voting rights has the right to initiate a recall election of a Medical Staff Officer by submitting a petition to the Medical Executive Committee signed by at least twenty percent (20%) of the Members of the Active Staff. Upon presentation of such a petition, the Medical Executive Committee will schedule a Special Staff Meeting for purposes of discussing the issue and (if appropriate) entertain a motion to recall the officer, which shall be effective only upon the affirmative vote of two-thirds of the voting Members present at the Special Meeting called and held for that purpose in accordance with the procedures set forth in these Bylaws.

5.1.5 TERM OF ELECTED OFFICE

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff Year following his election.

Each officer shall serve until the end of his term and until a successor is elected. No member may serve more than two (2) consecutive terms in a particular office.

5.1.6 REMOVAL OF OFFICERS

Grounds for removal shall include, but not be limited to: mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; abuse of the office; conviction of a felony; an immediate termination or precautionary suspension or restriction of privileges; sanction by Medicaid, Medicare or any other federal or state healthcare program; or for conduct or statements damaging to the Medical Center, the Medical/Dental Staff or their goals or programs.

Action directed towards removing an officer from office may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer, signed by not less than twenty-five (25) members of the Active Staff with voting rights; or by action by the Medical Executive Committee with concurrence of the Board.

An Officer may then be removed by the following process: a two-thirds (2/3) majority vote of the Staff by secret ballot of those present or participating via teleconference at a meeting of the Staff called for that purpose.

5.1.7 VACANCIES IN STAFF OFFICES

Vacancies in offices, other than that of President, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of President, the President-Elect shall become President and serve out the remaining term. In such instance, the President-Elect shall be eligible to run for the office of President after serving out the vacated term.

5.1.8 DUTIES OF ELECTED OFFICERS

(a) **President:** The President of the Medical/Dental Staff shall serve as the Chief Administrative Officer and principal elected official of the Staff. As such, he/she shall:

1. Aid in coordinating the activities and concerns of the Medical Center administration and of the nursing and other patient care services and with those of the Staff;

2. Be accountable to the Board, in conjunction with the Medical Executive Committee and the Chief Medical Officer, for the quality and efficiency of clinical services and performance within the Medical Center and for the effectiveness of the Performance Improvement, Risk Management and Utilization Management Programs;

3. Be accountable for development and implementation, in cooperation with the Chiefs of Service, Committee Chairs and the Chief Medical Officer, of appropriate procedures for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice and performance improvement;

4. Appoint the Medical/Dental Staff representatives to Staff and Medical Center committees, unless otherwise expressly provided by these Bylaws, or Medical Center Bylaws, Policies or Procedures;

5. Communicate and represent the opinions, policies, concerns, needs and grievances of the Staff to the Board, Chief Medical Officer and the CEO;

6. Be responsible for the enforcement of these Bylaws, Staff Rules and Regulations, policies and procedures for implementation of sanctions where

these are indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective or adverse action has been requested against a Staff member;

7. Call, preside at, and be responsible for the agenda of all general meetings of the Staff;

8. Serve as Chair of the Medical Executive Committee with voting rights, and as ex-officio member of all other Staff committees;

9. Attend the meetings of the Board;

10. Serve as the spokesman of the Staff in its external professional and public relations;

11. Be responsible for overseeing the Medical/Dental Staff's compliance with relevant accreditation standards, for providing sufficient education to the Chiefs of Service, associate chiefs of service , and committee chairs concerning their role in the accreditation process and reporting the accreditation status to the Medical Executive Committee, the Medical/Dental Staff and the Board; and

12. Assist the Chief Medical Officer in ensuring that the Medical/Dental Staff Office provides sufficient support to the Medical/Dental Staff by providing appropriate notice to all Medical/Dental Staff of meetings, providing appropriately recorded minutes to each assigned Medical/Dental Staff group and assistance in follow-up to any outstanding issues.

13. Serve as the Chair of the Medical/Dental Staff Leadership Council

(b) **President-Elect:** The President-Elect shall be a voting member of the Medical Executive Committee. In the temporary absence of the President, he/she shall assume all the duties and have the authority of the President. He/she shall perform such additional duties as may be assigned to him by the President, the Medical Executive Committee or the Board.

(c) **Secretary:** The Secretary shall be a voting member of the Medical Executive Committee who shall call meetings on order of the President, shall keep minutes of the Staff meetings and act as parliamentarian and shall attend to necessary correspondence.

(d) **Treasurer:** The Treasurer shall be a voting member of the Medical Executive Committee who shall collect Medical/Dental Staff dues and assessments, keep financial transactions and make financial disbursements as designated by the MEC and perform such other duties as pertain to his/her office. He/She shall make a financial report of all Medical/Dental Staff funds collected and disbursed during the year at the annual Staff meeting.

(e) **Immediate Past President:** The Immediate Past President shall be a voting member of the Medical Executive Committee, a voting member of the Medical/Dental Staff Leadership Council and shall serve in a consultant fashion to the President.

5.2 DEPARTMENT OFFICERS

5.2.1 CHIEF OF SERVICE

(a) **Qualifications:** Each Chief of Service shall be and remain a member in good standing of the Active Staff, shall have demonstrated ability in at least one of the clinical areas covered by the department**,** and shall be willing and able to faithfully discharge the functions of his office. For any clinical department led by a non- physician, its Chief of Service shall possess all rights entitled to a member of the Active Staff, including voting privileges. Each Chief of Service shall be certified by an appropriate specialty board, or affirmatively establish comparable competence through the credentialing process. Any person serving as a Chief of Service prior to the November 2006 adoption of these Bylaws shall be exempt from the qualifications set forth herein through the end of his tenure as a Chief of Service.

(b) **Appointment:** Each Chief of Service shall be appointed by the Board on the recommendation of the CMO with advice from the MEC for a one to three (1-3) year term.

(c) **Term of Office:** The Chief of Service shall serve the appointment term defined by the Board. A Chief of Service shall be eligible to succeed himself.

(d) **Special Review**: The President of the Staff, the Chief Executive Officer, a majority of the Medical Executive Committee, or a majority of the Members of the Active Staff in the relevant Clinical Service may, for good cause, request that the Chief Medical Officer review a Chief of Service prior to the expiration of his or her term of appointment. Any such request must be in writing and supported by reference to the specific activities or conduct which constitutes the grounds for the request. A copy of the request shall be sent to the Chief of Service and to the President of the Staff and the Chief Medical Officer. The Chief Medical Officer shall conduct a special review. The Chief Medical Officer shall formulate a recommendation which will be reviewed with the Medical Executive Committee. The Medical Executive Committee will confirm its concurrence or, if it does not concur, shall state its reasons and recommendations concerning the Chief of Service under review. After consideration of the Medical Executive Committee's reasons and recommendations, the Chief Medical Officer shall make his final determination. In the event that the Chief Medical Officer and Medical Executive Committee recommendations differ, both recommendations and reasons therein shall be sent to the Chief Executive Officer and Board of Directors for final determination.

(e) **Removal:** Removal of a Chief of Service from office may be made by the Board acting upon its own recommendation or a petition signed by fifty percent (50%) of the Active department members with ratification by the Medical Executive Committee and the Board for the same reasons outlined in Section 5.1.6 for Removal of Medical Staff Officers.

(f) **Vacancy:** Upon a vacancy in the office of Chief of Service, the Associate or Assistant Director, of the department shall become Chief of Service or other such practitioner named by the Board until a successor is named by the Board.

(g) **Duties:** Each Chief of Service shall:

1. Appoint an Associate Chief of Service, as determined necessary by the Chief of Service in conjunction with the Chief Medical Officer;

2. Account to the Medical Executive Committee for all professional, administrative, clinically related activities and quality review functions within his department and report minimally, on a quarterly basis the Performance Improvement activities within his department, including written recommendations, actions and follow-up.

3. Works collaboratively within the Practice Improvement Process with the Medical/Dental Staff Leadership Council and the Quality Executive Committee to foster a culture of clinical excellence and collegiality among practitioners.

4. Provide continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. Ensure that FPPE is performed within the timeframe defined in policy on all newly appointed members of the Department or for any department member granted new privileges. Performs OPPE at intervals defined in policy; Lead the development of department specific metrics for OPPE assessment.

5. Recommend to the Medical/Dental Staff the criteria for clinical privileges that are relevant to the care provided in the department;

6. Recommend and approve clinical privileges for each member of the Department. Will review and complete initial/reappointment files to the Medical/Dental Staff Office prior to each Credentials Committee meeting;

6. Assess and recommend to the relevant Medical Center authority off-site sources for needed patient care services not provided by the department or the organization;

7. Be responsible for the integration of the department or service into the primary functions of the organization;

8. Be responsible for the coordination and integration of interdepartmental and intradepartmental services. Participates directly, or through a designee, as needed and at the request of the CMO in the design and functioning of hospital service lines and on hospital committees and task forces. Assists the CMO in ensuring compliance by practitioners within his department with hospital policies and guidelines especially those related to documentation, corporate compliance and utilization review;

9. Be responsible for the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

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

11. Provide the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

12. Provide for the continuous assessment and improvement of the quality of care, treatment and services provided;

13. Provide for the maintenance of quality control programs, as appropriate;

14. Provide for the orientation and continuing education of all persons in the department or service, including medical students and residents assigned by the University at Buffalo;

15. Provide for the recommendations for space and other resources needed by the department or service;

16. Enforce the Medical Center and Medical/Dental Staff Bylaws, Rules, Policies and Regulations and related manuals within his department, including initiating corrective action and investigation of clinical performance and ordering required consultations. The Chief of Service will be versed in the hospital occurrence reporting system and will address in a timely fashion any patient care or physician behavior issues referred to him by the CMO;

17. Implement within his department actions taken by the MEC:

18. Be responsible for the teaching, education and research programs in his department. Work collaboratively with hospital administration to ensure hospital compliance with any and all affiliation agreements which the hospital has in place with external educational institutions;

19. Develop and maintain departmental policies and procedures as needed, Emergency Department coverage, and provisions for consultations or other patient care, treatment or services; and

20. Develop and maintain a schedule that provides for admission and treatment of Service Patients as defined in the Medical/Dental Staff Rules and Regulations.

21. Develop and maintain schedules to ensure that emergency coverage is provided to ECMC patients by his department on a 24 hours/7 days per week schedule.

22. Perform such duties commensurate with his office as may from time to time be reasonably requested of him by the President of the Medical/Dental Staff, the Medical Executive Committee or the Chair of the Board;

5.2.2 ASSOCIATE CHIEF OF SERVICE

(a) Each Associate Chief of Service shall have the qualifications set forth in Section 5.2.1 (a) for Chiefs of Service and shall be appointed by the Board on the recommendation of the Chief of Service with endorsement of the CMO and the MEC. The Chief of Service in conjunction with the Chief Medical Officer shall decide the need for an associate chief of service. An Associate Chief of Service, as a general rule does not have voting privileges on the Medical Executive Committee, except by proxy in the absence of the Chief. However, the Medical Executive Committee, at it's discretion, may grant voting rights on the recommendation of the Chief of Service and subject to Board approval. Associate chiefs of service are also eligible to election to the Medical Executive Committee as members at large.

(b) **Term of Office:** An Associate Chief of Service shall serve a term of one to three (1-3) years, as determined by the Board, commencing on his appointment and continuing until his successor is appointed. Removal of an Associate Chief of Service from office may be made by the Chief of Service for reasons as noted in Section 5.1.6.

(c) **Vacancy:** Upon a vacancy in the office of Associate Chief of Service, the Chief of Service shall recommend to the CMO a member of the department to fill the vacancy, subject to endorsement of the CMO with advice from the MEC and appointment by the Board.

(d) **Duties:** The Associate Chief of Service shall:

1. In the absence of the Chief of Service, carry out the duties of the Chief of Service. This would include attendance of the Medical Executive Committee meeting with proxy vote, and

2. Perform such duties as may be assigned to him by the Chief of Service.

5.3 ADDITIONAL OFFICERS

The Board may, after considering the advice and recommendations of the Medical Executive Committee, appoint additional practitioners to medical administrative positions within the Medical Center to perform such duties as are prescribed by the Board, or as defined by amendments to these Bylaws. To the extent that any such officer performs any clinical function, he/she must become and remain a member of the Medical/Dental Staff. In all events, he/she must be subject to these Bylaws and to the other policies of the Medical Center, except to the extent so provided by the Board.

5.4 AUTHORITY AND DUTIES OF THE CHIEF MEDICAL OFFICER

The Board has vested in the Chief Medical Officer, pursuant to New York State Department of Health regulations, the authority and responsibility for the operation, evaluation, and enforcement of Medical Center policies, rules and regulations relating to medical matters in the hospital and accordingly the oversight of the Medical/Dental Staff. One or more Associate Medical Directors may serve to assist the Chief Medical Officer, and in the temporary absence of the Chief Medical Officer, shall assume the duties and have the authority of the Chief Medical Officer. They may also perform such additional duties as may be requested by the President, the Medical Executive Committee or the Board.

5.5 BOARD ACTION

All elected and appointed officials of the Medical/Dental Staff organization are subject to the approval of the Board as the governing body of the Medical Center. The Board shall either accept the appointee or notify the Staff, or the appropriate department, that it will not accept the appointee and request another nominee.

ARTICLE VI
MEDICAL/DENTAL STAFF STRUCTURE AND PERFORMANCE IMPROVEMENT FUNCTIONS

6.1 ORGANIZATION OF MEDICAL/DENTAL STAFF DEPARTMENTS

The Medical/Dental Staff shall be organized as a departmentalized staff. Each department shall have an appointed Chief of Service and an appointed Associate Chief of Service, who are entrusted with the overall responsibility of the supervision and satisfactory discharge of assigned functions.

6.2 DEPARTMENTS

(a) **CURRENT CLINICAL DEPARTMENTS** are listed in the Medical/Dental Staff Rules and Regulations, Part II.

(b) **FUTURE DEPARTMENTS**

When deemed appropriate the Medical Executive Committee may, with the Board's approval, create a new department or eliminate, consolidate or subdivide a department.

6.3 DIVISIONS/CLINICAL SERVICES

6.3.1 The Medical Executive Committee may recognize any group of practitioners who wish to organize themselves into a clinical service. Divisions/clinical services are not required to hold regularly scheduled meetings, nor will attendance be required. Divisions/clinical services are completely optional and may exist to perform any of the following activities:

(a) continuing medical education
(b) grand rounds
(c) discussion of policies
(d) discussion of equipment needs
(e) development of recommendations for Medical Executive Committee
(f) participation in the development of criteria for clinical privileges when requested by the Medical Executive Committee or Chief of Service
(g) discussion of a specific issue at the request of the Chief of Service or Medical Executive Committee

6.3.2 PHYSICIAN ADVISORS: Liaison or resource physicians for clinical specialties may be appointed by the Chief Medical Officer or the CEO to assist Medical Center or Medical/Dental Staff personnel in the development of policies and procedures, the resolution of problems and other matters involving the clinical specialty. Such physician advisors shall not have the title or responsibilities traditionally granted to Chiefs of Service.

6.4 ASSIGNMENT TO DEPARTMENTS

Each member of the Staff shall be assigned membership in one department, but may be granted clinical privileges in one or more of the other Departments. The exercise of privileges within each department shall be subject to the Rules and Regulations therein and to the authority of the Chief of Service. An Active Staff member with privileges in more than one department shall vote and attend meetings in the department in which he/she holds primary privileges.

6.5 FUNCTIONS OF DEPARTMENTS The clinical departments are responsible for performing the performance improvement functions as noted below under the Medical/Dental Staff performance improvement functions. The departments:

(a) May establish performance improvement subcommittees that have the responsibility and the authority to act on behalf of the department; i.e., complete departmental performance improvement activities, report to the full department, and perform any other function which the Chief of Service deems necessary.

(b) May establish action groups as an ad-hoc committee charged with a specific responsibility to address any specific issue assigned by the full department or the Medical/Dental Staff Performance Improvement Committee and implement a corrective action plan using the plan, do, study, act methodology.

6.6 MEDICAL/DENTAL STAFF PERFORMANCE IMPROVEMENT FUNCTIONS

Performance improvement functions are the way the Medical/Dental Staff works to improve clinical and non-clinical processes that require Medical/Dental Staff leadership or participation. These functions shall be accomplished as indicated in these Bylaws through assignment to the Staff as a whole, clinical departments or services, to Staff committees, to Staff leaders, or other individual Staff members or to interdisciplinary Medical Center committees with participation of Medical/Dental Staff members. Works collaboratively with the Medical Center Quality Plan.

6.7 GOVERNANCE, DIRECTION, COORDINATION AND ACTION Medical/Dental Staff Officers, Chiefs of Service and Medical Executive Committee members shall be responsible to:

(a) Receive, coordinate and act upon, as necessary, the reports and recommendations from committees, clinical units, other groups and leaders concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

(b) Coordinate the activities of and policies adopted by the Medical/Dental Staff, departments and/or divisions/clinical services and committees;

(c) Account to the Board and to the Medical/Dental Staff on the overall quality and efficiency of patient care in the Medical Center as documented in the findings and actions from the Medical/Dental Staff's quality assessment and performance improvement activities;

(d) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted;

(e) Make recommendations on medico-administrative and Medical Center management matters;

(f) Inform the Medical/Dental Staff of the accreditation program and the accreditation status of the Medical Center; and

(g) Act on all matters of Medical/Dental Staff business, subject to such limitations as may be imposed by the Staff.

6.8 CLINICAL PERFORMANCE IMPROVEMENT ACTIVITIES

a) The Medical/Dental Staff shall adopt and modify, subject to the approval of the MEC and the Board, the Medical/Dental Staff Performance Improvement Plan, in collaboration with the Medical Center Quality Plan and supervise the conduct of specific programs and procedures for assessing, maintaining and improving, as required, the quality and efficiency for medical care provided at the Medical Center.

b) The Medical/Dental Staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the Medical/Dental Staff process. These include, but are not limited to:

- Medical assessment and treatment of patients;
- Use of information about adverse privileging decisions for any practitioner privileged through the Medical/Dental Staff process;
- Use of medications;
- Use of blood and blood components;
- Operative and other procedure(s);
- Appropriateness of clinical practice patterns;
- Significant departures from established patterns of clinical practice;
- The use of developed criteria for autopsies;
- Sentinel event data
- Patient safety data; and
- Patient Satisfaction

6.9 PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS

The Medical/Dental Staff shall also participate in the measurement, assessment and improvement of other patient care processes. These include, but are not limited to:

- Education of patients and families;
- Coordination of care, treatment and services with other practitioners and Medical Center personnel, as relevant to the care, treatment and services of an individual patient; and
- Accurate, timely and legible completion of patients' medical records;

6.10 USE OF PERFORMANCE IMPROVEMENT FINDINGS

When the findings of any assessment process are relevant to an individual's performance, the organized Medical/Dental Staff is responsible for determining the use of this information in peer review or the ongoing evaluations of a practitioner's competence. Communication of findings, conclusions, recommendations and actions to improve organization performance shall be communicated to appropriate Medical/Dental Staff members and the Board.

6.11 DISCHARGE PLANNING FUNCTION

(a) The Medical/Dental Staff shall participate in discharge planning activities.

6.12 CREDENTIALLING FUNCTION

The Credentials Committee shall:

(a) Review, evaluate and transmit written reports as required by Credentials Procedures Manual on initial appointments, FPPE,(Focused Professional Practice Evaluation, reappointments, modifications of appointment and clinical privileges.

(b) Initiate, investigate, review and report on corrective action matters according to the procedures set forth in the hearing procedures outlined in the Collegial Intervention, Peer Review, Fair Hearing & Appellate Review Procedures and on any other matters involving the clinical, ethical or professional conduct of any practitioner.

(c) Submit written reports/minutes monthly to the MEC and the Board.

(d) Maintain a credentials file for each member of the Medical/Dental Staff, including records of participation in Staff activities and results of quality assessment and performance improvement activities.

6.13 EDUCATION FUNCTION

The Medical/Dental Staff shall:

(a) Participate in developing, planning, implementing, and evaluating programs of, and requirements for, continuing education that is relevant to the type and scope of patient care services delivered at the Medical Center, designed to keep the Medical/Dental Staff informed of significant new developments and new skills in medicine, and responsive to quality assessment and performance improvement activities.

(b) Coordinate, as necessary, the various educational activities of the Medical/Dental Staff.

(c) Review the research projects and clinical investigations and maintain liaison with the Infection Control and Medication Management functions.

(d) In conjunction with the Chief Medical Officer, participate in developing, planning, implementing and evaluating programs of, and requirements for the graduate medical education program provided.

6.14 INFORMATION MANAGEMENT FUNCTION

Medical/Dental Staff Officers and the Director of Health Information Management shall:

(a) Review and evaluate medical records to determine that they:

1. properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and

2. are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Medical Center.

(b) Develop, review, enforce and maintain surveillance over enforcement of Staff and Medical Center policies and rules relating to medical records, including medical records completion and preparation and recommend methods of enforcement thereof and changes therein.

(c) Provide liaison with Medical Center administration, nursing service and health information management professionals in the employ of the Medical Center on matters relating to medical records practices.

6.15 MEDICAL/DENTAL STAFF ORGANIZATIONAL FUNCTIONS

(a) The Medical/Dental Staff shall direct Staff organizational activities, including Staff Bylaws and related policy and procedure review and revision, identifying nominees for election to the Medical/Dental Staff officer positions and to other elected positions in the Medical/Dental Staff organizational structure, Staff committee appointments, liaison with the Board and Medical Center administration and review and assist in maintaining Medical Center accreditation.

6.16 EMERGENCY PREPAREDNESS

(a) The Medical/Dental Staff shall assist the Medical Center's administration in developing, periodically reviewing and implementing a crisis management manual that addresses disasters both external and internal to the Medical Center.

6.17 PLANNING

The Medical/Dental Staff shall:

(a) Participate in evaluating existing programs, services and facilities of the Medical Center and Medical/Dental Staff; and recommend continuation, expansion, abridgement or termination of each.

(b) Participate in evaluating the financial, personnel and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment and assess the relative priorities of services and needs and allocation of present and future resources.

(c) Communicate strategic, operations, capital, human resources, information management and corporate compliance plans to Medical/Dental Staff members.

6.18 MEDICAL CENTER-WIDE INFECTION CONTROL FUNCTION

The Medical/Dental Staff shall oversee the development, coordination and implementation of the Medical Center-wide program for surveillance, prevention and control of infection.

6.19 MEDICAL CENTER-WIDE MEDICATION MANAGEMENT FUNCTION

The Medical/Dental Staff shall oversee the development and surveillance of all medication utilization policies and practices within the Medical Center to assure optimum clinical results and a minimum for potential hazard. The Medical/Dental Staff shall assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to medication usage at the Medical Center.

ARTICLE VII
COMMITTEES OF THE MEDICAL/DENTAL STAFF

7.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the Staff as established by the MEC, as may from time to time be necessary and desirable to perform the functions of the Staff required by these Bylaws. All Medical/Dental Staff members serving on committees and committee chairs shall be appointed by the President of the Medical/Dental Staff except as otherwise provided in these Bylaws. All Medical Center personnel, other than Medical/Dental Staff members, to serve on committees shall be appointed by the CEO or his designee. The President of the Medical/Dental Staff shall appoint Medical/Dental Staff members to Medical Center-wide committees if requested by the CEO. All committee appointments are for a two-year (2) term, unless otherwise specified

Committee meetings may be conducted by any means of communication by which all members participating may simultaneously hear or read each others' comments during the meeting.

All committees shall:

(a) Maintain a record of attendance at their meetings;

(b) Maintain a record of discussions, recommendations and actions;

(c) Submit timely reports of their activities and/or copies of the minutes of their meetings to the Medical Executive Committee;

(d) Supply upon request, a report of activities for the Medical/Dental Staff meetings

(e) When applicable, submit a report of ongoing activities to the Quality Improvement Committee summarizing actions, conclusions, recommendations and follow-up activities, of performance improvement activities.

7.2 TERMS AND REMOVAL OF COMMITTEE MEMBERS

Unless otherwise specified, a committee member shall be appointed for a term of two (2) years, and shall serve until his successor is appointed. Any committee member who is appointed by the President of the Medical/Dental Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by a Chief of Service may be removed by a majority vote of the department or the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee, ex officio, because he/she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

7.3 PRINCIPLES GOVERNING COMMITTEES

Any committee, whether Staff-wide, department based, standing or special that is carrying out all or any portion of a function or activity required by these Bylaws and pertaining to the evaluation or improvement of the quality of health care rendered by providers of health care services, the determination whether health care services were performed in compliance with the applicable standards of care, determination whether the cost of the health care services rendered was considered reasonable by the providers of health services in the area, the determination of whether a health care provider's actions call into question the provider's fitness to provide health care services or the evaluation and assistance of health care providers impaired or allegedly impaired is deemed a duly appointed and authorized professional and medical peer review

committee of the Medical/Dental Staff and the Medical Center under and entitled to the protection of New York Education Law §6527.

7.4 OPERATIONAL MATTERS RELATING TO COMMITTEES

Medical/Dental Staff leaders and organizational components of the Staff as described in these Bylaws and Medical/Dental Staff representation on Medical Center committees shall participate in certain Medical Center deliberations and shall provide staff functions and responsibilities to liaison with the Board and administration regarding, accreditation/licensure/certification, disaster planning, facility and services planning, financial management and functional and physical plant safety. The Medical/Dental Staff, through its general staff and Chiefs of Service or their respective designees or through other organizational components will be represented and participate in any Medical Center deliberations affecting the performance of Medical/Dental Staff responsibilities.

The purpose of the Medical/Dental Staff and Medical Center committees are to:

(a) Perform such functions and carry out such business of the Medical/Dental Staff as may be outlined in the Medical/Dental Staff Bylaws, and Rules and Regulations;
(b) Document meaningful compliance with the functions and goals defined in the Medical/Dental Staff's and Medical Center's Performance Improvement Plan;
(c) Provide a forum for ongoing review of clinical care rendered by the members of the Medical/Dental Staff;
(d) Provide professional education of its members; and
(e) Improve the clinical care of patients.

7.5 EX-OFFICIO MEMBERS

The Medical/Dental Staff President, the Chief Medical Officer and the Chief Executive Officer or their respective designees, are ex-officio members of all standing and special committees of the Staff with or without vote as specified in the provision or resolution creating the committee. Ex-officio members shall not be counted when determining the existence of a quorum, except in instances where they are entitled to vote.

7.6 ACTION THROUGH SUBCOMMITTEE or AD HOC COMMITTEE

7.6.1 Any standing committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, reporting such action to the MEC. Any such subcommittee may include individuals in addition to or other than members of the standing committee. The committee chairperson appoints such additional members after consultation with the Medical/Dental Staff President in the case of Medical/Dental Staff members and with the approval of the Chief Executive Officer or his designee when administrative staff appointments are to be made.

7.6.2 The Medical/Dental Staff President or Medical Executive Committee may appoint an ad hoc committee as needed. Each committee shall confine its work to the purposes for which it was appointed. An ad hoc committee shall be discharged when it has made a final report to the Medical Executive Committee with recommendations, if any, or at the expiration of the term of the President of the Medical/Dental Staff by whom it was appointed.

7.7 APPOINTMENT

(a) **COMMITTEE CHAIRS** – Appointment of all committee chairs, unless otherwise provided for in these Bylaws, will be approved upon receiving recommendations from the President of the Medical/Dental Staff, the MEC and confirmation by the Board. All chairs shall be selected from among Medical/Dental Staff members who shall have served for at

least a year on the committee or otherwise have experience in the functions assigned to the committee. Each committee chair has the right to participate in discussion of and to vote on issues presented to the committee. Such appointments will be reviewed and endorsed by the MEC at its first meeting after the end of the Medical/Dental Staff year.

(b) **MEMBERS** – Physician members of each committee, except as otherwise provided for in these Bylaws, shall be appointed every two (2) years by the President of the Medical/Dental Staff. There shall be no limitation in the number of terms a member may serve. A Medical/Dental Staff member may be removed from the committee for failure to maintain himself in good standing as a Staff member, or termination of an employment or contract relationship with the Medical Center, loss or limitation of practice privileges, for good cause or by action of the MEC. Any ex-officio member of a Staff committee ceases to be such if he/she ceases to hold a designated position which is the basis of ex-officio membership.

(c) **VACANCIES -** Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

7.8 MEDICAL EXECUTIVE COMMITTEE

There shall be a Medical Executive Committee which includes physicians and which may include other licensed independent practitioners:

7.8.1 COMPOSITION

The MEC shall be composed of:

(a) President of the Medical/Dental Staff, as chair, with vote;
(b) President-Elect of the Medical/Dental Staff, with vote;
(c) Secretary of the Medical/Dental Staff, with vote;
(d) Treasurer of the Medical/Dental Staff, with vote;
(e) Immediate Past President, with vote;
(f) Chiefs of Service for: Anesthesiology, Cardiothoracic Surgery, Dentistry, Dermatology, Emergency Medicine, Family Medicine, Internal Medicine, Laboratory Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Oral & Maxillo-Facial Surgery, Orthopaedic Surgery, Otolaryngology, Pathology, Plastic and Reconstructive Surgery, Psychiatry, Radiology, Rehabilitation Medicine, Surgery and Urology, with vote;
(g) Associate Chiefs of Service for Internal Medicine-Specialty Care, Internal Medicine-Hospitalist Service and Internal Medicine-Ambulatory Care, with vote.
(h) Associate Chief of Service, representing Chemical Dependency
(i) Three (3) members-at-large of the Staff, elected for a two (2) year term at the Annual Meeting of the Staff, with vote.
(j) Two (2) Allied Health Practitioners-at-large, elected for a two (2) year term at the annual meeting of the Staff, with vote;
(k) Chair, Credentials Committee, with vote;
(l) Chief Executive Officer, ex-officio, without vote;
(m) Chief Medical Officer, ex-officio, without vote;’
(n) Associate Medical Directors, ex-officio without vote
(o) Chief Operating Officer, ex-officio, without vote
(p) Senior VP of Nursing, ex-officio, without vote; and
(q) Director, Medical Dental Staff Services, without vote
(r) Additional at large members, with vote as determined by the Medical Executive Committee.

7.8.2 DUTIES AND RESPONSIBILITIES

The duties of the Medical Executive Committee shall be to:

(a) Act on behalf of the organized Medical/Dental Staff between Medical/Dental Staff meetings;

(b) Receive and act upon reports and recommendations from the departments, committees and officers of the Staff concerning the findings of the performance improvement/utilization management program and other performance improvement activities and the discharge of their delegated administrative responsibilities;

(c) Coordinate the activities of, and policies adopted by the Staff, departments and committees;

(d) Recommend to the Board all matters relating to appointments, reappointments, Staff category, department assignments, admitting and clinical privileges, disciplinary and corrective action;

(e) Request evaluations of practitioners privileged through the Medical/Dental Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested;

(f) Account to the Board and to the Staff for the overall quality and efficiency of care rendered to patients in the Medical Center;

(g) Initiate and pursue corrective action, when warranted, in accordance with these Bylaws and corresponding policies and procedures

(h) Make recommendations on medico-administrative and Medical Center management matters to the Board through the CEO;

(i) Make recommendations to the Board on at least the following: the Medical/Dental Staff structure, the process used to review credentials and to delineate privileges for each eligible individual; the mechanism by which Medical/Dental Staff membership may be terminated and the mechanism for collegial intervention, peer review and fair hearing and appeal procedures;

(j) Assist in obtaining and maintaining Medical Center accreditation, maintain communication with the Staff concerning the accreditation program and the accreditation status of the Medical Center;

(k) Participate in identifying community health needs and in setting Medical Center goals and implementing programs to meet those needs; and

(l) Be responsible for assuring the appropriate performance of Medical/Dental Staff performance improvement/risk management activities in all its departments and committees and is accountable to administration and the Board of Directors to ensure that these activities are performed. It delegates the responsibility for the planned systematic, ongoing process of monitoring and evaluation of the quality and appropriateness of care to each department and to the Chief of Service. It assists the Chief of Service with corrective actions concerning individual practitioners with identified problems. It will ensure that the performance improvement reviews are done, problems identified and corrective actions are taken and that documentation of all these activities are completed in a timely manner, and if necessary make recommendations to take action and perform follow-up.

The Committee Chairs and Chiefs of Service are accountable to the Medical Executive Committee by conforming to the requirements set forth, and by actively participating, in the Medical Center's Performance Improvement Program.

7.8.3 MEETINGS AND MAINTENANCE OF RECORDS

The MEC shall meet at least ten (10) times a year or more often if necessary to fulfill its functions. It shall maintain a permanent record of its proceedings and actions and shall report to the Board of Directors. A summary of the minutes of the meetings shall be made available to the general Staff.

7.8.4 CONFLICT RESOLUTION

Whenever the Board of Directors determines that it will decide a matter contrary to the MEC's recommendations, the matter will be submitted to a committee of an equal number of Medical/Dental Staff members of the MEC and Board of Directors for review and recommendation before the Board of Directors makes its final decision. The committee will submit its recommendation to the Board of Directors within thirty (30) days of notification of issue.

7.8.5 REMOVAL FROM THE MEDICAL EXECUTIVE COMMITTEE

A member of the Medical Executive Committee may be removed by the Staff, through a two-thirds (2/3) majority vote by secret ballot of those present at a meeting of the Staff called for that purpose.

7.9 ADDITIONAL MEDICAL/DENTAL STAFF COMMITTEES

The additional Medical/Dental Staff Committees are described in the Medical/Dental Staff Rules and Regulations Part II Policy and Procedure Manual.

ARTICLE VIII
MEETINGS

8.1 MEDICAL STAFF YEAR

For the purpose of these Bylaws, the Medical/Dental Staff year commences on the first day of January and ends on the thirty-first day of December each year.

8.2 GENERAL STAFF MEETINGS

(a) **REGULAR MEETINGS**

The Staff shall hold at least one regular Staff meeting each year. One meeting shall take place in the last quarter of the calendar year and will be designated the annual meeting at which the election of officers and at-large Medical Executive Committee members shall be conducted.

(b) **SPECIAL MEETINGS**

Special meetings of the Staff may be called at any time by the Board, the President of the Medical/Dental Staff, the Medical Executive Committee, or shall be called by the President of the Medical/Dental Staff within thirty days after receipt of a written request by at least twenty (20) voting members of the Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

8.3 COMMITTEE AND DEPARTMENT MEETINGS

(a) **REGULAR MEETINGS**
Committees and departments may, by resolution, provide for the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws and related policies and procedures. Each Committee Chair or Chief of Service shall make every reasonable effort to ensure that the meeting dates are disseminated to the members with adequate notice.

(b) **SPECIAL MEETINGS**
A special meeting of any committee or department may be called by, or at the request of:
1. The Chair of the committee;
2. The Board;
3. The President of the Medical/Dental Staff; or
4. At least one third (1/3) of its current members but no less than two (2) members.

The meeting shall be held within thirty (30) days after receipt of written request. No business shall be transacted at any special meeting except that stated in the meeting notice.

8.4 NOTICE OF MEETINGS
Written or printed notice stating the place, day and hour of any general Staff meeting, or any special meeting or of any regular committee, department or service meeting not held pursuant to resolution shall be posted in appropriate and visible locations, on the Medical Center's website or delivered to each person entitled to be present not less than two (2) days before the date of such meeting. Notice of department and committee meetings may be given orally or by electronic means. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

8.5 QUORUM
(a) **GENERAL STAFF MEETINGS**
Those Active Staff members present and eligible to vote shall constitute a quorum for all actions other than amendment of these Bylaws.

(b) **DEPARTMENT AND COMMITTEE MEETINGS**
Those members of a department or committee present and eligible to vote, including at least two (2) Active Medical/Dental Staff members, shall constitute a quorum at any meeting of such department or committee. Members specifically described as ex-officio shall not be counted in determining the presence of a quorum.

(c) **CREDENTIALS COMMITTEE MEETINGS**
Those Credentials Committee members present and entitled to vote shall constitute a quorum.

(d) **MEDICAL EXECUTIVE COMMITTEE MEETINGS**
Fifty (50) percent of the voting members of the Medical Executive Committee will constitute a quorum.

8.6 MANNER OF ACTION
Except as otherwise specified in these Bylaws, the action of a majority of the members present and voting, at a meeting at which a quorum is present or participating via teleconference, shall be the action of the group. Action may be taken without a meeting by a department or committee by setting forth the action in writing and signature (paper or electronic mail) by each member entitled to vote. Members of committees appointed by the CEO in conformity with Section 6.1 shall not

have the same rights and privileges as members of the Staff serving on the committees and shall not have the right to vote.

8.7 MINUTES

Minutes of all meetings shall be prepared and shall include a record of attendance, the findings, conclusions and recommendations made on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees at subsequent meetings, forwarded to the Medical Executive Committee and made available to the Staff. The Medical/Dental Staff Office shall maintain a permanent file of minutes from the Medical Executive, Credentials, Bylaws, General Staff and other designated Medical/Dental Staff departmental and committee meetings. The Performance Improvement Committee minutes will also be maintained in the Patient Safety Office.

8.8 ATTENDANCE REQUIREMENTS

(a) **REGULAR ATTENDANCE**

Each member of the Active Staff shall be encouraged to attend each year:

1. At least fifty percent (50%) of all Staff meetings duly convened pursuant to these Bylaws; and

2. At least fifty percent (50%) of all meetings of each department and committee of which he/she is a member.

Members appointed to the Associate, Courtesy, Emeritus Allied Health Professional category shall be encouraged to attend and participate in departmental meetings, educational activities and any committees of which he/she is a member.

(b) **SPECIAL APPEARANCE**

1. A member of any category of the Medical/Dental Staff whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting shall be so notified and invited to present the case. If the practitioner is not present, the case will be discussed unless the practitioner has requested a postponement. In no case shall a postponement be granted beyond the next regular meeting.

2. Whenever a Staff or Department education program or clinical conference is prompted by findings of review, evaluation and monitoring activities, the practitioner(s) whose patterns of performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered and of its special applicability to the practitioner(s)' practice. Attendance is mandatory. Failure to attend, unless excused by the appropriate Chief of Service, upon a showing of good cause, may result in such corrective action under the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Procedures, as deemed necessary by the MEC or Board, as applicable.

3. Whenever a pattern or significant instance of apparent or suspected deviation from standard clinical practice is identified within a practitioner's practice, the Chief Medical Officer, the Medical/Dental Staff President or the applicable Chief of Service, or Chair of the Quality Executive Committee may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter or to respond in such form as requested to the particular concern raised. If the practitioner fails to appear for a requested conference or fails to respond in such form as requested, the Chief Medical Officer, the Medical/Dental Staff President or the applicable Chief of Service shall give the practitioner special notice indicating that failure to appear or respond within five (5) days of the notice, unless excused upon a showing of good cause as determined by the Chief Medical Officer, may result in a

precautionary suspension of all or such portion of the practitioner's clinical privileges as the Chief Medical Officer or the Medical/Dental Staff President may direct, all in accordance with the Collegial Intervention, Fair Hearing and Appellate Review Procedures. A suspension under this section will remain in effect until the matter is resolved by final action of the Board following the applicable provisions of the Credentials Procedures Manual, the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Procedures.

8.9 CONDUCT OF MEETINGS

The MEC shall establish the parliamentary authority for conducting deliberations for all committees.

8.10 EXECUTIVE SESSION

Any meeting of the Medical/Dental Staff or of a Medical/Dental Staff committee or department may go into executive session upon adoption of such a motion by majority vote. No meeting, whether or not in executive session, shall exclude a designated representative(s) of the Medical Center Board.

ARTICLE IX
BOARD APPROVAL AND INDEMNIFICATION

9.1 Any Medical/Dental Staff officer, Chief of Service, committee chairperson, committee member and individual Staff appointee who acts for and on behalf of the Medical Center in discharging duties, functions or responsibilities stated in these Medical/Dental Staff Bylaws and other related current Medical/Dental Staff or Medical Center policies and procedures, shall be indemnified and held harmless to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board of Directors, except to the extent such person commits fraud or acts in bad faith and/or engages in intentional misconduct or knowing violation of law or engages in any transaction for which such person received a personal benefit in violation or breach of any fiduciary duty or provision of this Agreement. No amendment or repeal of this paragraph shall adversely affect any of the rights or protection afforded to a person for or with respect to any acts or omissions of such person occurring prior to such amendment or repeal.

ARTICLE X
CONFIDENTIALITY, IMMUNITY AND RELEASE

10.1 SPECIAL DEFINITIONS

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

(a) "Information" means all acts, communication, records or proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written, computerized or oral form relating to any of the subject matter specified in Article IX.

(b) "Malice" means the dissemination of a known falsehood or of information with a reckless disregard for whether it is true of false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

(c) "Representative" means the Board and any member or committee thereof, the CEO, the Staff organization and any member, officer, department, service or committee thereof and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

(d) "Third parties" means both individuals and organizations that are not representatives providing information to any representative.

10.2 CONFIDENTIALITY OF INFORMATION

Information submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical/Dental Staff for the purpose of: assessing, reviewing, evaluating, monitoring or improving the quality and efficiency of health care provided; evaluating current clinical competence and qualifications for Staff appointment/affiliation, or clinical privileges for specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, be confidential. This information shall not be disseminated to anyone other than a representative of the Medical Center or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information of like kind that may be provided by third parties. Each practitioner expressly acknowledges that violation of the confidentiality provided there are grounds for immediate and permanent revocation of Staff appointment and/or clinical privileges for specified services.

10.3 IMMUNITY FROM LIABILITY

In addition to immunity provided by applicable law, no representative shall be liable to a practitioner for damages or other relief for any good faith decision, opinion, action, statement or recommendation made within the scope of his duties as an official representative of the Medical Center or for providing information, opinion, counsel or services to a representative or to any health care facility or organization of health professionals concerning said practitioner.

10.4 ACTIVITIES AND INFORMATION COVERED

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

(a) Applications for appointment/affiliation, clinical privileges or specified services;

(b) Periodic reappraisals for renewed appointment/affiliation, clinical privileges and specified services;

(c) Corrective or disciplinary actions;

(d) Hearings and appellate reviews;

(e) Quality assessment and performance improvement activities;

(f) Utilization reviews;

(g) Claims reviews;

(h) Risk management and liability prevention activities; and

(i) Other Medical Center, department, service, committee and subcommittee activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.5 RELEASES

Each applicant or member shall, upon request of the Medical/Dental Staff or Medical Center, execute general and specific releases in accordance with the express provisions and general intent of this Article.

10.6 DUALITIES OF INTEREST RELATED TO MEDICAL/DENTAL STAFF FUNCTIONS

When performing a function outlined in these Bylaws and other related current Medical/Dental Staff or Medical Center policies and procedures, if any Medical/Dental Staff appointee has or reasonably would be perceived as having a duality of interest or bias in any matter involving another individual related to the function being performed, the conflicted member shall first declare the conflict and shall not vote on the matter. However, the individual may be asked and may answer any questions concerning the matter.

Any other member with knowledge of such may call the existence of a potential duality of interest or bias on the part of any member to the attention of the Medical/Dental Staff President. The Medical/Dental Staff President shall have a duty to delegate the performance of the function in question to another member when a conflict of interest is disclosed or is reasonably perceived to exist.

10.7 MEDICAL CENTER DUALITY OF INTEREST POLICIES

Members of the Medical/Dental Staff who have interests outside the Medical Center and their own personal practice which have or might reasonably create a duality of interest with the Medical Center or with their membership on the Medical/Dental Staff or its committees, shall submit to the Medical Executive Committee a written statement concerning the name and address of the organization and the nature of the interest.

Medical/Dental Staff members shall also be bound by corporate conflict of interest policies adopted by the Board to the extent those policies apply to the Medical/Dental Staff member in question.

ARTICLE XI
GENERAL PROVISIONS

11.1 STAFF RULES AND REGULATIONS AND/OR POLICIES AND PROCEDURES

The Medical/Dental Staff shall adopt such policies, procedures, rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws and other related current Medical/Dental Staff documents. The policies, procedures, rules and regulations shall be related to the proper conduct of Medical/Dental Staff organizational activities and will embody the specific standards and level of practice that are required of each Medical/Dental Staff member and other designated individuals who exercise clinical privileges or provide designated patient care services at the Medical Center. Such rules and regulations may be amended or repealed upon recommendation of the Medical Executive Committee and approval by the Board of Directors.

Medical/Dental Staff policies may also be adopted, amended or repealed upon recommendation of the Medical Executive Committee with final approval by the Board.

11.2 DEPARTMENT POLICIES AND PROCEDURES

Subject to the approval of the Medical Executive Committee and the Board, each department may formulate its own policies and procedures for the conduct of its affairs and the discharge of

its responsibilities. Such policies and procedures shall not be inconsistent with these Bylaws, the Medical Center Bylaws, the general rules and regulations or policies of the Staff, or other policies of the Medical Center.

11.3 FORMS

Application forms and any other prescribed forms required by these Bylaws and for use in connection with Staff appointments, re-appointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be adopted by the Board after considering the advice or recommendation of the Medical Executive Committee.

11.4 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural as the contest and circumstances require. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE XII
ADOPTION AND AMENDMENT OF BYLAWS

12.1 STAFF RESPONSIBILITY AND AUTHORITY

The Staff shall have the initial responsibility and delegated authority to formulate and to submit recommendations to the Board, through the Medical Executive Committee regarding Medical/Dental Staff Bylaws and other related Medical/Dental Staff policies and procedures. All amendments or revisions shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. A standing or special committee of the Staff shall review the Medical/Dental Staff Bylaws and its related policies at least every three (3) years.

12.2 METHODOLOGY

12.2.1 MEDICAL/DENTAL STAFF BYLAWS AND PROCEDURES FOR COLLEGIAL INTERVENTION, PEER REVIEW, HEARING AND APPELLATE REVIEW PROCEDURES

(a) Medical/Dental Staff Bylaws and the Procedures for Collegial Intervention, Peer Review, Hearing and Appellate Review may be adopted, amended, or repealed by the following process:

(i) Affirmative vote of the Medical Executive Committee; followed by

(ii) Affirmative vote of the Active Medical/Dental Staff as described in 12.2.1 (b) followed by

(iii) Approval of the Board of Directors

(b) An affirmative vote of the Medical/Dental Staff will have occurred when, no fewer than fifteen (15) days after the proposed documents or amendments have been made available to the Medical/Dental Staff members entitled to vote, either of the following processes have been completed:

(i) After being provided notice of the meeting no fewer than fifteen (15) days prior an affirmative vote is cast by a majority of the members eligible to vote present at said meeting.

or

(ii) In lieu of a meeting, a majority of the members of the Medical/Dental Staff eligible to vote, do so in the affirmative by mail or electronically (as decided by the Medical/Dental Staff) through a process that includes all of the following:

- Amendments and ballots are distributed by mail or electronically (as decided by the Medical/Dental Staff) to all Medical/Dental Staff members entitled to vote no fewer than fifteen (15) days prior to the deadline for receipt of the ballot by the Medical/Dental Staff Office.
- Affirmative votes are cast by marking the ballot "yes" in writing or electronically, as applicable, and returning it to the Medical/Dental Staff Office prior to the deadline for receipt of the ballot;
- Negative votes are cast by marking the ballot "no" in writing or electronically, as applicable, and returning it to Medical/Dental Staff Office prior to the deadline for receipt of the ballot; and
- No less than fifty (50) members of the Medical/Dental Staff eligible to vote do so.

12.2.2 MEDICAL/DENTAL STAFF POLICIES AND PROCEDURES

The Rules and Regulations, Policies and Procedures of the Medical/Dental Staff and the Credentials Procedures Manual may be amended or repealed, in whole or in part, or a new one proposed to the MEC by the appropriate Staff committee at a regular or special meeting of the MEC. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff. An affirmative vote shall consist of the majority of the votes of the MEC members eligible to vote at which a quorum is present. For Rules and Regulations, a copy of the proposed documents or amendments will be made available to each member at least fifteen (15) days prior to the meeting. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with the law or regulation, the MEC may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the MEC. The medical staff has the opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the organizational medical staff and the MEC, the provisional amendment stands. Amendments or new documents will become effective upon the approval of the Board of Directors. For the initial adoption process, these documents will follow the process outlined in 12.2.1 above. In the event of a conflict, the matter will be resolved through the process defined in 2.4 (c) and 8.2 (b).

12.2.3 TECHNICAL AND EDITORIAL AMENDMENTS

The MEC shall have the power to adopt such amendments to the Bylaws and other related Medical/Dental Staff policies and procedures as are in its judgment not substantive, but technical or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression, inaccurate cross-references or to reflect changes in committee names. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical/Dental Staff or the Board of Directors within ninety (90) days of adoption by the MEC. After adoption, such amendments shall be communicated by a reasonable mechanism and in writing to the Staff and the Board of Directors.

12.2.4 ADOPTION

These bylaws and other related Medical/Dental Staff policies and procedures shall be adopted through the processes outlined above; shall become effective when approved by the Board of Directors of the Medical Center and shall be equally binding on the Board of Directors and the Medical/Dental Staff. The Medical/Dental Staff and Board of Directors are responsible for upholding the Medical/Dental Staff Bylaws, rules, regulations and policies and ensuring they do not conflict with the Medical Center Bylaws. Neither the organized Medical/Dental Staff nor the Board of Directors may unilaterally amend the Medical/Dental Staff Bylaws, rules or regulations. The Medical/Dental Staff Bylaws and other related Medical/Dental Staff policies and procedures shall be, and at all times

remain, in conformity with the laws and statutes of the State of New York and in conformity with the and Bylaws of the Medical Center. In the event of a conflict between these Bylaws and the Bylaws of the Medical Center, the latter shall prevail. The Medical/Dental Staff Bylaws and other related Medical/Dental Staff policies and procedures shall become effective upon final approval by the Board (the "Effective Date"), except with respect to individual cases involving formal investigation or request for corrective action, precautionary suspension or restriction, hearing or appeals processes as set forth in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures, in which case the newly-adopted Bylaws and other related Medical/Dental Staff policies and procedures ("New Policies") and the preceding Bylaws and other related Medical/Dental Staff policies and procedures ("Existing Policies") shall apply as follows: 1) in the event a formal investigation or request for corrective action, precautionary suspension or restriction, hearing or appeals process commenced prior to the Effective Date (regardless of the status or completion thereof), then the Existing Policies shall continue to apply through completion of such processes and final action by the Board and any further action and appeal directly related thereto; 2) in the event an incident(s) occurred prior to the Effective Date (regardless of when it was reported to the MEC, the Board or any committees, representatives or designees thereof), but no formal investigation or request for corrective action, precautionary suspension or restriction, hearing or appeal was commenced prior to the Effective Date, then the New Policies shall apply through completion of such processes and final action by the Board and any further action and appeal directly related thereto; and 3) in the event an incident(s) occurred after the Effective Date, then the New Policies shall apply through completion of such processes and final action by the Board and any further action and appeal directly related thereto.

ADOPTION AND APPROVAL

Adopted by the Medical/Dental Staff:

Medical/Dental Staff President – Jennifer Pugh, MD Date: 01/25/2023

Approved by the Board of Directors:

Chief Executive Officer,
Erie County Medical Center Corporation
Thomas Quatroche, Jr., PhD

Date: 01/25/2023

Revisions:

Medical Executive Committee:	05/20/2019
Board of Directors Committee:	07/30/2019

Medical Executive Committee: 10/24/2022
Annual Meeting of the Medical/Dental Staff: 11/17/2022
Board of Directors ECMCC: 1/24/2023

Collegial Intervention

Part II

BYLAWS OF THE MEDICAL/DENTAL STAFF
ERIE COUNTY MEDICAL CENTER CORPORATION
PART II
COLLEGIAL INTERVENTION AND THE FAIR HEARING PROCESS

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PART II
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MEDICAL/DENTAL STAFF BYLAWS

PART II

COLLEGIAL INTERVENTION AND THE FAIR HEARING PROCESS

ARTICLE I
COLLEGIAL, EDUCATION AND/OR INFORMAL PROCEEDINGS

1.1 CRITERIA FOR INITIATION

These bylaws encourage the use of progressive steps by medical staff leaders and hospital management, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review/practice improvement activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

(a) Educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

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

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

Following efforts at collegial intervention, if it appears that the practitioner's performance places patients in danger or the quality of care is compromised, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether a recommendation to restrict or revoke membership and/or privileges should be made to the Board. Before issuing such a recommendation the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

ARTICLE II
INVESTIGATIONS

2.1 INITIATION

A request for an investigation must be submitted by a medical staff officer, committee chair, department/clinical service chief, CEO, CMO or hospital Board chair to the MEC and supported by reference to the specific activities or conduct of concern. If the MEC initiates the request, it shall make an appropriate record of its reasons.

2.2 INVESTIGATION

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the medical staff. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant necessary and such use is approved by the MEC and the CEO. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The practitioner of concern shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. This meeting (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws, nor shall the procedural rules with respect to hearings or appeals apply. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

An external peer review consultant should be considered when:

(a) Litigation seems likely;

(b) The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;

(c) There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2.3 MEC ACTION

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

(a) Determining no corrective action is taken, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information to the extent reasonably possible from the member’s file;

(b) Deferring action for a reasonable time when circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate [committee/department/section] chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner’s file;

(d) Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring

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

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

(g) Recommending suspension, revocation, or probation of medical staff membership;

(h) Taking other actions deemed appropriate under the circumstances.

2.4 SUBSEQUENT ACTION

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, that recommendation shall be transmitted in writing to the Board. The recommendation of the MEC shall become final unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

ARTICLE III
CORRECTIVE ACTIONS

3.1 AUTOMATIC RELINQUISHMENT/VOLUNTARY RESIGNATION

In the following instances, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, which action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as practicable. The Medical/Dental Staff President may reinstate the practitioner's privileges or membership if she/he determines the triggering circumstances have been rectified or are no longer present within sixty days of the relinquishment. After sixty (60) (unless specified otherwise below) days the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 LICENSURE

3.1.1.1 REVOCATION AND SUSPENSION

Whenever a practitioner's license or other legal credential authorizing practice in this or another state is revoked, suspended, or voluntarily relinquished to avoid disciplinary action, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

3.1.1.2 RESTRICTION

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

3.1.1.3 PROBATION

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

3.1.1.4 MEDICARE, MEDICAID, TRICARE (A MANAGED-CARE PROGRAM THAT REPLACED THE FORMER CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES), OR OTHER FEDERAL PROGRAMS

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.2 CONTROLLED SUBSTANCES

3.1.2.1 DEA CERTIFICATE

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

3.1.2.2 PROBATION

Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.3 PROFESSIONAL LIABILITY INSURANCE

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

3.1.4 MEDICAL STAFF DUES/SPECIAL ASSESSMENTS

Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

3.1.5 FELONY/MISDEMEANOR CONVICTION

A practitioner who has been convicted of, or pled "guilty", “no contest”, or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall automatically relinquish medical staff membership and

privileges. Such relinquishment shall become effective immediately upon such conviction or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.6 FAILURE TO SATISFY THE SPECIAL APPERANCE REQUIREMENT

A practitioner who fails without good cause to appear at a meeting where his special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored upon compliance with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

3.1.7 FAILURE TO PARTICIPATE IN AN EVALUATION

A practitioner who fails to participate in an evaluation of his qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored upon compliance with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

3.1.8 FAILURE TO EXECUTE RELEASE AND/OR PROVIDE DOCUMENTS

A practitioner who fails to execute a general or specific release and/or provide documents when requested by the president of the medical staff or designee in order to evaluate the competency and credentialing/privileging qualifications of the practitioner to assure patient safety shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within sixty (60) calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.9 MEC DELIBERATION

As soon as practicable after action is taken or warranted as described in Sections 3.1.1 through Section 3.1.8, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in the Section 2.3 above.

3.2 PRECAUTIONARY RESTRICTION OR SUSPENSION

3.2.1 CRITERIA FOR INTIATION

Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution, or to impair the reputation of the medical staff or hospital, then any two of the following:, President of the Medical/Dental Staff or designee, Chief of Service, CMO, or the MEC, may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital.

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

Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the president of the medical staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.2 MEC ACTION

As soon as practicable and within 14 calendar days after such precautionary suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and if necessary begin the investigation process as noted in Article II above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 PROCEDURAL RIGHTS

Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2.3, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

3.3 ADMINISTRATIVE TIME OUT

The MEC may, with approval of the CEO and the Board Chair, institute one or more administrative time outs for a practitioner for a cumulative period not to exceed fourteen (14) consecutive calendar days in a calendar year. During an administrative time out the practitioner may not exercise any clinical privileges except in an emergency situation or to address an imminent delivery. An administrative time out may be instituted only under the following circumstances:

(a) When the action that has given rise to the time out relates to one of the following policies of the medical staff: Completion of medical records, practitioner behavior (or Professionalism Policy) or requirements for emergency department coverage;

(b) When the action(s) have been reviewed by the MEC and only when the MEC has determined that one or more of the above policies have been violated;

(c) When the practitioner has received at least two written warnings within the last twelve (12) months regarding the conduct in question. Such warnings must state the conduct or behavior that is questioned and specify or refer to the applicable policy, and state the consequence of repeat violation of the policy;

(d) When the affected practitioner has been offered an opportunity to meet with the MEC prior to the imposition of the administrative time out. Failure on the part of

the practitioner to accept the MEC offer of a meeting will constitute a violation of the medical staff bylaws regarding special meetings and will not prevent the MEC from issuing the administrative time out.

(e) An administrative time out will take effect after the practitioner has been given an opportunity to either arrange for his patients currently at the hospital to be cared for by another qualified practitioner or until s/he has had an opportunity to provide needed care prior to discharge. During this period, the practitioner will not be permitted to schedule any elective admissions, surgeries, or procedures. The president of the medical staff or designee will determine details of the extent to which the practitioner may continue to be involved with hospitalized patients prior to the effective date of the administrative time out.

(f) Medical record completion requirements: A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

ARTICLE IV
INTIATION AND NOTICE OF HEARING

4.1 INITIATION OF HEARING

Any practitioner eligible for medical staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

(a) Denial of medical staff appointment or reappointment;

(b) Revocation of medical staff appointment;

(c) Denial or restriction of requested clinical privileges;

(d) Involuntary reduction or revocation of clinical privileges;

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

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

4.2 HEARINGS WILL NOT BE TRIGGERED BY THE FOLLOWING ACTIONS:

(a) Issuance of a letter of guidance, warning or reprimand.

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

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

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

(e) Requirement to appear for a special meeting under the provisions of these bylaws.

(f) Automatic relinquishment or voluntary resignation of appointment or privileges.

(g) Imposition of a precautionary suspension or administrative time out that does not exceed fourteen (14) consecutive calendar days.

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

(i) Determination that an application is incomplete or untimely.

(j) Determination that an application will not be processed due to misstatement or omission.

(k) Decision not to expedite an application.

(l) Termination or limitation of temporary privileges unless for demonstrated incompetence (or unprofessional conduct)

(m) Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership.

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

(o) Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted.

(p) Termination of any contract with or employment by hospital.

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

(r) Any recommendation voluntarily accepted by the member, including, but not limited to a Voluntary Improvement Plan as administered within the Practice Improvement Process.

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

(t) Change in assigned staff category.

(u) Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request.

(v) Removal or limitations of emergency department call obligations.

(w) Any requirement to complete an educational assessment.

(x) Retrospective chart review.

(y) Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws.

(z) Grant of conditional appointment or appointment for a limited duration.

(aa) Appointment or reappointment for duration of less than 24 months

4.3 NOTICE OF RECOMMENDATION

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

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

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

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

(d) The individual shall receive a copy of the procedural rights with regard to the hearing.

4.4 REQUEST FOR HEARING DATE

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

4.5 NOTICE OF HEARING AND STATEMENT REASONS

The CEO, in consultation with the President of the Medical and Dental Staff, shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

(a) The time, place and date of the hearing;

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

(c) The names of the hearing panel members and presiding officer or hearing officer, if known;

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

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

4.6 WITNESS LIST

At least fifteen (15) calendar days before the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf. The list of witnesses who will testify in support of the recommendation of the MEC or the Board will include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

ARTICLE V
HEARING PANEL AND PRESIDING OFFICER OR HEARING OFFICER

5.1 HEARING PANEL

(a) When a hearing is requested, the President of the Medical/Dental Staff shall appoint a hearing panel that shall be composed of not fewer than three individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

(b) The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

(c) The President of the Medical/Dental Staff shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the President of the Medical/Dental Staff, who, shall determine whether a replacement panel member should be identified. While the practitioner who is the subject of the hearing may object to a panel member, s/he

is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the President of the Medical/Dental Staff.

5.2 HEARING PANEL CHAIRPERSON OR PRESIDING OFFICER

5.2.1 PRESIDING OFFICER APPOINTMENT

In lieu of a hearing panel chair, the President of the Medical/Dental Staff may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 CHAIR APPOINTMENT

If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the President of the Medical/Dental Staff to serve as the presiding officer and shall be entitled to one vote.

5.2.3 DUTIES/RESPONSIBILITIES

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

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

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

(c) Maintain decorum throughout the hearing;

(d) Determine the order of procedure throughout the hearing;

(e) Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

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

(g) Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel;

(h) Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 HEARING OFFICER

(a) As an alternative to the hearing panel described in Section 5.1 of this manual, the President of the Medical/Dental Staff, may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.

(b) The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the

"hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

ARTICLE VI
PRE-HEARING AND HEARING PROCEDURE

6.1 PROVISION OF RELEVANT INFORMATION

6.1.1 ACCESS TO INFORMATION

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

(a) Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

(b) Reports of experts relied upon by the MEC;

(c) Copies of redacted relevant committee minutes;

(d) Copies of any other documents relied upon by the MEC.

(e) No information regarding other practitioners shall be requested, provided or considered;

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

6.1.2 EXHIBITS AVAILABLE TO THE INDIVDUAL

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

6.1.3 DOCUMENTATION PROVIDED

Prior to the hearing, on dates set by the presiding officer, the individual requesting the hearing shall, upon specific request, provide the credentials committee or MEC copies of any expert reports or other documents upon which the individual will rely at the hearing.

6.1.4 WITNESSES

There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his counsel. Exempt from this would be any mandated regulatory investigation conducted under the Risk Management or Patient Safety offices.

6.2 PRE-HEARING CONFERENCE

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

6.3 FAILURE TO APPEAR

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

6.4 RECORD OF HEARING

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

6.5 RIGHTS OF BOTH SIDES

6.5.1 BOTH SIDES

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

(a) To call and examine witnesses to the extent available;

(b) To introduce exhibits;

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

(d) To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may call, examine, cross-examine witnesses and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

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

6.5.2 INDIVIDUAL

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

6.5.3 HEARING PANEL

The hearing panel may question the witness, call additional witnesses or request additional documentary evidence.

6.6 ADMISSABILITY OF EVIDENCE

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

6.7 BURDEN OF PROOF

The hearing panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved with a preponderance of the evidence that the recommendation which prompted the hearing was arbitrary, capricious, or appears to be unfounded or not supported by credible evidence. It is the burden of the practitioner under review to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital policies.

6.8 POST-HEARING MEMORANDA

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

6.9 OFFICIAL NOTICE

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

6.10 POSTPONEMENT AND EXTENSIONS

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

6.11 PERSONS TO BE PRESENT

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the president of the medical staff or CEO.

6.12 ORDER OF PRESENTATION

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

6.13 BASIS OF RECOMMENDATION

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

6.14 ADJOURNMENT AND CONCLUSION

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

6.15 DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL

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

6.16 DISPOSITION OF HEARING PANEL REPORT

The hearing panel shall deliver its report and recommendation to the MEC. The MEC will consider the decision made by the hearing panel and make its final recommendation, along with all supporting documentation, to the Board for further action. The MEC shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the CEO for information.

ARTICLE VII
APPEAL TO THE HOSPITAL BOARD

7.1 TIME FOR APPEAL

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

7.2 GROUNDS FOR APPEAL

The grounds for appeal shall be limited to the following:

(a) There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or
(b) The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or
(c) The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 TIME, PLACE AND NOTICE

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

7.4 NATURE OF APPELLATE REVIEW

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

(b) The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the

party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

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

7.5 FINAL DECISION OF THE HOSPITAL BOARD

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

7.6 RIGHT TO ONE APPEAL ONLY

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to member, that individual may not apply within five (5) years of the medical staff appointment or for those clinical privileges at this hospital unless the Board provides otherwise.

ADOPTION AND APPROVAL

ADOPTION:

Adopted by the Medical/Dental Staff:

Jennifer Pugh, MD
Medical/Dental Staff President Date: 1/25/2023

Approved by the Board of Directors:

Thomas Quatroche, Jr., PhD
CEO, Erie County Medical Center Corporation Date: 1/25/2023

Rules and Regulations

Part I

ERIE COUNTY MEDICAL CENTER CORPORATION
BUFFALO, NEW YORK

MEDICAL/DENTAL STAFF

RULES & REGULATIONS
PART I

MEDICAL/DENTAL STAFF ORGANIZATION

MEDICAL/DENTAL STAFF RULES AND REGULATIONS
ERIE COUNTY MEDICAL CENTER CORPORATION

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RULES AND REGULATIONS OF THE MEDICAL/DENTAL STAFF OF THE ERIE COUNTY MEDICAL CENTER CORPORATION

SECTION I GENERAL RULES OF CONDUCT

I.A. ECMCC Policies and Procedures

ECMCC has adopted written policies and procedures to govern the conduct of patient care in the Hospital and to assure compliance with Federal and State law. These include, but are not limited to:

1. Advance Directives
2. Blood Transfusions
3. Brain Death
4. Clinical Research
5. Conditions Reportable to Law Enforcement (Abuse and Domestic Violence)
6. Conflict Resolution in Care Decisions
7. Emergency Preparedness Management Plan
8. Guardianship
9. Harassment
10. HIV Illness and HIV Related Information
11. Identity and/or Medical Identity Theft
12. Informed Consent
13. Medical Record Requirements
14. EMTALA Medical Screen Examinations and Interinstitutional Patient Transfer
15. Moral Objection/Matters of Conscience
16. Organ and Tissue Donation
17. Pain Assessment and Management
18. Patient's Rights and Responsibilities
19. Patient Bill of Rights
20. Restraints – Acute Medical Surgical
21. Restraints and Seclusion – Psychiatry
22. Time Out Universal Protocol for all Surgical and Non-Surgical Consented Invasive Procedures
23. Transfer of Internal Patients between Clinical Services

ECMCC Policies and Procedures are available on the ECMCC Intranet. A hard copy of these policies is available in the Patient Safety and the Nurse Staffing Offices. It is the responsibility of each Staff Member to know the location of the current ECMCC Policy and Procedure Manual and to consult and comply with the relevant ECMCC Policy and Procedure in performing patient care activities in the Hospital. Any capitalized term used in these rules and regulations shall have the same meanings given to such term in the Bylaws of the Medical/Dental Staff of ECMCC if it is defined therein.

I.B. Mandatory Reporting

It is the responsibility of each Staff Member, working in collaboration with the appropriate Medical Center representatives, to notify the appropriate regulatory agency regarding all reportable conditions. Staff Members are required to comply with all current State, Federal, and ECMCC Policies and Procedures with regard to reportable conditions.

Reportable conditions include, but are not limited to:

1. infectious/communicable diseases at the time of clinical diagnosis
2. child abuse, neglect
3. incidents

I.C. Confidentiality

All Staff Members and their respective employees and agents shall maintain the confidentiality, privacy, security, and availability of all Protected Health Information maintained by ECMCC or by business associates of ECMCC, in accordance with any and all health information policies adopted by ECMCC to comply with current federal, state, and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected Health Information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of ECMCC and HIPAA.

I.D. Clinical Service Operations

Each Clinical Service ("Service") may choose to have policies governing the operation of the Service and the conduct of patient care activities in the Service. These policies may include requirements for supervision, as appropriate, of residents, medical students, physicians with limited permits, and allied health professionals. On-call schedule requirements will be Service specific and each service will be responsible for publishing and distributing an on-call schedule. It is the responsibility of each Staff Member to know and comply with the policies of the Service to which he/she is assigned and in which he/she conducts patient care activities.

I.E. Patient Care Responsibilities

1. General Responsibility. The attending Staff Member is responsible for the medical care and treatment of his patient in the Hospital, for the prompt completion and accuracy of the medical

record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician, if any, and to other appropriate persons, subject to all applicable legal requirements regarding the confidentiality of medical information and records.

2. Transfer of Responsibility. If primary responsibility for a patient's care is transferred, a note documenting the transfer of responsibility and acceptance of same must be entered in the patient's medical record. If the patient requests a transfer of care, the attending Staff Member shall cooperate to assure continuity of care.

3. Coverage. With the exception of those services staffed as shift work, each Staff Member must ensure timely, adequate, professional care for his or her patients in the Hospital by being available to provide such care and by designating an appropriately privileged Staff Member ("Coverage") to care for the patient in the absence of the attending Staff Member. If a Covering Staff Member is unavailable or not designated, the President of the Staff, Chief Executive Officer or applicable Chief of Service may assign any qualified Staff Member to provide necessary care to the patient.

4. Timely Visitation after Admission. An attending Staff Member, or Covering Staff Member, must see his patient within twenty-four (24) hours of admission or within such shorter time period as necessitated by the patient's condition.

5. Infection Control. Insofar as it is practicable, the admitting Staff Member shall obtain information from the patient concerning signs or symptoms of recent exposure to communicable or infectious disease. It is the attending Staff Member's responsibility to ensure that any patient with a known or suspected infectious disease is managed in accordance with the ECMCC policies and procedures on infection control.

6. Medical Screen Examinations and Interinstitutional Patient Transfer. Every person who comes to the Erie County Medical Center Corporation (ECMCC) requesting assistance for a potential emergency medical condition/emergency services will be triaged and receive a medical screening performed by a physician, physician assistant, or nurse practitioner to determine whether an emergency medical condition exists. The judgment of the physician, PA or NP will guide what tests, treatments or observation period is appropriate for each individual patient. Persons with emergency conditions will be treated and their condition stabilized without regard to ability to pay for services.

7. Criteria for Notification of Change in Clinical Condition. In the event of an untoward change in clinical condition (including but not limited to cardiac arrest, rapid response, incident with injury) for a patient *with cognitive compromise*, the service attending physician or designee is to notify the responsible third party designated in the medical record of said change in clinical status and corresponding plan of care. If the patient is cognitively intact, there is no need to notify the third party unless so requested by the patient. The service attending physician or designee must place an entry in the medical record documenting the assessment and conversation with the patient, or if applicable, the name of the third party contacted, along with date and time of the notification.

I.F. Consent

A general treatment consent form, signed by each patient or his or her legal representative, must be included in the patient's medical record. Prior to performing specific diagnostic and treatment procedures or services, a Staff Member shall obtain informed consent pursuant to and in compliance with the relevant ECMCC Policy and Procedure. Informed consent must be documented in the patient's medical record.

I.G. Orders

1. Written Orders. All orders for treatment or diagnostic tests must be written accurately, legibly and completely and shall include the date, time, name, title/status (e.g. M.D., D.O., D.D.S., D.P.M., NP, PA, resident, medical student, etc.) and signature of the Staff Member or practitioner responsible for the order.

2. Standing Orders. Standing orders may be developed by the appropriate health care teams, in consultation with Staff Members and other practitioners involved in the care of patients, and approved by the Medical Executive Committee in order to standardize certain procedures in a Service or specialty unit. Standing orders are subject to periodic review by the Medical Executive Committee, as appropriate.

3. Verbal Orders. Telephone or other verbal orders should be used sparingly and shall be accepted only by a registered nurse or pharmacist or such other licensed practitioner as permitted by regulation or law. All verbal/telephone orders shall be transcribed immediately in a medical entry which shall include the date, time, name, title/status (e.g., M.D., D.O., D.D.S., D.P.M., nurse, resident, pharmacist, etc.), read back to the prescribing practitioner and signature of the person transcribing the order and the name of the prescribing practitioner and shall be countersigned **as soon as possible, and within 48 hours.** Verbal/telephone orders shall not be accepted when the prescribing practitioner is present and able to write/enter and sign the order, except in an emergency.

4. Do Not Resuscitate Orders. A do not resuscitate order ("DNR Order") shall be made only in conformance with the applicable ECMCC Policy and Procedure. Staff Members should consult the ECMCC Policy and Procedure Manual to determine the circumstances under which a DNR Order may be written and the documentation required for such an order.

5. Automatic Cancellation of Orders. With the exception of a DNR Order, when a patient undergoes an operative procedure, all previous orders are canceled. Orders must be rewritten after each operative procedure. With respect to DNR Orders, Staff Members should consult the applicable ECMCC Policy and Procedure. Accordingly, Medical Orders for Life sustaining Treatment (MOLST) forms will be completed by appropriate Staff Members in accordance with ECMCC Policy and Procedure (AMD-029).

6. Health Care Declarations. Each Staff Member shall determine whether his patient has executed a living will, advance directive or health care proxy appointing a health care agent or surrogate and shall carefully review any such written declaration and any other relevant evidence of

the patient's wishes with respect to treatment. A copy of any such written declaration shall be placed in the patient's medical record or, if unavailable, appropriate notation shall be made in the patient's medical record. Staff Members should consult the ECMCC Policy and Procedure on Advance Directives (PAT-001) and may request consultation with the Hospital's Ethics Committee and Chief Medical Officer if there is disagreement or uncertainty about a patient's wishes with respect to treatment.

I.H. Consultations

1. Responsibility. The attending Staff Member is primarily responsible for requesting a consultation when indicated or required pursuant to the guidelines herein. If required under these rules, a consultation also may be requested by the appropriate Chief of Service, the Medical/Dental Staff President or the Chief Medical Officer. In an emergency, residents, nurses, and other practitioners involved in the care of the patient may also request a consultation.

2. Criteria. In general, consultation is required in the following cases:

   a) significant questions exist as to the diagnosis or best/optimal treatment or therapy to utilize; or

   b) the necessary treatment falls outside the scope of the attending Staff Member's privileges.

3. Qualifications and Report. A consultant must be qualified to give an opinion in the field in which his or her opinion is sought based upon his or her delineation of privileges. The consultant shall write and sign a report of findings, opinions and recommendations that reflects an actual examination of the patient and the patient's medical record. The consultant's report should be completed and included in the patient's medical record within twenty-four (24) hours of the request for such a consultation. If the report has been dictated, but not recorded in the patient's chart, a brief note must be placed in the chart at the time of the evaluation to that effect and a note summarizing the consultant's findings should be made in the chart within the twenty-four (24) hour time period.

If a consult is requested, STAT, it is expected that the referring service will communicate directly with the consultant service. The consultant is expected respond to the call within 30 (thirty) minutes and make every possible attempt to complete the consult within one hour.

4. 24-Hour Report Exclusion. In limited circumstances where it is impractical or not clinically required to provide the consultative service within 24 hours, the timeframe for the completion of the consult can be at the discretion of the Chief Medical Officer.

I.I. Research and Use of Investigational Drugs

Staff Members who conduct or propose to conduct research on patients or other human subjects, tissue, or medical records, shall comply with the appropriate Institutional Review Board

guidelines and with ECMCC Policy and Procedure for the protection of human subjects. Investigational drugs may be used only in accordance with all pertinent Federal and State regulations and current ECMCC Policy and Procedures.

SECTION II ADMISSION AND DISCHARGE OF PATIENTS

II.A. Non-discrimination

Patients will be admitted without regard to race, creed, color, religion, national origin, sex, sexual orientation, gender identity or expression, physical appearance, source of payment, age, genetic information or disability within the capacity of the Hospital to accommodate.

II.B. Admission of Patients

1. Authority to Admit. Patients may be admitted to the Hospital only by Staff Members or others who have been granted admitting privileges by the ECMCC Board of Directors. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been established and noted in the patient's medical record. In the case of an emergency, such statement shall be recorded as soon as possible after admission.

2. Emergency Admissions. Emergency patients may be admitted upon the request of the attending Staff Member at any time. A patient to be admitted on an emergency basis, who does not have a personal physician or dentist, will be assigned to a designated Staff Member on the appropriate Service.

3. Protection of Patients and Other Persons. Members are responsible for taking such action as may be necessary, and permitted by law, to protect the patient and other persons from a patient who may be a source of danger.

II.C. Discharge of Patients

1. Authorized Patient Discharges.

a). Patients shall be discharged from the Erie County Medical Center only pursuant to a written discharge plan and order, provided that:

(i) the responsible practitioner certifies that, in his or her opinion, such discharge does not create a medical hazard to the patient or that discharge is considered to be in the best interest of the patient despite the potential hazard of movement;

(ii) the patient or, where applicable, the patient's family or representative(s) receives an explanation for the discharge;

(iii) the written discharge plan or order is reasonably expected to meet the patient's post-hospital care needs;

(iv) the practitioner has arranged for or determined that such continuing care service, if any, are reasonably available to the patient; and

(v) the transferee medical or special care facility expected to receive the patient is given prior notification of the discharge and transfer (if applicable).

b). A definitive discharge ("final") diagnosis shall be prepared, signed, and entered on the patient's medical record by the responsible practitioner at or before the time of discharge.

2. Unauthorized Patient Discharges.

An unauthorized patient discharge occurs when a patient is not discharged pursuant to a written discharge plan and order, or in accordance with the policies and procedures st forth above. In the event of an unauthorized patient discharge, the responsible practitioner shall obtain, where practicable, a written release from the patient absolving Erie County Medical Center Corporation and the responsible practitioner of liability and damages arising out of or relating to such unauthorized discharge.

II.D. Transfer of Patients to Other Facilities

The transfer of a patient to another facility shall be accomplished in accordance with the provisions of the ECMCC Policy and Procedure on patient transfers and the applicable provisions of Federal and State law. A patient shall be transferred to another medical care facility only upon the order of the attending Staff Member and only after the patient is considered sufficiently stabilized for transfer, after reasonable steps have been taken to secure the patient's written informed consent, and after arrangements have been made with the other facility, including communication between the Staff Member and the receiving physician and consent by the receiving physician and facility to accept the patient. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

II.E. Leaving Against Medical Advice

If a patient desires to leave the Hospital against the advice of the attending Staff Member or without proper discharge or transfer instructions, the patient will be requested to sign an appropriate release attested by the patient or legal representative and witnessed by a third party. A notation of the incident must be made in the patient's medical record including documentation of the advice given and the refusal to comply.

SECTION III DEATHS AND AUTOPSIES

III.A. Pronouncement and Reporting of Deaths

In the event of the death of a patient in the Hospital, the patient shall be pronounced dead within a reasonable period of time by the attending Staff Member or an appropriately privileged provider acting on his behalf or, in the case of brain death, by a physician with privileges to determine brain death. If necessary, the death shall be reported to the Medical Examiner. A death certificate must be signed by the attending Staff Member, or an appropriately privileged and licensed physician, nurse practitioner, or physician assistant acting on his behalf, except in those cases where such a certificate is issued by the Medical Examiner. A death certificate must be promptly signed in accordance with the legal requirement that such certificate must be filed with the appropriate governmental authority within 72 hours of death. A body may not be released from the Hospital until an entry verifying death has been made in the medical record of the deceased patient and signed by a Staff Member or his appropriately privileged designee.

III.B. Autopsies

It is the responsibility of every Staff Member to attempt to secure permission for autopsies in all cases of unusual death or where an autopsy would be of medical or educational value. Proper consent for an autopsy shall be obtained and documented in accordance with New York State law.

III.C. Organs and Tissue Donation

ECMCC has a legal obligation to notify a federally designated Organ Procurement Organization of all imminent or actual deaths in the Hospital. It is the responsibility of every Staff Member to consult and comply with the provisions of the ECMCC Policy and Procedure on organ and tissue donations.

SECTION IV MEDICAL RECORDS

IV.A. Responsibility/General Content

The attending Staff Member is responsible for the prompt preparation of a complete, accurate and legible medical record for each patient. The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify admission and continued hospitalization and treatment, describe the patient's progress and response to medications and services, and promote continuity of care among health care providers. All medical record entries must be dated, timed and authenticated by their authors. The author of each entry shall be identified by name and status/title (e.g. M.D., D.O., D.D.S., D.P.M., NP, PA, resident, medical student, etc.)

IV.B. Symbols and Abbreviations

Symbols and abbreviations may be used in a medical record only when they have been approved by the Medical Executive Committee.

IV.C. Documentation

1. History and Physical Examination. Every patient shall have a complete history taken and physical examination performed by a qualified practitioner within thirty (30) days before or within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical records within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An attending Staff Member is responsible for reviewing and countersigning a history and physical examination recorded in the patient's medical record by another practitioner. If the history and physical examination findings have been dictated but are not yet available in the chart, a statement to that effect and a note summarizing the pertinent facts and findings, provisional diagnosis and treatment plan must be made in the chart within twenty-four (24) hours following admission.

An updated examination of the patient is to be performed including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient's medical records within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. If the findings of a history and physical examination performed no more than thirty (30) days before admission accurately reflect the patient's condition at admission, such prior history and physical examination may be utilized for that admission so long as a copy of such prior history and physical examination is immediately placed in the patient's chart and an update or a note which confirms that the patient has been examined, and the information is current and accurate is made in the chart within 24 hours by the attending Staff Member.

For detail regarding minimum requirements for the content of the Hx and Px, please refer to the following policy and procedure: "Hybrid Medical Record Requirements", HIM -030.

2. Progress Notes. Progress notes shall be written at least daily on acute care patients and at a frequency as required by law for other patients. Progress notes shall be recorded at the time of observation in a manner sufficient to facilitate the quality of performance in delivery of patient care. Clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

3. Pre-Operative Notes/Operative Reports. The medical record will thoroughly document all operative and other procedures and the use of anesthesia. A pre-operative diagnosis will be recorded prior to surgery by the attending Staff Member responsible for the patient. Operative reports shall be dictated or written immediately (or no later than twenty-four [24] hours) after surgery and shall record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed and postoperative diagnosis. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. In case of an emergency, when the operative report is not placed in the medical record immediately after surgery, a progress note must be entered immediately.

4. Post-Operative Documentation. Postoperative documentation shall include the patient's vital signs, level of consciousness, medications (including intravenous fluids), blood, and blood components, any unusual events or postoperative complications, and management of such events.

5. Entries at Conclusion of Hospitalization. A discharge clinical summary shall be dictated on all medical records of patients hospitalized over twenty-four (24) hours except for certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Executive Committee of the Medical Staff, and for these, a final summation type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be properly authenticated by the responsible practitioner and shall contain a final diagnosis, final disposition, condition at discharge and instructions for follow up care. House Staff, including interns and Fourth Year Medical Students, may dictate the discharge summary, but it is the responsibility of the attending physician to complete the medical record within thirty (30) days following the date of discharge.

6. Delinquent Records. Physicians who have been continuously on the medical records delinquent list for more than three (3) months with more than twenty (20) delinquent charts or physicians that have been on the delinquent list continuously for more than twelve (12) months will be contacted in writing by the CMO Office. This first communication will indicate that all charts must be completed within fourteen (14) days so that the physician may be removed from the delinquent list. Should the physician not meet this requirement, the CMO Office and President of the Medical-Dental Staff will issue a second and final written communication via courier or overnight express carrier. This final communication will notify the physician that if the records are not completed by a certain date (at least fourteen (14) days from the date of the letter), the matter will be referred to the Leadership Council for consideration in accordance with the Medical/Dental Staff's Professionalism Policy.

Failure to complete operative reports in a timely fashion may be subject to an administrative timeout, whereby the CMO may instruct the OR to hold scheduling of elective procedures until all outstanding reports have been completed.

In addition, applications for renewal of Medical/Dental Staff membership may not be processed from individuals who, at the time of submission of their application, have not yet remediated the outstanding medical records or operative reports that are the subject of a second and final communication from the CMO Office.

IV.D. Ambulatory Care Services

For patients receiving continuing ambulatory care services, the medical record must contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications with this list being initiated for each patient and maintained thereafter.

IV.E. Access to Records

All medical records are the property of ECMCC. Access to such records shall be in accordance with ECMCC Policy and Procedure which shall reflect the requirements of applicable State and Federal statutes and regulations.

IV.F. Non-Compliance

Failure to maintain appropriate medical records will subject the responsible Staff Member to possible disciplinary action according to the ECMCC Bylaws.

SECTION V. SUPERVISION

V.A. Medical/Dental Students

Medical/Dental students may take patient histories, perform complete physical examinations and enter findings in the medical record of the patient with the approval of the patient's attending Staff Member. All medical/dental student entries in the medical record must be countersigned within twenty-four (24) hours by an appropriately privileged Staff Member.

Student privileges shall be limited to those delineated and conferred by the University designee, under the auspices of the School of Medicine and Biomedical Sciences or School of Dental Medicine, State University of New York at Buffalo. The patient shall be informed that the individual performing a procedure is a student in all such cases. All Medical/Dental student activity must conform to applicable ECMCC Policies and Procedures.

V.B. Residents

Residents will function under the supervision of a Staff Member. Decisions in regard to patient care management will be under the supervision of the attending Staff Member. Overall coordination of resident activity will be provided by the residency program director or designee. Participation of residents will be in conformance with the policies and regulations of the Graduate Medical/Dental Education Committee of Buffalo, the Erie County Medical Center, and all relevant regulatory agencies.

Documentation of attending Staff Member supervision of the patient care provided by residents must include as a minimum:

Co-signature by the attending Staff Member of the resident's History and Physical in the medical record, and

a) a note in the medical record by the attending Staff Member; or

b) a note in the medical record by the resident documenting discussion of the care with the attending Staff Member;

c) Any resident may write patient care orders under the general supervision of the attending Staff Member.

V.C. Physicians on Limited Permit

Physicians on limited permit will be restricted by site as designated by New York State and listed on their permit. Physicians on limited permit will be restricted to those privileges granted by ECMCC. The Medical/Dental Staff shall continuously monitor patient care services rendered by unlicensed physicians granted limited hospital privileges and take appropriate disciplinary action or other corrective measures against the individual, the attending or supervising physician, or both, when services provided exceed the scope of privileges granted.

V.D. Other Students

Staff Members may be requested to participate and provide supervision to students in health related professions. All such student activity must comply with applicable ECMCC Policies and Procedures.

Adopted by the Medical/Dental Staff:

By:
Medical/Dental Staff President – Jennifer Pugh, MD Date: 1/25/2023

Approved by the Board of Directors:

Chief Executive Officer, Date: 1/25/2023
Erie County Medical Center Corporation
Thomas Quatroche, PhD

Revisions:
Medical Executive Committee: 11/22/2021
Board of Directors Committee: 11/23/2021

Medical Executive Committee: October 24, 2022
Annual Meeting of the Medical Staff: November 17, 2022
ECMCC Board of Directors: January 25, 2023

Rules and Regulations

Part II

ERIE COUNTY MEDICAL CENTER CORPORATION
BUFFALO, NEW YORK

MEDICAL/DENTAL STAFF
RULES & REGULATIONS
PART II
MEDICAL/DENTAL STAFF ORGANIZATION

DEPARTMENTS AND COMMITTEES

MEDICAL/DENTAL STAFF RULES AND REGULATIONS
Part II

ERIE COUNTY MEDICAL CENTER CORPORATION

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PART II

SECTION I: MEDICAL/DENTAL STAFF DEPARTMENTS

Per the Medical/Dental Staff Bylaws, Article V, the Medical/Dental Staff of the Erie County Medical Center Corporation is a departmentalized Medical/Dental staff. Future departments may be created, or current departments eliminated or consolidated by recommendation of the Medical Executive Committee with the approval of the Board of Directors.

Current Medical/Dental Staff Departments include:

1) Department of Anesthesiology
2) Department of Dentistry
3) Department of Dermatology
4) Department of Emergency Medicine
5) Department of Family Medicine
6) Department of Internal Medicine
7) Department of Laboratory Medicine
8) Department of Neurology
9) Department of Neurosurgery
10) Department of Obstetrics and Gynecology
11) Department of Ophthalmology
12) Department of Oral & Maxillo-Facial Surgery
13) Department of Orthopaedic Surgery
14) Department of Otolaryngology
15) Department of Pathology
16) Department of Plastic and Reconstructive Surgery
17) Department of Psychiatry
18) Department of Radiology/Imaging Services
19) Department of Rehabilitation Medicine
20) Department of Surgery
21) Department of Thoracic/Cardiovascular Surgery
22) Department of Urology

SECTION II – MEDICAL/DENTAL STAFF COMMITTEES

Per Article VII of the Medical/Dental Staff Bylaws: There shall be such standing and special committees of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff. All committees listed below, whether standing or special, shall be responsible to the Medical Executive Committee of the Medical/Dental Staff and shall submit reports as designated by the Medical Executive Committee.

- II-1 Bylaws Committee
- II-2 Credentials Committee
- II-3 Nominating Committee
- II-4 Professional Development and Wellness Committee
- II-5 Quality Improvement Committee
- II-6 Resource Utilization Committee
- II-7 Cancer Committee
- II-8 Quality Executive Committee
- II-9 Medical/Dental Staff Leadership Council

II-1. BYLAWS COMMITTEE

A) PURPOSE: The purpose of the Bylaws Committee is to periodically review, revise and maintain the Medical/Dental Staff Bylaws, Rules and Regulations, Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Procedures and other such Medical/Dental Staff documents as assigned by the Medical Executive Committee.

B) COMPLIANCE: The Medical/Dental Staff is charged with the responsibility to maintain a set of Bylaws and related manuals by the Centers for Medicare and Medicaid and the Joint Commission. The responsibility for oversight is assigned by the Medical Executive Committee to the Bylaws Committee.

C) REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION

1) **Joint Commission** Current Accreditation Manual for Hospitals, Medical Staff Standards

2) **CMS, Conditions of Participation for Hospitals**: 42 CFR 482.22

3) **Applicable New York State laws and regulations**

D) MEMBERSHIP

1) **APPOINTMENT**: Members and chair are appointed by the Medical/Dental Staff President and approved by the Medical Executive Committee. Medical Center/administrative representatives are appointed by the Chief Executive Officer or his designee.

2) **COMPOSITION:** In addition to the chair, membership will include:
   - Three (3) members of the Medical/Dental Staff, with vote;(may be members of the Medical/Dental Staff Leadership Council or designees);
   - Chief Medical Officer, ex-officio, without vote;
   - Director, Medical Dental Staff Services, ex-officio, without vote;
   - Medical Center Legal Counsel, as needed; without vote.

3) **TERM LIMITS:** Committee members will serve for an initial two (2) year term and may be reappointed for additional terms without limit. No more than fifty (50%) percent of the members will rotate off on any one year to ensure consistency in process.

4) **VACANCY:** Vacancies will be filled in the same manner as original appointment is made.

E) RESPONSIBILITIES

1) Review (at least every 3 years) and maintain the Medical/Dental Staff Bylaws, and related documents upon written request of the Medical Executive Committee, Credentials Committee, or any member of the Active Staff.

2) Recommend revisions to all documents, as appropriate and necessary, to the Medical Executive Committee.

3) Maintain current knowledge of federal and state laws, guidelines and regulations and appropriate accrediting agency requirements as they relate to the Medical/Dental Staff documents or avail themselves of the necessary resources.

F) MEETINGS

1) **FREQUENCY:** The Bylaws Committee will meet as often as necessary to fulfill its responsibilities.

2) **ATTENDANCE**: Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** Those members present and eligible to vote, including at least two (2) Medical Staff members.

4) **SUPPORT:** Administrative support will be provided by the Medical/Dental Staff Office.

5) **AGENDA and MINUTES:** Medical/Dental Staff Office personnel and the chair will be responsible for the development of meeting agendas and for maintaining minutes where applicable.

6) **REPORTING RELATIONSHIP:** The Bylaws Committee reports to the Medical Executive Committee via report of proceedings presented for adoption.

G) CONFIDENTIALITY

All members of the Bylaws Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

II-2. CREDENTIALS COMMITTEE

A) PURPOSE: The purpose of the Credentials Committee is to receive, review and analyze the credentials for all applicants to the Medical/Dental staff or licensed independent practitioners or health professionals who are requesting Medical/Dental staff membership and/or privileges at Erie County Medical Center Corporation.

B) COMPLIANCE: The Medical/Dental Staff is charged with the responsibility to review the credentials of all Staff members and/or individuals requesting privileges and assess their ongoing competence, including focused professional practice evaluation required by the Centers for Medicare and Medicaid and the Joint Commission. The responsibility for oversight is assigned by the Medical Executive Committee to the Credentials Committee.

C) REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION

1) **Joint Commission,** Current Accreditation Manual for Hospitals, Medical Staff Standards
2) **CMS, Conditions for Participation for Hospitals**: 42 CFR 482.22
3) New York Codes, Rules and Regulations, Volume C (Title 10) Part 405.4

D) MEMBERSHIP

1) **APPOINTMENT**: Members and chair are appointed by the Medical/Dental Staff President and approved by the Medical Executive Committee. Medical Center administrative representatives are appointed by the Chief Executive Officer or his designee.

2) **COMPOSITION:** The President of the Medical/Dental Staff shall appoint the chair. Membership will include:
   - At least five (5) members of the Active Staff all of whom shall not be University department chairs, with vote
   - Two (2) members of the Allied Health Professional Staff, with vote
   - Chief Medical Officer, ex-officio, without vote
   - Director, Medical Dental Staff Services, ex-officio, without vote
   - Medical Center Legal Counsel, as needed, ex officio, without vote

   Members of the Credentials Committee shall have served at least two (2) years on the Active Staff and have expressed interest and/or experience in the function of the committee and have served in some other Medical/Dental Staff leadership activity. All new members will be provided an orientation to the roles and responsibilities of the committee and will also be provided an opportunity for medical staff leadership training. Representatives may be re-appointed for additional terms without limit.

3) **TERM LIMITS:** Committee members will serve for an initial two (2) year term and may be reappointed for additional terms without limit. No more than fifty (50%) percent of the members will rotate off on any one year to ensure consistency in process.

4) **VACANCY:** Vacancies will be filled in the same manner as original appointment is made.

E) RESPONSIBILITIES

1) To receive and analyze applications and recommendations for initial appointment, reappointment, provisional period conclusion or extension, return from leave of absence, clinical privileges and changes therein and recommending action to the Medical Executive Committee;

2) To review and recommend qualifications and criteria for granting clinical privileges;

3) To investigate, review and report on matters referred by the Medical/Dental Staff President or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any licensed independent practitioner, applicant or Medical/Dental Staff member;

4) To develop, recommend, maintain and consistently implement contemporary policies and procedures for all credentialing activities at the Medical Center by recommending standards for the content and organization of the credentials files including periodically reviewing and revising the Credentials Procedures Manual.

F) **MEETINGS**

1) **FREQUENCY:** The Credentials Committee will meet as often as necessary to fulfill its responsibilities, at a minimum at least ten (10) times a year.

2) **ATTENDANCE**: Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** Those members present and eligible to vote, including at least two (2) Medical Staff members.

4) **SUPPORT:** Administrative support will be provided by the Medical/Dental Staff Office.

5) **AGENDA and MINUTES:** The Medical/Dental Staff Office personnel and the chair will be responsible for the development of meeting agendas one (1) week prior to scheduled meetings, taking and maintaining minutes. Minutes will be maintained in the Medical/Dental Staff Office.

6) **REPORTING RELATIONSHIP:** The Credentials Committee reports to the Medical Executive Committee via minutes of proceedings presented for adoption.

G) **CONFIDENTIALITY**
All members of the Credentials Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee. Credentials Committee shall be considered a peer review committee under New York Education Law §6527.

II-3. NOMINATING COMMITTEE

A) **PURPOSE:** The Nominating Committee provides qualified candidates to be placed on the ballot for election to Medical/Dental Staff leadership positions.

B) **COMPLIANCE & REGULATORY /ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION:** This committee function is not required by any regulatory, licensing or accreditation standards, however both the Joint Commission and Centers for Medicare and Medicaid require a structured, organized medical staff and this committee helps support the maintenance of the Medical/Dental Staff organization.

C) **MEMBERSHIP**

1) **APPOINTMENT:** Members and chair are appointed by the Medical/Dental Staff President and approved by the Medical Executive Committee; Medical Center administrative representatives are appointed by the Chief Executive Officer or his designee.

2) **COMPOSITION:** The Nominating Committee shall be composed of the current members of the Medical/Dental Staff Leadership Council.

3) **TERM LIMITS:** Committee members will serve in accordance with the term of the elected office. No more than fifty (50%) percent of the members will rotate off on any one year to ensure consistency in process.

4) **VACANCY:** Vacancies will be filled in the same manner as original appointment is made.

D) RESPONSIBILITIES

1) The Nominating Committee shall identify one or more qualified nominees for the vacant Medical/Dental Staff officer positions and for the at-large members of the Medical Executive Committee.

2) The Nominating Committee shall be responsible for contacting the prospective nominees to ensure their interest and ability to perform the required responsibilities of each position. The committee shall discuss the proposed positions and the responsibilities involved, as well as the training, orientation and administrative support that will be provided to the officers, to ensure that prospective nominees understand the roles and responsibilities of the positions for which they are being nominated.

3) The Nominating Committee will present a slate of nominees for officers of the Medical/Dental Staff and at–large members to the Medical Executive Committee, prior to the Annual Medical/Dental Staff meeting at which the election will take place.

4) The Nominating Committee shall also submit nominees for any positions in which vacancies occur.

E) MEETINGS

1) **FREQUENCY:** The Nominating Committee will meet as often as necessary to fulfill its responsibilities.

2) **ATTENDANCE:** Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** Those members present and eligible to vote, including at least two (2) Medical/Dental Staff members.

4) **SUPPORT:** The Medical/Dental Staff Office personnel shall provide administrative support.

5) **AGENDA and MINUTES:** Personnel from the Medical/Dental Staff Office and the Chair of the committee will be responsible for the development of meeting agendas, notices and maintenance of minutes/reports.

6) **REPORTING RELATIONSHIP:** The Nominating Committee reports to the Medical Executive Committee via the Medical/Dental Staff Secretary and President.

F) CONFIDENTIALITY

All members of the Nominating Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

II-4. PROFESSIONAL DEVELOPMENT AND WELLNESS COMMITTEE

A) **PURPOSE**: The purpose of the Professional Development and Wellness Committee is to foster professional growth and leadership development, provide collegial support to allow providers to practice at the top of their scope and promote the physical, mental and emotional wellness of all members of the Medical/Dental Staff.

B) **COMPLIANCE:** Although a committee function is not required by regulatory, licensing or accreditation standards, the oversight of the process is assigned by the Medical Executive Committee to the Professional Development and Wellness Committee.

C) **REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION**

Joint Commission Current Accreditation Manual for Hospitals, Medical Staff Standards

D) **MEMBERSHIP**

1) **APPOINTMENT:** Physician/Allied Health Professional members and chair are appointed by the Medical/Dental Staff President and approved by the Medical Executive Committee; Medical Center administrative representatives are appointed by the Chief Executive Officer or designee.

2) **COMPOSITION:** In addition to the chair, membership will include:

- No fewer than three (3) members of the Active Staff, with vote
- At least two (2) members of the Allied Health Professional Staff
- Insofar as possible, members of this committee should not be current Medical/Dental Staff leaders who would have to get involved in a disciplinary situation; and should have some experience in dealing with impairment issues.
- Consultant/additional members may be asked to join the group as needed for their expertise concerning a particular issue or problem.

3) **TERM LIMITS:** Committee members will serve for an initial two (2) year term and may be reappointed for additional terms without limit. No more than fifty (50%) percent of the members will rotate off on any one year to ensure consistency in process.

4) **VACANCY:** Vacancies will be filled in the same manner as original appointment is made.

E) **RESPONSIBILITIES:** The duties of the Professional Development and Wellness Committee shall include:

1) Serve as content leaders on the topics of professional development and wellness, with an emphasis on Efficiency of Practice, Personal Resilience and a Culture of Wellness and their impact on Professional Fulfillment.

2) Be accessible to members of the medical-dental staff for collegial support and to inspire leadership development.

3) Ongoing engagement with the organized medical staff for feedback as to how the committee can best support its needs.

4) Recommend to the Medical Executive Committee educational programs and resources that promote the purpose of the committee and support the staff.

5) Partner with the hospital Administration and Board of Directors to proactively address practitioner issues to ensure timely intervention and successful outcomes.

6) Create an infrastructure that protects patients, staff and practitioners by establishing a process where information and concerns about potentially impaired (physical, mental or emotional) practitioners, including issues related to behavior as described in the Professionalism Policy and/or Provider Health and Wellness Policy, may be presented for consideration. This process must facilitate rehabilitation rather than discipline and provide education about licensed independent practitioner health, addressing prevention, facilitating confidential diagnosis, treatment and rehabilitation and

   Activities supporting the aforementioned infrastructure:

   - Education of the Medical/Dental Staff and other Medical Center personnel about illness and impairment recognition issues specific to physicians and other health care professionals;
   - An identified process for self-referral by a practitioner and referral by other Medical Center personnel;
   - Confidentiality for informants;
   - Referral of the affected practitioner to the appropriate professional internal or external resources for the diagnosis and treatment of the condition or concerns;
   - Maintenance of the confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened;
   - Evaluation of the credibility of a complaint, allegation or concern;
   - Monitoring of the affected practitioner and the safety of patients until the rehabilitation, treatment or any disciplinary process is complete and periodically thereafter; and
   - Reporting to the Medical/Dental Staff leadership instances in which a practitioner is providing unsafe treatment or failed to complete the required rehabilitation program.

5) Consider general matters related to the health and well-being of the Medical/Dental Staff and licensed independent practitioners applying for or granted privileges at the Medical Center and make recommendations to the Credentials Committee and Medical Executive Committee, the CEO and the Board of Directors where appropriate.

F) MEETINGS AND MINUTES

1) **FREQUENCY**: The Professional Development and Wellness Committee shall meet on an as needed basis or as often as necessary to fulfill its functions and responsibilities. Confidential documentation shall be maintained.

2) **ATTENDANCE:** Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** Those members present and eligible to vote, including at least two (2) Active Staff members.

4) **SUPPORT**: Administrative support will be provided by the personnel in the Medical-Dental Staff Office.

5) **AGENDA and MINUTES:** Personnel from the Medical-Dental Staff Office and the Chair shall be responsible for the development of meeting agendas prior to scheduled meetings, maintenance of minutes/reports.

6) **REPORTING RELATIONSHIP:** The Professional Development and Wellness Committee shall report to the Medical Executive Committee.

G) CONFIDENTIALITY

Pursuant to N.Y. Educ. Law, §6527 the information and records of this committee as related to peer review activities are designated as "proceedings, reports and records of a medical peer review committee."

All members of the Professional Development and Wellness Committee will, consistent with the Medical-Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

Pursuant to Article XI, § 11.1* The following change to the Rules & Regulations governing the Chiefs of Service (Medical/Dental Staff Quality Improvement Committee) is for your consideration:

II-5. MEDICAL/DENTAL STAFF QUALITY IMPROVEMENT COMMITTEE

A) PURPOSE: The purpose of the Quality Improvement Committee is to assure appropriate organization and presentation of medical staff quality and performance information and data to the MEC.

B) REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION

The Quality Improvement Committee assures reporting of activities required by:

1) **Joint Commission:** Current accreditation manual for hospitals, Medical Staff, Leadership and Improving Organizational Performance Standards
2) **CMS Conditions of Participation for Hospitals** 42CFR482.21 (Quality Assurance)

C) **MEMBERSHIP**

1) **APPOINTMENT**: Members and chair are appointed by the Medical/Dental Staff President with approval of the Medical Executive Committee. The Chief Medical Officer, whose responsibilities include the oversight of quality improvement serves as the chair, though this duty may be delegated to his designee.

2) **COMPOSITION**:
- Chief Medical Officer (or designee), Chair
- Medical-Dental Staff members of the Medical Executive Committee
- Members of the Medical-Dental Staff (in good standing) who fill leadership roles with an impact on Quality Improvement, on the recommendation of the Chair, appointed as above.

D) **RESPONSIBILITIES**

The responsibilities of the Quality Improvement Committee include:

1) Review information and reports from the Medical/Dental staff Quality Peer Review Committees, the Patient Safety Office, Risk Management, Board Performance Improvement and other QA/PI committees and teams.

2) Identify reports and information to be included on the MEC agenda, assure appropriate and complete report format, and assign accountability for presentation to the MEC.

3) Identify information to be included on the ECMC Quality dashboard and affiliated documents and assign accountability for presentation to the MEC.

4) Ensure compliance with regulatory and accreditation requirements, providing leadership to assure compliance with appropriate Medical/Dental Staff standards.

E) **MEETINGS**

1) **FREQUENCY:** The Quality Improvement Committee will meet no less than as part of the confidential portion of each MEC meeting.

2) **ATTENDANCE:** Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** A quorum is not required for this committee as membership is not responsible for decisions requiring a vote.

4) **SUPPORT**: Administrative input and support will be provided by the Department of Patient Safety and Quality Office and the CMO Office.

5) **AGENDA and MINUTES**: The Chief Medical Officer, working with the Patient Safety and Quality Office, shall be responsible for the development of meeting agendas prior to scheduled meetings and maintenance of minutes.

7) **REPORTING RELATIONSHIP**: The Quality Improvement Committee reports to the Medical Executive Committee.

F) CONFIDENTIALITY

Pursuant to N.Y. Educ. Law, §6527 the information and records of this committee as related to peer review activities are designated as "proceedings, reports and records of a medical peer review committee."

All members of the Quality Improvement Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

11.1 STAFF RULES AND REGULATIONS AND/OR POLICIES AND PROCEDURES
The Medical/Dental Staff shall adopt such policies, procedures, rules and regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws and other related current Medical/Dental Staff documents. The policies, procedures, rules and regulations shall be related to the proper conduct of Medical/Dental Staff organizational activities and will embody the specific standards and level of practice that are required of each Medical/Dental Staff member and other designated individuals who exercise clinical privileges or provide designated patient care services at the Medical Center. Such rules and regulations may be amended or repealed upon recommendation of the Medical Executive Committee and approval by the Board of Directors.

Medical/Dental Staff policies may also be adopted, amended or repealed upon recommendation of the Medical Executive Committee with final approval by the Board.

II-6. RESOURCE UTILIZATION COMMITTEE

A) PURPOSE: The Resource Utilization Committee is established as a standing committee of the Medical/Dental Staff. The Resource Utilization Review Plan is developed by the Committee and is incorporated into the Medical Staff Rules and Regulations following approval by the Medical Executive Committee and the Board of Directors.

B) REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION

The Resource Utilization Committee assures the reporting of activities required by:

1) CMS Conditions of Participation for Hospitals

C) MEMBERSHIP

1) **APPOINTMENT:** Members and chair are appointed by the Medical/Dental Staff President with approval of the Medical Executive Committee.

2) **COMPOSITION:** In addition to the chair, membership will include:
- Members of the Active Medical Staff, with vote
- Quality Information Personnel, as staff, without vote

3) **TERM LIMITS:** Committee members will serve for an initial two (2) year term and may be reappointed for additional terms without limit. No more than fifty (50%) percent of the members will rotate off on any one year to ensure consistency in process.

4) **VACANCY:** Vacancies will be filled in the same manner as original appointment is made.

D) RESPONSIBILITIES

The responsibilities of the Resource Utilization Committee include:

1) Report review findings and recommendations to the Medical Executive Committee, COO, CMO, and Senior Vice President of Nursing.

2) Review third-party payor denials, make recommendations and/or take appropriate actions.

3) Collect and analyze data necessary to carry out its responsibilities.

4) Analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution and/or refer to appropriate entities for resolution.

E) MEETINGS

1) **FREQUENCY:** The Resource Utilization Committee will meet as often as necessary to fulfill its responsibilities

2) **ATTENDANCE:** Committee members are expected to attend as many of the meetings as possible. The chair is responsible for ensuring that all members fulfill their committee obligations.

3) **QUORUM:** A quorum is not required for this committee as membership is not responsible for decisions requiring a vote.

4) **SUPPORT**: Administrative support will be provided by the Utilization Review Department.

5) **AGENDA and MINUTES**: The Resource Utilization Professional and the Chair shall be responsible for the development of meeting agendas prior to scheduled meetings, taking and maintenance of minutes.

6) **REPORTING RELATIONSHIP**: The Resource Utilization Committee reports to the Medical Executive Committee.

F) CONFIDENTIALITY

Pursuant to N.Y. Educ. Law, §6527 the information and records of this committee as related to peer review activities are designated as “proceedings, reports and records of a medical peer review committee.”

All members of the Resource Utilization Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

II-7. CANCER COMMITTEE

A. **PURPOSE:** The purpose of the Cancer Committee is to provide governance over the Cancer Program in totality, ensuring a multi-disciplinary effort to provide quality-driven, comprehensive, medical, surgical and radiation oncology services.

B. COMPLIANCE: The Cancer Committee is charged with meeting all standards to achieve and maintain American College of Surgeons Commission on Cancer Accreditation in

addition to ensuring regulatory compliance with all ECMCC accrediting bodies as it pertains to the provision of cancer care.

C. **REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION**:

1. **Joint Commission** Current Accreditation Manual for Hospitals, Medical Staff Standards
2. **CMS, Conditions of Participation for Hospitals: 42 CFR 482.22**
3. **Applicable New York State laws and regulations**
4. **American College of Surgeons Commission on Cancer**

D. **MEMBERSHIP**

1. **APPOINTMENT:** Members, Chair and Cancer Liaison Physician are appointed by the Medical/Dental Staff President upon recommendation of the current Committee or a sub-committee representative of the Medical Staff and ECMC Administration committed to the Commission on Cancer Program. The appointments will be approved by the Medical Executive Committee. Medical Center/administrative representatives are appointed by the Chief Executive Officer or his designee. Appointments for required members must occur at the first meeting of a calendar year and be documented in the cancer committee minutes.
2. **COMPOSITION:** In addition to the Chair and the Cancer Liaison Physician multi-disciplinary membership will include:
   - **a.** At least one board certified/eligible (or equivalent) physician from diagnostic and treatment specialties including, but not limited to surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology.
   - **b.** Non-physician administrative and ancillary services members including, but not limited to Cancer Program Administrator, Clinical Research Manager, oncology nurse, social services, quality and patient safety, Certified Tumor Registrar
   - **c.** Required Coordinator roles will be defined by the most recent Commission on Cancer standards and may include:
     - **i.** Cancer Registrar
     - **ii.** Quality & Patient Safety
     - **iii.** Psychosocial Services
     - **iv.** Clinical Research
     - **v.** Multidisciplinary Tumor Board
     - **vi.** Survivorship Program Director
     - **vii.** Prevention and Screening

   Additional Members may be appointed upon assessment of need by the Committee. Ad hoc committee members may include a palliative care professional, a genetics professional, a pharmacist, a pastoral care representative, an American Cancer Society representative, a rehabilitation services professional, a nutritional services professional.
3. **TERM LIMITS:** Committee members will serve for a one (1) year term and may be reappointed for additional terms without limit. No more than fifty (50%) of the members will rotate off on any one year to ensure consistency in process.
4. **VACANCY:** Vacancies will be filled in the same manner as original appointment is made. If a required member cannot continue to serve, a new member must be appointed at the next meeting and documented in the meeting minutes of the next Cancer Committee meeting.

E. **RESPONSIBILITIES:**

1. The multi-disciplinary Committee establishes program goals, plans, initiates, implements and monitors program activity and evaluates patient outcomes.

2. Each year, the Cancer Committee establishes, implements and monitors all Commission on Cancer standards to achieve and/or maintain CoC accreditation status.

3. Ensures eligibility requirements by:
- **a.** Monitoring, assessing and identifying changes needed yearly
- **b.** Delegates responsibilities (involving appointed coordinators in the process) to CoC workgroups or subcommittees and monitors progress and outcomes.
- **c.** Reviews and documents the assessment of all eligibility requirements in the Committee Minutes annually

F. **MEETINGS**

1. **FREQUENCY:** The Cancer Committee meets as often as necessary to fulfill its responsibilities, but not less than once each calendar quarter.

2. **ATTENDANCE**: Committee members are expected to attend as many of the meetings as possible. Committee members or their appointed designee (may be another committee member) must attend no less than 75% of the scheduled meetings per year.

3. **QUORUM:** Fifty (50) percent of the members present who are required members of the Committee.

4. **SUPPORT**:

5. **AGENDA and MINUTES:** All Cancer Committee meetings are expected to have an agenda. Cancer Committee minutes are to be reviewed and approved in the subsequent Cancer Committee meeting, prior to reporting to the Medical Executive Committee.

6. **REPORTING RELATIONSHIP:** The Cancer Committee reports to the Medical Executive Committee via minutes of the proceedings presented for adoption.

G. CONFIDENTIALITY

All members of the Cancer Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

II-8. QUALITY EXECUTIVE COMMITTEE

A. **PURPOSE:** The purpose of the Quality Executive Committee is to operationalize, facilitate and oversee the Medical and Dental Staff's performance improvement function as defined by the Erie County Medical Center Corporation Medical Dental Staff Bylaws.

B. **COMPLIANCE:** The Quality Executive Committee is charged with meeting all regulatory requirements for assuring the Medical Dental Staff evaluates the quality of care provided by its members and identifies opportunities to improve the delivery of care.

C. **REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION**:

1. **Joint Commission** Current Accreditation Manual for Hospitals, Medical Staff Standards

2. **CMS, Conditions of Participation for Hospitals: 42 CFR 482.22**

3. **Applicable New York State laws and regulations**

D. **MEMBERSHIP**

1. **APPOINTMENT:** Members are appointed by the Medical/Dental Staff President upon recommendation of the current Chiefs of Service. The appointments will be approved by the Medical Executive Committee and the Board of Directors. Medical Center/administrative representatives are appointed by the Chief Executive Officer or his designee.

2. **COMPOSITION:**
- **a.** Chair: It is recommended that the Chair of this Committee be the Immediate Past President of the Medical Staff. If that is not possible, the Chair may be

appointed by the President of the Medical/Dental Staff and approved by the Medical Executive Committee and the Board.

b. Members should include representatives with diverse clinical expertise including, **but not limited to**:

- **i.** Surgical Specialties; Recommended a minimum of 2 representatives
- **ii.** Medical Specialties; Recommended a minimum of 2 representatives
- **iii.** Anesthesia Services; Recommended a minimum of 1 representative
- **iv.** Radiology Services; Recommended a minimum of 1 representative
- **v.** Behavioral Health Specialties; Recommended a minimum of 1 representative.
- **vi.** Allied Health Professionals; Recommended a minimum of 1 representative

c. Non-physician administrative and ancillary services members including, but not limited to the Practice Improvement Coordinator and Practice Improvement Specialists are appointed by the Chief Executive Officer or his designee.

Additional Members may be appointed upon assessment of need by the Committee. Members of the Quality Executive Committee shall have served a minimum of two years on the Active Staff and have expressed interest and/or experience in the function of the committee. All new members will be provided an orientation to the roles and responsibilities of the committee and will also be provided an opportunity for medical staff leadership training.

3. TERM LIMITS: Committee members will serve for a three (3) year term and may be reappointed for additional terms without limit. No more than fifty (50%) of the members will rotate off on any one year to ensure consistency in the process.

4. VACANCY: Vacancies will be filled in the same manner as original appointment is made. If a required member cannot continue to serve, a new member must be recommended to the Medical Executive Committee for approval at their next scheduled meeting.

E. RESPONSIBILITIES:

a. The multi-disciplinary Quality Executive Committee (QEC), utilizing collegial efforts and progressive steps, facilitates a systematic process to evaluate medical staff professional practice and identify opportunities to improve the quality of medical care provided.

b. The Committee establishes program goals, plans, initiates, implements and monitors program activity and evaluates patient outcomes.

c. The Committee is empowered under Article VI of Medical and Dental Staff Bylaws to conduct specific practitioner reviews, review aggregate data, make policy recommendations, monitor the peer review process, share lessons learned and educational guidelines, monitor system fixes and initiate and oversee voluntary improvement plans (VIP). The QEC is a non-disciplinary committee with no authority to restrict clinical privileges.

d. The Committee works collegially with the Physician Leadership Council, the Chiefs of Service, the Resource Utilization Committee, the Chief Medical Officers and the Medical Executive Committee to oversee the Peer Review Process in accordance with these Bylaws, Rules & Regulations and its related policies.

F. **MEETINGS**

1. FREQUENCY: The Quality Executive Committee meets as often as necessary to fulfill its responsibilities, but at a minimum of ten (10) times a year.

2. ATTENDANCE: Committee members are expected to attend as many of the meetings as possible. Committee members must attend no less than 75% of the scheduled meetings per year.

3. QUORUM: Fifty (50) percent of the members present who are required members of the Committee.

4. SUPPORT: Support will be provided by the Medical Dental Staff Office and the Quality and Patient Safety Office.

5. **AGENDA and MINUTES:** All Quality Executive Committee meetings are expected to have an agenda. Minutes are to be reviewed and approved in the subsequent meeting, prior to submitting aggregate reports to the Medical Executive Committee.
6. **REPORTING RELATIONSHIP:** The Quality Executive Committee reports to the Medical Executive Committee and works in concert with the Chiefs of Service Committee on Quality Initiatives.

G. CONFIDENTIALITY

Pursuant to N.Y. Education Law, §6527 the information and records of this committee as related to peer review activities are designated as "proceedings, reports and records of a medical peer review committee."

All members of the Quality Executive Committee will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

II-9. MEDICAL/DENTAL STAFF **LEADERSHIP COUNCIL**

A. **PURPOSE:** ECMCC and its Medical and Dental Staff are committed to providing safe, quality patient care. The Leadership Council is established to further that commitment by providing guidance and assisting in the resolution of complex clinical and administrative issues including practitioner professionalism, health and wellness, quality assurance and performance improvement, education, communication and leadership development. It is the goal of The Leadership Council to act in a collegial manner, utilizing a progressive steps continuum in conjunction with the confidential Practice Improvement process. Issues that are disciplinary in nature will be referred to the Medical Executive Committee.

B. COMPLIANCE: The Leadership Council complies with all regulatory requirements for assuring the Medical Dental Staff evaluates the quality of care provided by its members and identifies opportunities to improve the delivery of care, including professionalism and wellness concerns.

C. REGULATORY/ACCREDITING REQUIREMENTS RELEVANT TO FUNCTION:

1. **Joint Commission** Current Accreditation Manual for Hospitals, Medical Staff Standards
2. **CMS, Conditions of Participation for Hospitals: 42 CFR 482.22**
3. **Applicable New York State laws and regulations**

D. MEMBERSHIP

1. **APPOINTMENT:** Membership is determined by leadership role identified in Section D. 2 below and will be appointed as provided for in these Bylaws. Medical Center administrative representatives are appointed by the Chief Executive Officer or his designee.
2. **COMPOSITION:** Voting members include:
   - **a.** President of the Medical Dental Staff serves as Chair.
   - **b.** President Elect of the Medical Dental Staff
   - **c.** Treasurer of the Medical Dental Staff
   - **d.** Secretary of the Medical Dental Staff
   - **e.** Chief Medical Officer
   - **f.** Chair of the Quality Executive Committee
   - **g.** Immediate Past President of the Medical Dental Staff
   - **h.** Chair of the Credentials Committee
3. **TERM LIMITS:** Committee members will serve for the duration of their term as a medical staff officer, CMO or Chair of the Credentials Committee.
4. **VACANCY:** Vacancies will be filled in the same manner as original appointment is made. If a required member cannot continue to serve, a new member must be elected as provided for in these Bylaws.

E. RESPONSIBILITIES:

1. Source of issues for review include but are not limited to: The Practice Improvement (PI) process, including electronically submitted occurrence events, referrals from Service Line Directors and Chiefs of Service, Office of the Chief Medical Officer, Hospital Administration, Professional Development and Wellness Committee, Utilization Review Committee, Credentials Committee.
2. Determines the appropriate avenue of review for all administratively complex issues and can facilitate review itself.
3. Discusses and coordinates quality issues.
4. Recommends and facilitates leadership development for the Medical Dental Staff.
5. Acts as the Nominating Committee (see ECMC Rules & Regulations, Part II, § 11-3.)
6. Practitioner wellness issues shall be addressed by the Leadership Council. The Leadership Council works collegially with the Professional Development and Wellness Committee to address issues arising from the policies related to conduct, professionalism, health or wellness.
7. The Leadership Council may request the assistance of the Professional Development and Wellness Committee or other practitioners to assist, on an ad hoc basis, if additional expertise or experience would be helpful in addressing the wellness concerns that are identified in a particular case.
8. Facilitate external review for clinical issues when necessary.
9. Assists the Quality Executive Committee in the development, facilitation and oversight of Voluntary Improvement Plans.
10. Initiates Voluntary Improvement Plans for conduct when indicated.
11. Assists with or provides collegial counseling when indicated.

F. **MEETINGS**

1. **FREQUENCY:** The Leadership Council meets as often as necessary to fulfill its responsibilities, but at a minimum of six (6) times a year.
2. **ATTENDANCE**: Committee members are expected to attend as many of the meetings as possible. Committee members must attend no less than 75% of the scheduled meetings per year.
3. **QUORUM:** Fifty (50) percent of the members present who are required members of the Committee.
4. **SUPPORT**: Support will be provided by the Director of Medical and Dental Staff Services.
5. **REPORTING RELATIONSHIP:** The Leadership Council reports to the Medical Executive Committee via aggregate report or formal referral.

G. CONFIDENTIALITY

Pursuant to N.Y. Education Law, §6527 the information and records of this committee as related to practice improvement (PI) activities are designated as “proceedings, reports and records of a medical peer review committee.”

All members of the Leadership Council will, consistent with the Medical/Dental Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports and information obtained by virtue of membership on the committee.

Adopted by the Medical/Dental Staff:

Medical/Dental Staff President Date: 1/25/2023
Jennifer Pugh, MD

Approved by the Board of Directors:

Thomas J. Quatroche, PhD
Chief Executive Officer Date: 1/25/2023
Erie County Medical Center Corporation

Revisions:
Medical Executive Committee: 01/27/2020
Board of Directors Committee: 01/28/2020

Medical Executive Committee: October 24, 2022
Annual Meeting of the Medical/Dental Staff: November 17, 2022
ECMCC Board of Directors: January 25, 2023

Credentials Procedure Manual

CREDENTIALS PROCEDURES MANUAL OF THE MEDICAL-DENTAL STAFF
ERIE COUNTY MEDICAL CENTER CORPORATION

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ERIE COUNTY MEDICAL CENTER CORPORATION
BUFFALO, NEW YORK

MEDICAL/DENTAL STAFF

CREDENTIALS PROCEDURES MANUAL

ARTICLE I: APPLICATION POLICY

SECTION A: GENERAL POLICY: Erie County Medical Center Corporation permits application to the Medical/Dental Staff from licensed medical and osteopathic physicians, oral surgeons, dentists, podiatrists and allied health professionals as defined in the bylaws.

SECTION B: SIGNIFICANCE OF APPLICANT AUTHORIZATION AND ACCOUNTABILITY By requesting an application and/or applying for appointment or reappointment of Clinical Privileges, the individual accepts the following conditions whether or not appointment or Clinical Privileges are granted, and throughout the term of any appointment or reappointment:

(1) Signifies his willingness to appear for interviews in connection with the application;

(2) Authorizes Medical Center representatives to consult with others who have been associated with him and/or who have or may have information bearing on the applicant's competence and qualifications;

(3) Consents to Medical Center and Medical/Dental Staff representatives' inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence, ability to safely and competently perform Clinical Privileges requested and his professional and ethical qualifications;

(4) Releases from any and all liability, and extends absolute immunity to the Medical Center, any Medical/Dental Staff member and their authorized representatives for their acts performed in connection with the evaluation, review and processing of his credentials and qualifications for appointment, reappointment, or Clinical Privileges. This includes any actions, recommendations, reports, statement, communications or disclosures involving the applicant which are made, taken or received by the Medical Center, any Medical/Dental Staff member, or their authorized representatives. The applicant specifically authorizes the Medical Center, Medical/Dental Staff leaders and their authorized representatives to consult with any third party who may have information bearing on the applicant's competence, professional ethics, ability to get along with others, character, ability to safely and competently perform the Clinical Privileges requested, and other qualifications for Medical/Dental Staff appointment, reappointment or Clinical Privileges and to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions;

(5) Releases from any and all liability, and extends absolute immunity to all appropriate third parties who provide information, including otherwise privileged or confidential information, to the Medical Center, any Medical/Dental Staff member, and their authorized representatives concerning his competence, professional ethics, ability to get along with others, ability to safely and competently perform the Clinical Privileges requested, and other qualifications for Medical/Dental Staff appointment, reappointment or Clinical Privileges. This includes any actions, communications, reports, records, statements, documents, recommendations or disclosures involving the applicant which are made, taken or received by the Medical Center, any Medical/Dental Staff member or appropriate third parties by an individual or organization. The applicant specifically authorizes third parties to release such information to the Medical Center, any Medical/Dental Staff member and their authorized representatives;

(6) Authorizes and consents to Medical Center representatives providing third parties and their agents with whom the applicant has or is seeking employment or other contractual opportunities or other affiliations (and who are concerned with provider performance and the quality and efficiency of patient care) with any information

relevant to such matters that the Medical Center may have concerning this applicant, and releases from any and all liability, and extends absolute immunity to Medical Center representatives for so doing;

(7) Signifies that he/she has had access to the current Medical/Dental Staff Bylaws and Rules and Regulations and agrees to abide by their provisions in regard to the application for appointment to the Medical/Dental Staff and while serving as a member of the Medical/Dental Staff;

(8) Pledges to conduct his medical practice at the Medical Center in an ethical manner, using the Codes of Ethics and Principles adopted by his profession or specialty and state and federal law. Pledges to refrain from fee-splitting or other inducements relating to patient referral; to abide by the provisions of the Medical Center's Corporate Compliance Policy; to provide for continuous patient care; to delegate in his absence the responsibility for diagnosis and care of his patients only to a practitioner who is qualified to undertake this responsibility; to seek consultation whenever necessary. The Medical Center pledges not to engage in any behavior which could be construed as unprofessional with respect to and/or detrimental to the quality of patient care or safety at the Medical Center, disruptive to the Medical Center's operations;

(9) Agrees to provide immediately, with or without request, new or updated information to the Chief Medical Officer, Medical/Dental Staff President, or Credentials Chair as it occurs, that is pertinent to any question on the application form. Agrees to keep the Medical/Dental Staff Office current in relation to all demographic information related to the appointee and his practice;

(10) **Agrees to abide by the Medical/Dental Staff Provider Health and Wellness Policy.** Agrees to provide proof of immunization from Rubeola, Varicella, Rubella, and any other vaccinations required by federal or New York state law. Alternatively, an applicant may obtain an appropriate waiver in accordance with the Medical Center's immunization policy. Provide proof of tuberculin testing or history of positive PPD within the past twelve (12) months at time of initial application;

(11)Agrees that any significant misrepresentation or misstatement in, or omission from the application, whether intentional or not, may constitute cause for immediate cessation of the processing of the application. When and if the practitioner will be afforded the opportunity to reapply will be determined on a case by case basis, with the nature of the misrepresentation, misstatement or omission as the primary criteria. A second application fee may be applied based on the circumstances. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be grounds for disciplinary action, including termination of Clinical Privileges and Medical/Dental Staff appointment pursuant to Medical/Dental Staff Bylaws, rules, policies and procedures. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in this policy;

(11) Agrees to use the Medical Center and its facilities sufficiently, or to provide sufficient practice volume and quality information as available from another institution, to allow the Medical Center through assessment by appropriate Medical/Dental Staff processes and chiefs of service, to evaluate in an on-going manner the current competence of the appointee; agrees to assist the Medical Center in fulfilling its mission and responsibility to provide emergency and uncompensated care;

(12) Agrees to promptly notify the Chief Medical Officer and the Medical/Dental Staff President in writing, within fifteen (15) days of the receipt of notice of:

a) The suspension, limitation or loss of admitting or Clinical Privileges imposed

by the final act of another health care facility or which occurred through the resignation or withdrawal of association or of Privileges at such facility in order to avoid imposition of any disciplinary action, where the restriction was related to standards of patient care, patient welfare or the character, competence and qualifications of the Staff member.

b) The imposition of any sanction against the Staff member's professional license in the State of New York or any other jurisdiction or upon agreement to limit or qualify the terms of the license;

c) The imposition of any sanction against the Staff member's DEA registration in the State of New York or any other jurisdiction or upon agreement to limit or qualify the terms of the registration.

d) Any change in eligibility for payments by third-party payers or for participation in Medicare or Medicaid programs, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a Peer Review Organization ("PRO") citation and/or quality denial letter concerning alleged quality problems in patient care; or

e) Convicted of, pled guilty, "no contest" or its equivalent to any felony, or any misdemeanor relating to the practice of the profession of medicine, dentistry, podiatry or other healthcare-related matters, or involving a charge of moral turpitude, third-party reimbursement, violence, or controlled substances violations;

(15) Agrees to complete, in a timely manner, the medical and other required records for all patients as required by the Medical/Dental Staff bylaws, rules and regulations, this Credentials Procedures Manual and other applicable policies and procedures of the Medical Center and the Medical/Dental Staff; agrees to comply with Medical Center policies and procedures that ensure appropriate and confidential use of electronic or computer transmissions and authentication;

(16) Agrees to work cooperatively and professionally and to abide with the Medical/Dental StaffProfessionalism Policy, with Medical/Dental Staff appointees, licensed independent practitioners, Medical/Dental Staff leadership, Medical Center management, non-physician clinical practitioners, nurses and other Medical Center personnel;

(17) Agrees to promptly pay any applicable Medical/Dental Staff application fees, dues and assessments;

(18) Agrees to participate in continuing education programs relevant to the Privileges granted, in compliance with the Medical/Dental Staff's requirement of: MD/DOs: completion of at least fifty (50) hours of CME every two years, all must be in Category 1; DMD/DDS': completion of New York State Board of Dentistry continuing education requirements; Podiatrists: completion of New York State Board of Podiatry continuing education requirements; Allied Health Professionals: completion of New York State requirements as defined for each profession;

(19) Agrees that the hearing and appeal procedures for Staff members set forth in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review section of the Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken by the Medical Center and/or the Medical/Dental Staff;

(20) Agrees to perform and participate in such personal, Medical/Dental Staff, committee and Medical Center functions, including but not limited to: peer review/Practice Improvement, quality or performance improvement review, professional practice evaluation process, compliance with established quality indicators, utilization review, teaching, consultation assignments, emergency service and on-call functions, or exercise of staff Privileges, prerogatives or other rights in the Medical Center;

(21) Agrees if requested, to submit to any physical and/or mental examination which may include testing for alcohol and/or chemical abuse, and to provide evidence of both physical and mental health that does not impair the fulfillment of his responsibilities of Medical/Dental Staff membership and/or specific Privileges requested by and granted to the applicant; and

(22) Agrees to maintain current and provide to the Medical-Dental Staff Office all applicable expirable documents between re-appointment cycles. This includes, but is not limited to license, DEA registration, annual health assessment and PPD test results, malpractice insurance, board certification renewals, required certifications including, but not limited to NYS Infection Control Training and any vaccinations required by federal or New York state law.

ARTICLE II: INITIAL APPOINTMENT PROCESS AND PROCEDURES

SECTION A: **NATURE OF MEDICAL/DENTAL STAFF MEMBERSHIP** Appointment to the Medical/Dental Staff of the Medical Center is a privilege which shall be extended only to Practitioners who continuously meet the qualifications, standards and requirements set forth in this manual and the Medical/Dental Staff Bylaws. All Practitioners as defined in the bylaws, unless excepted by specific provisions of this policy, must first have been appointed to the Medical/Dental Staff.

SECTION B CONFIDENTIALITY All processes described in this Part shall be subject to the confidentiality provisions described in Article X of the Medical/Dental Staff Bylaws.

SECTION C: CONDITIONS OF APPOINTMENT
Staff and/or Privilege appointments shall be made only if required by the needs of the particular service for which the Practitioner is eligible, if the applicant has demonstrated an ability to enhance that service through prior training or experience, and if it is anticipated that the activities of the applicant as a member of the staff will represent a positive contribution to the academic and economic well-being of the Medical Center.

SECTION D: MEDICAL CENTER NEED AND ABILITY TO ACCOMMODATE
In evaluating the applicant’s eligibility for Medical/Dental Staff membership and/or Clinical Privileges, consideration will be given to any policies, plans and objectives formulated by the Board of Directors, including a policy to provide for the delivery of one or more clinical services through the granting of exclusive contracts, the availability of adequate physical, personnel and financial resources and consideration of quality and efficient patient care.

SECTION E: TERM OF APPOINTMENT
All appointments to the Medical/Dental Staff and the granting of Privileges are for a two-year period or less as defined by the particular circumstance.

SECTION F: REQUEST FOR APPLICATION AND APPLICATION PACKET

(1) An individual shall submit a request for application to the Medical/Dental Staff noting the reasons for requesting appointment and/or Privileges. Where appropriate,

approval of the Chief of Service from the department the applicant is seeking Privileges is to be obtained prior to issuing an application.

(2) Those individuals who meet the threshold criteria for consideration for appointment to the Medical/Dental Staff and/or Clinical Privileges shall be given an application. Individuals who fail to meet these criteria or refuse to accept the responsibilities of a Medical/Dental Staff member shall not be given an application and shall be notified that they are not eligible.

(3) The application packet provided to the prospective applicant includes, but not limited to:

- Cover letter; with instructions for completion of the application and application fee request;
- An application for Medical/Dental Staff Appointment;
- CV gap form;
- Appropriate delineation of privilege request form(s) and criteria for Privileges;
- Medical/Dental Staff Bylaws, Code of Conduct Policy, Rules and Regulations and related manuals;
- Criminal Records Release and Disclosure Authorization Form;
- Statement of Applicant;
- Statement of Health, (Initial History & Physical Exam Form, which includes immunization history and TB testing result);
- Confidentiality Statement/Systems Access Application Form;
- Medicare Acknowledgment Statement (within application form);
- Liability claims history form
- Orientation materials and corresponding attestation form.

SECTION G: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

(1) Information

(a) Applications for appointment to the Medical/Dental Staff and/or Clinical Privileges shall be in writing and shall be submitted on forms approved by the Board of Directors upon recommendation of the Credentials and Medical Executive Committees. These forms shall be obtained from the Medical/Dental Staff Office.

(b) The application shall contain a request for specific Clinical Privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications, including:

(i) the names of three peers (same type credential: physician, dentist or other professional, for AHP this may be a physician), as appropriate, and when possible, at least two of whom are not associated or about to be associated with the applicant in professional practice or related to the applicant by blood or marriage, or the ECMC Chief of Service in the department to which applying; and who have had extensive experience in observing and working with the applicant within the past 5 years, and who can provide adequate references pertaining to the applicant's professional competence and character;

(ii) the names and complete addresses all hospitals or other institutions at which the applicant has worked or trained.

(iii) information as to whether the applicant's Medical/Dental Staff appointment or Clinical Privileges have ever been voluntarily or

involuntarily relinquished, withdrawn, limited, denied, revoked, suspended, subjected to probationary or other conditions, reduced, or not renewed at any other medical center or health care facility;

(iv) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his application for appointment, reappointment and Clinical Privileges, or resigned from a medical staff before final decision by a medical center's or health care facility's governing board;

(v) information as to whether the applicant's membership in local, state or national medical societies, or license to practice any profession in any state, or DEA registration has ever been suspended, modified, voluntarily or involuntarily relinquished or terminated;

(vi) information as to whether the applicant has currently in effect professional liability insurance coverage, the name of the insurance company, as well as the amount and classification of such coverage and whether said insurance covers the clinical procedures for which the applicant is seeking Clinical Privileges; ECMCC should be listed on the certificate of Insurance as the certificate holder, unless otherwise designated through a contractual agreement with ECMCC;

(vii) information as to whether the applicant has ever been named as a defendant in a criminal action, entered a plea of guilty or no contest and/or convicted of a felony, or to any misdemeanor with details about any such instance;

(viii) a consent to the release of information from his present and past malpractice insurance carriers and a directive to all such carriers to notify the Medical Center of any change in insurance status;

(ix) information concerning the applicant's professional litigation experience, specifically information concerning final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Credentials or Medical Executive Committees deem appropriate;

(x) a request for the specific Clinical Privileges desired by the applicant;

(xi) if so designated, current information on the applicant's ability to perform the Clinical Privileges requested;

(xii) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state or country, whether such proceedings are closed or still pending;

(xiii) information concerning the suspension or termination, for any period of time, of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance or health coverage program, and information as to whether the applicant is currently under investigation;

(xiv) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions in month/year format;

(xv) information on the citizenship and/or visa status of the applicant;

(xvi) the applicant's signature and a request to provide government issued photo for identification purposes (Attestation upon confirmation);

(xvii) signed attestation of completion of orientation materials; and

(xviii) such other information as the Board of Directors, Medical Executive or Credentials Committee may require.

The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment and the granting of Clinical Privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular Clinical Privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular privilege or general behavior.

SECTION H: BURDEN OF PROVIDING INFORMATION

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. He/She shall have the burden of providing evidence that all statements made and information given on the application are factual and true. The applicant retains the right to be informed of the application status and review the information contained therein, and correct erroneous information throughout the duration of the appointment/privileging process as defined in these policies. This shall be coordinated with the Medical-Dental Staff Office and the Chair of the Credentials Committee.

SECTION I: PROCEDURE FOR INITIAL APPOINTMENT

(1) Submission of Application

(a) The application for Medical/Dental Staff appointment and/or Clinical Privileges shall be submitted by the applicant to the Medical/Dental Staff Office. It must be accompanied by payment of the application fee as determined by the Medical Executive Committee

(b) An application shall be deemed to be complete and ready for review by the appropriate Chief of Service when all questions on the application form have been answered, the applicant has dated and signed in all appropriate areas, all supporting documentation has been supplied and all information verified. Any application submitted not filled out in its entirety will be returned to the applicant. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An application shall be deemed incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. It is the responsibility of the applicant to contact the Medical/Dental Staff Office to inquire about the progress of the application and provide missing documentation.

(c) After reviewing the application to ensure completeness, and after verification of information provided with the primary sources, The Medical/Dental Staff office shall forward the complete and processed application and all supporting materials to the appropriate Chief of Service.

(d) In the event that an applicant is requesting membership or privileges in a department or clinical area in which the Medical Center has entered into an exclusive contract for the provision of medical services, the applicant will be notified that exclusivity precludes the granting of Clinical Privileges and will be offered the option of membership in the Courtesy, Refer and Follow category.

(2) Verification of Information

Upon receipt of a completed application, the personnel in the Medical/Dental Staff Office or its designee will verify its contents from the appropriate primary source(s) and collect additional information as follows:

(a) Information from all prior and current liability insurance carriers concerning claims, suits and settlements (if any) for the past five (5) years;
(b) All current licenses and applicable registrations;
(c) Administrative and clinical reference questionnaires from all significant past and present practice settings, at minimum for the past five (5) years;
(d) Documentation of the applicant's clinical work experiences during the past twenty four (24) months;
(e) Licensure status in current or past states of licensure; (New York licensure will be verified at time of initial appointment, reappointment, request for new privilege and expiration)
(f) Academic appointments;
(g) Military service; malpractice history where applicable
(h) Visa and Immigration status
(i) When appropriate or necessary, information from the AMA or AOA Physician Master Files, Federation of State Medical Boards or other such databanks or approved verification sources;
(j) Completion of medical/osteopathic/dental/podiatry school, residency/fellowship programs, and if applicable, specialty board certification;
(k) Documentation from three (3) peer references;
(l) ECFMG certification, if applicable;
(m) Information from the National Practitioner Data Bank (also at new privilege request) established pursuant to the Healthcare Quality Improvement Act of 1986, including Medicare/ Medicaid, OMIG sanctions and Medicare Opt-Out;
(n) Information regarding clinical ability, ethical character and ability to work with others from identified references;
(o) Satisfactory explanation of any issues regarding: successful or pending challenges to any state licensure(s), or Federal DEA certification(s) or voluntary or involuntary relinquishment, withdrawal, denial, limitation, suspension or revocation of same; voluntary or involuntary termination, suspension, diminishment, revocation, limitation or refusal of membership, employment or Clinical Privileges at any health care facility; involvement in any professional liability actions, settlements or final judgments and suspensions or terminations of membership from any medical society or board;
(p) Criminal background check, which may include a credit check;
(q) With the exception of applicants of services staffed as shift work, covering physicians' names and addresses; For Allied Health Professionals, the name of the supervising/collaborative physician, along with a practice agreement signed by both parties;

(r) Continuing medical education documentation/attestation; and

(s) Personal Identification: The Medical/Dental Staff Office shall collect government issued photo identification from the applicant at the beginning of the process to verify identification of the individual. When practicable, prior to the review of the file by the Chief of Service, the applicant shall be asked to present to the Medical/Dental Staff Office, such document for verification of identification. This document will be copied by a member of the Medical/Dental Staff Office staff and noted as such in the credentials file;

(t) For Pediatric/Adolescent Behavioral Health Providers: collaborate with Behavioral Health to obtain for file the Office of Mental Health (OMH) Abuse Allegation records;

(u) For services routinely caring for patients with special needs (including, but not limited to Behavioral Health, Chemical Dependency, Hospitalists, medical providers to the Geriatric Psychiatry Unit): Justice Center Code of Conduct Attestation; and Staff Exclusion List check (SEL for all providers).

(v) Any additional information as may be requested to ensure the applicant meets the criteria for Medical/Dental Staff membership;

NOTE: In the event there is undue delay in obtaining required information, the Medical/Dental Staff Office will request assistance from the applicant.

If any verbal exchange takes place with primary sources or references, documentation of said exchange shall be placed in the applicant's confidential credentials file. If any reference refuses to respond to inquiries, the applicant shall be notified to provide another reference. This will be documented in the applicant's credentials file and flagged for Credentials Committee review and any action deemed appropriate.

When items noted above have been obtained, the file will then be summarized on a practitioner profile in preparation for review by the Department Chief of Service.

(3) Applicant Interview Policy:

It is Erie County Medical Center Corporation's policy that all applicants may be required to participate in an interview as part of the application for appointment to the Medical/Dental Staff or the granting of Clinical Privileges. The interview may be conducted by the Chief of Service, members of the Credentials Committee, the Credentials Committee as a whole or other designated Medical/Dental Staff members. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community.

SECTION J: CHIEF OF SERVICE ACTION

All applications are presented to the Department Chief of Service for review and recommendation. The Chief of Service reviews the application and its supporting documentation to ensure that it fulfills the established standards for membership and Clinical Privileges. The Chief of Service must document his findings pertaining to adequacy of education, training, experience and current competence for all Privileges requested. Reference to any criteria for Clinical Privileges must be documented and included in the credentials file. The Chief of Service shall be available to the Credentials Committee to answer any questions that may be raised with respect to that chief's findings. The Chief of Service may take actions as noted below.

(1) **DEFERRAL:** Chiefs of Service may not defer consideration of an application for any longer than thirty (30) days without cause. In the event a Chief of Service is unable

to formulate a report for any reason, he/she must so inform the Credentials Committee and the applicant.

(2) **FAVORABLE RECOMMENDATION**: When the recommendation of the Chief of Service is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Credentials Committee.

(3) **ADVERSE RECOMMENDATION:** The Chief of Service will document the rationale for all unfavorable findings. Reference to any criteria for Clinical Privileges not met will be documented and included in the credentials file. The application, along with the adverse recommendation of the Chief of Service and supporting documentation, will be forwarded to the Credentials Committee.

SECTION K: CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, including the findings from the Chief of Service of each clinical department in which Privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the Clinical Privileges requested.

As part of the process of making its recommendation, the Credentials Committee may require the applicant to undergo a physical and/or mental examination which may include testing for alcohol and/or chemical abuse or meet with the Professional Development and Wellness Committee, to assess the applicant's ability to perform the Privileges requested, by a physician selected by the Credentials Committee. The results of any such examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.

The Credentials Committee may require the applicant to meet with the Committee to discuss any aspect of his application, qualifications, or Clinical Privileges requested. If the Credentials Committee is considering a negative recommendation, it may offer to meet with the applicant prior to making the recommendation.

The Credentials Committee may use the expertise of the Chief of Service, or any member of the department, or an outside consultant if additional information is required regarding the applicant's qualifications.

The Credentials Committee reviews the application and votes for one of the actions noted below.

(1) **DEFERRAL:** Action by the Credentials Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent requests for additional or supporting information or documentation, and/or recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and Privileges, department and/or section assignments and scope of Clinical Privileges.

(2) **FAVORABLE RECOMMENDATION**: When the Credentials Committee's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Medical Executive Committee.

(**3)** **ADVERSE RECOMMENDATION**: When the Credentials Committee's recommendation is adverse to the applicant, the application, with its supporting

documentation, and all dissenting views, shall be forwarded to the Medical Executive Committee.

SECTION L: MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the application by the Credentials Committee, the Medical Executive Committee reviews the report and recommendation of the Credentials Committee. If the Medical Executive Committee has determined to make a recommendation contrary to the Recommendation of the Credentials Committee, the Medical Executive Committee shall either:

(a) refer the matter back to the Credentials Committee for further investigation and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(b) set forth in its report and recommendation and its reason(s) therefore, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, through the CEO or designee to the Board of Directors in accordance with the procedures set forth below.

The Medical Executive Committee shall vote for one of the actions below:

(1) **DEFERRAL**: Action by the Medical Executive Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent requests for additional or supporting information or documentation, and/or recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and Privileges, department or section affiliation(s), and Clinical Privileges.

(2) **FAVORABLE RECOMMENDATION**: When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the Board of Directors for further action.

(3) **ADVERSE RECOMMENDATION**: When the Medical Executive Committee's recommendation is adverse to the practitioner, the reasons for the adverse recommendation shall be stated and documented. The CEO or designee shall notify the practitioner by certified mail, return receipt requested or other delivery method capable of verified receipt of the recommendation, the reason(s) therefore and the right to request a fair hearing (if applicable). With respect to applicants seeking an initial appointment to the Medical/Dental Staff, an adverse recommendation based primarily on issues of professional competence or conduct shall entitle the applicant to the right to request a review of the adverse recommendation as provided in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

In the event the applicant has the right to a hearing, the Medical Executive Committee shall then hold the application until after the applicant has exercised or has been deemed to have waived his right to a hearing. Whenever the applicant has been deemed to have waived his right to a hearing, or upon conclusion of the hearing process, the CEO shall forward the recommendation of the Medical Executive Committee, together with all supporting documentation and the hearing decision and related materials, if applicable, to the Board.

SECTION M: BOARD OF DIRECTORS ACTION

Upon receipt of a recommendation from the Medical Executive Committee, the Board of Directors reviews the application and votes for one of the following actions:

(1) ACTION UPON FAVORABLE RECOMMENDATION BY MEC: The Board of Directors may

- appoint the applicant and/or grant Clinical Privileges as recommended

or

- reject in whole or in part a favorable recommendation of the Medical Executive Committee

or

- refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made.

If the Board determines to reject the favorable recommendation of the Medical Executive Committee, it should first discuss the matter with the President of the Medical/Dental Staff. If the Board's determination remains unfavorable to the applicant, for Medical/Dental Staff appointment, it shall go to Conflict Resolution as set forth in Section O below, and then that determination and the reasons in support thereof, shall be sent to the CEO, who shall promptly notify the applicant in writing, by certified mail, return receipt requested or other delivery method capable of verified receipt of the determination, the reason(s) therefore and the right to request a hearing, if applicable. The applicant may be entitled to request a hearing pursuant to the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures. In the event an applicant is entitled to a right to a fair hearing, the Board shall take no final action until the applicant has completed the hearing and appeal process or waived the right to a hearing and appeal as outlined in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

(2) ADVERSE RECOMMENDATION: If the Board of Directors' action is adverse to the applicant, a special written notice sent by certified mail, return receipt requested or other delivery method capable of verified receipt will be sent to him by the CEO stating the determination, the reason(s) therefore and when applicable, that he/she may be entitled to the procedural rights provided in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures. In the event an applicant is entitled to a right to a fair hearing, the Board shall take no final action until the applicant has completed the hearing and appeal process or waived the right to a hearing and appeal as outlined in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

(3) AFTER PROCEDURAL RIGHTS: In the case of an adverse Medical Executive Committee recommendation and after waiver or completion of the hearing and appeal process (if applicable), the Board of Directors shall take final action in the matter as provided in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

SECTION N: BASIS FOR ADVERSE RECOMMENDATION AND ACTION

The report of each individual or group, including the Board of Directors required to act on an appointment application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be documented, supported by reasons and references, and transmitted with the majority report.

SECTION O: CONFLICT RESOLUTION

Whenever the Board of Directors determines that it will decide a matter contrary to the MEC's recommendations, the matter will be submitted to a committee of an equal number of Medical/Dental Staff members of the MEC and Board of Directors for review and recommendation before the Board of Directors makes its final decision. The committee will submit its recommendation to the Board of Directors within thirty (30) days of notification of issue.

SECTION P: NOTICE OF FINAL DECISION

(1) Notice of the Board of Directors' final decision shall be given through the Medical/Dental Staff Office. The applicant shall receive written notice of appointment or special notice, sent in writing by certified mail, return receipt requested, of any adverse final decisions, including the reason(s) therefore and the right to request a hearing, if applicable, within 30 days of the Board of Directors' decision.

(2) A decision and notice of appointment includes the staff category to which the applicant is appointed, the section or department assignment and the Clinical Privileges he/she may exercise, and any special conditions attached to the appointment.

SECTION Q: ASSESSMENT OF COMPETENCY

Any applicant appointed to the medical dental staff with clinical privileges will immediately enter a period of Focused Professional Practice Evaluation (FPPE) as outlined in the Professional Practice Evaluation Policy (ADM-043)

SECTION R: TIME PERIODS FOR PROCESSING

Upon receipt of a completed application, the application and appointment process shall not exceed 180 days, except for cause, as determined by the Chief Medical Officer. This time period is deemed a guideline and does not create any right to have an application processed within these precise periods. When directed by the Credentials Committee, the applicant will re-sign and date the original application. If the hearing and appellate procedures are activated, the time requirements provided herein shall be tolled during such procedures and shall govern the continued processing of the application.

ARTICLE III: REAPPOINTMENT PROCESS AND PROCEDURES

All reappointments and renewal of Clinical Privileges are for a period of two (2) years and will be processed according to this Part. The granting of new Clinical Privileges to existing Medical/Dental Staff members will follow the procedures outlined in Article II of this manual concerning the initial granting of new Clinical Privileges.

The Medical/Dental Staff Office shares responsibility with the appointee to maintain the credentials file as current. On no less than a monthly basis, the office staff will monitor the following: License, DEA and malpractice insurance renewals, required certifications and expirables, State licensure sanctions (OPMC), OIG, OMIG, and Medicare Opt Out are managed through a contracted vendor by Corporate Compliance. These activities will be logged in departmental records.

SECTION A: INFORMATION COLLECTION AND VERIFICATION

(1) **FROM STAFF APPOINTEES**: On or before six (6) months prior to the date of expiration of a Medical/Dental Staff appointment, the Medical/Dental Staff Office shall notify the appointee of the date of expiration and supply him with a reappointment application packet. The reappointment format shall be approved by the Credentials and Medical Executive Committees and the Board of Directors.

With receipt of the reappointment application packet, the appointee must furnish, in writing:

(a) A completed reappointment form that includes complete information to update his file on items listed in his original application;
(b) Payment of reappointment processing fee;
(c) Information concerning continuing training and education internal and external to the Medical Center during the preceding period;
(d) Any change in specialty board certification or maintenance of certification;
(e) Documentation of current New York licensure DEA registration;
(f) Documentation/attestation of completion of continuing medical education requirements: For MD/DOs: completion of at least fifty (50) hours of CME every 2 years, all of which must be in Category 1; for DMD/DDS': completion of New York State Board of Dentistry continuing education requirements; for Podiatrists: completion of New York State continuing education requirements; for Allied Health Professionals: completion of New York State continuing education requirements as defined for their profession
(g) Tuberculosis screening form, within the past twelve (12) months and completion of the Medical Evaluation form;
(h) Specific request for the Clinical Privileges sought on reappointment, with any basis for changes; and
(i) Requests for changes in staff category (if applicable)
(j) Statement of Applicant

By signing the reapplication form, the appointee agrees to the same terms as identified in Article I, Section B. Failure to file a timely reappointment application, without good cause as determined by the Chief Medical Officer, or failure to provide any requested information is deemed a voluntary resignation from the staff and shall result in expiration of appointment at the end of the current appointment period. If the staff member fails to submit a completed application for reappointment within sixty (60) days of the mailing, a courtesy phone call is provided as a reminder. If the member does not respond to this request, he/she shall be deemed to have resigned his membership and/or Clinical Privileges. A letter advising the staff member of the automatic conclusion will be sent by certified mail, return receipt requested. In the event that such a resignation takes place, the procedures in the hearing and appeal procedures shall not apply. Notwithstanding the above, the Chief Medical Officer may be required to report to the New York State Department of Health, Office of Professional Medical Conduct and to the Medical Licensing Board of the Office of the Professions any voluntary or involuntary termination of Privileges in the event it is to avoid the imposition of disciplinary measures, when and as required by applicable state law or the Health Care Quality Improvement Act of 1986.

The reappointment application shall be considered incomplete and shall not be processed unless the applicant is current with respect to the payment of Medical/Dental Staff dues and assessments.

The Medical/Dental Staff Office or its designee verifies the information submitted, and notifies the staff appointee of any information inadequacies or verification problems. The staff appointee then has the burden of producing adequate information and resolving any doubts about the data.

(2) **INTERNAL AND/OR EXTERNAL SOURCES**: The Medical/Dental Staff Office, in conjunction with the Patient Safety and Risk Management Department personnel, collects and verifies for each staff appointee, information regarding his professional activities to include:

(a) A summary of clinical competence and, when available, activity at the Medical Center or from the primary admitting institution, during the preceding two year period;
(b) Current licensure and DEA registration including any currently pending challenges to any license or registration;
(c) Maintenance of professional board certification status, if applicable;
(d) Current professional liability insurance status (ECMC should be listed on the Certificate of Insurance cover sheet as the certificate holder, unless otherwise designated through a contractual agreement with ECMCC), and any pending malpractice challenges, including claims, lawsuits, judgments or settlements since the time of the last (re)appointment;
(e) Any pending or completed disciplinary actions or sanctions since the time of the last reappointment; including The Justice Center Staff Exclusion List.
(f) Performance and conduct in the Medical Center and/or other healthcare organizations, including without limitation, patterns of care, as demonstrated in findings of quality assessment or performance improvement activities, his clinical judgment and skills in the treatment of patients, his behavior and cooperation with Medical Center personnel, patients, and visitors;
(g) Report from National Practitioner Data Bank, including Medicare/Medicaid sanctions;
(h) Satisfactory explanation of any issues regarding: successful or pending challenges to licensure in any state or federal DEA or voluntary or involuntary relinquishment, denial, limitation, suspension or revocation of such licensure(s) or registration(s), or voluntary or involuntary termination of membership at any health care facility; voluntary or involuntary limitation, reduction or loss of Clinical Privileges at any health care facility, felony convictions or charges, suspensions, sanctions or any other type of restrictions from participation in any private, federal or state health insurance program such as Medicare or Medicaid fraud and suspension or termination of membership from any medical society or specialty board;
(i) Accuracy and timeliness of medical records/Medical Center reports;
(j) Service on Medical/Dental staff, department and Medical Center committees and other staff affairs;
(k) Compliance with all applicable bylaws, policies, rules, regulations and procedures of the Medical Center and Medical/Dental Staff; and
(l) Current information regarding the applicant's ability to perform the Privileges requested competently and safely and to perform the duties and responsibilities of appointment.

(3) All returned documents shall be reviewed and verified as described in the initial appointment procedure in Article II of this manual.

(4) Where available, the Medical/Dental Staff Office, in conjunction with the Patient Safety Office, will compile a summary of activity at the Medical Center for each appointee due for reappointment. If this is unavailable or the practitioner has had little

or no clinical volume, as identified in the OPPE process, the staff member will be asked to provide two peer references as defined in the By-laws, Rules & Regulations.

SECTION B: CHIEF OF SERVICE ACTION

When the items identified in Article IV, Section A of this manual have been obtained, the file will then be summarized on a practitioner profile and forwarded to the Chief of Service.

Each Chief of Service overseeing a Department or Service in which the practitioner requests or has exercised Privileges shall review the reappointment application and its supporting information, the information gathered under Article IV, Section A above, and other pertinent aspects of the practitioner's activity and shall evaluate the information for continuing satisfaction of the qualifications for appointment, the department/services and staff status assignment and the Privileges requested.

In the case of the reappointment of a Chief of Service, the review of his application shall be conducted by the Chief Medical Officer in conjunction with physician in the same department.

If a Chief of Service requires further information, the Chief of Service shall notify the practitioner, in writing, through the Medical/Dental Staff Office, of the information required. If the practitioner is to provide additional information, the notice to him must be a special written notice and must include a request for the specific information required and the deadline for response. Failure to respond in a satisfactory manner by the date specified is deemed a resignation of staff appointment and all Clinical Privileges, unless the Credentials Committee determines that the failure to respond was caused by circumstances beyond the practitioner's control. The CEO or designee shall send the practitioner special written notice by certified mail, return receipt requested, or other delivery method capable of verified receipt, of any deemed resignation, along with the reason(s) therefore and of the right to request a hearing, if applicable.

Upon completion of review of the application for reappointment, each Chief of Service shall document his recommendation and forward to the Credentials Committee, through the Medical/Dental Staff Office, all conclusions regarding reappointment or non-reappointment, staff category, department or other clinical unit assignment and Clinical Privileges, or if no such conclusions are made, the reason(s) therefore.

SECTION C: CREDENTIALS COMMITTEE RECOMMENDATION

The Credentials Committee reviews the appointee's file, all relevant information available to it, and forwards to the Medical Executive Committee a written report with recommendations for reappointment, or non-reappointment and for staff category and Clinical Privileges. The decision process outlined in Part Two, Section K of this manual shall be followed.

In the event that the appointee has failed to achieve board certification as outlined in Section 2.2.1.6 of the medical-dental staff bylaws or has failed to maintain such board certification, the appointee will be granted a one time 4 year grace period to remediate. The appointee will be notified of such in writing by the Chair of the Credentials Committee and the President of the Medical-Dental Staff. If the appointee fails to achieve board (re)certification during this time frame, he/she may apply to the Medical Executive Committee for an exception as described in Section 2.2.1 of the medical-dental staff bylaws.

(1) MEETING WITH AFFECTED INDIVIDUAL

The chair of the Credentials Committee shall notify the individual, in writing if, during the review of a particular individual's reappointment, the Credentials Committee is considering a recommendation that would deny reappointment, deny a requested change

in staff category or Clinical Privileges, or reduce Clinical Privileges. The applicant may be invited to meet with the Committee and/or the Chief of Service or designee prior to any final recommendation being made by the Committee. The affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings shall apply, nor shall minutes of the discussion in the meeting be kept. However, the Committee shall indicate as part of its report to the Board of Directors whether such a meeting occurred.

SECTION D: MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

The Medical Executive Committee reviews the Credentials Committee report(s), and all relevant information available to it and forwards to the Board of Directors a written report with recommendations for reappointment, or non-reappointment and for staff category and Clinical Privileges and the reason(s) therefore. The decision process outlined in Article II, Section L of this manual shall be followed.

If the Medical Executive Committee's recommendation is deemed adverse, no such adverse recommendation will be forwarded to the Board of Directors until after the practitioner has completed, the hearing and appeals process or has waived his right to a hearing as provided in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

SECTION E: FINAL PROCESSING AND BOARD OF DIRECTORS ACTION

Final processing of requests for reappointment follows the procedure set forth earlier for initial appointment, Article II, Section P of this manual. The effective date of the reappointment cycle shall be less than or equal to two years to the date of the initial appointment.

SECTION F: REQUEST FOR MODIFICATION OF APPOINTMENT STATUS

A Staff appointee, whether in connection with reappointment or at any other time, may request modifications of his staff category or department assignment by submitting a written request for modification. Such a request may not be filed within ninety (90) days after a similar request has been denied, unless significant extenuating circumstances have occurred, as determined by the Chief Medical Officer.

SECTION G: FAILURE TO FILE APPLICATION FOR REAPPOINTMENT

Failure to return the re-appointment paperwork by the date designated in the re-appointment packet will result in a late fee. Failure without cause, as determined by the Chief Medical Officer, to timely file a completed application for reappointment shall result in the expiration of the Staff appointee's appointment and Clinical Privileges at the end of the current Staff appointment. In the event membership on the Medical/Dental Staff and/or Clinical Privileges expire for the reasons set forth here, the hearing procedures set forth in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Manual shall not apply.

In the event the applicant for reappointment is the subject of an investigation or hearing at the time of reappointment is being considered, a conditional appointment for a period of less than two years may be granted pending the completion of that process. Notwithstanding the above, the Chief Medical Officer may be required to report to the New York State Department of Health, Office of Professional Medical Conduct and to the Medical Licensing Board of the Office of the Professions any voluntary or involuntary termination of Privileges in the event it is to avoid the imposition of disciplinary measures, when and as required by applicable state law or the Health Care Quality Improvement Act of 1986.

SECTION H: VOLUNTARY RELINQUISHMENT

In the event a Staff appointee voluntarily relinquishes his Staff appointment and, at a later date, requests reinstatement as a member of the Medical/Dental Staff, the individual must apply for staff appointment as an initial appointment as outlined in Article II of this Manual.

ARTICLE IV: CLINICAL PRIVILEGES

SECTION A: EXERCISE OF PRIVILEGES

Medical/Dental Staff appointment or reappointment shall not confer any Clinical Privileges or right to practice in the Medical Center. Each practitioner providing clinical services at the Medical Center may exercise only those Privileges granted to him by the Board of Directors, except as stated in policies adopted by the Board or emergency Privileges as described herein.

SECTION B: PRIVILEGES IN GENERAL

(1) **REQUESTS**: With exception of the Courtesy, Refer and Follow category, each application for appointment or reappointment to the Medical/Dental Staff must contain a request for specific Clinical Privileges. Specific requests must also be submitted for temporary Privileges, as specified in Article V, Section J and for revision of Privileges in the interim between reappointments as specified in Article V, Section H of this manual.

Valid requests for Clinical Privileges will be evaluated on the basis of defined criteria which may include, but shall not be limited to, need, exclusive contracts, education, training, experience, demonstrated current competence, ability and judgment. The basis for a privilege determination made in connection with a periodic reappointment or as a requested change in Privileges must include current clinical competence for the Privileges requested. Privilege determinations may also be based upon pertinent information from other sources, especially other institutions and health care settings where a professional exercises Clinical Privileges. Any individual seeking reappointment who has minimal activity at the Medical Center must comply with the provisions of the PPE policy regarding an attestation from his primary medical center and/or such other information or peer references as may be requested before the individual's reappointment application shall be considered complete and processed further.

(2) **BASIS FOR PRIVILEGES DETERMINATION**: Requests for Clinical Privileges will be considered only when accompanied by evidence of education, training, experience, demonstrated current competence, judgment, references and other relevant information, including an appraisal by the clinical department in which such Privileges are sought. The applicant shall have the burden of establishing qualifications for and competence to exercise the Clinical Privileges he/she requests.
Valid requests for Clinical Privileges will be evaluated on the basis of

(a) prior and continuing education, training, and experience;
(b) utilization practice patterns, when available;
(c) current ability to perform the Privileges requested;
(d) demonstrated current competence;
(e) adequate levels of malpractice insurance coverage as may be required by the Board of Directors with respect to the Clinical Privileges requested;
(f) ability and judgment;
(g) patient care needs and the Medical Center's need and capability to support the type of Privileges being requested through appropriate resources and personnel; and
(h) availability of qualified coverage in the applicant's absence.

Privilege determinations, as much as possible, will be performance based,

utilizing the processes outlined in the PPE policy.

Privileges shall not be granted (including temporary Privileges) until the investigation into the applicant's performance at other institutions during the past five (5) years, as required by New York Public Health Law Part 405.6, has been undertaken.

The procedure by which requests for Clinical Privileges are processed and the specific qualifications for the exercise of Privileges are as outlined in Article II of this manual.

SECTION C: CLINICAL PRIVILEGES FOR EXPERIMENTAL PROCEDURES

Experimental drugs, procedures, or other therapies or tests may be administered or performed only after written approval of the protocols involved by an Institutional Review Board formally recognized by the Medical Center and only by an approved investigator for that drug/procedure/ therapy/test.

SECTION D: CLINICAL PRIVILEGES FOR NEW PROCEDURES, TREATMENTS AND TECHNOLOGY

Whenever a Medical/Dental Staff appointee or applicant requests Clinical Privileges to perform a procedure, provide a service or use new technology that has never been used/provided/performed previously at the Medical Center, those for which additional training is necessary because the technique is wholly or partially new to the practitioner, those that may be performed by members of more than one clinical specialty and those that may be considered controversial, risky or of particularly high visibility, shall be subject to specific privileging procedures and monitoring such that necessary privileging criteria will be formulated in advance of the procedure/service being provided. The Chief of Service and the Chief Medical Officer will together recommend which specific clinical procedures/treatments/services will be subject to such privileging mechanisms. The Board of Directors will make final determinations as to the clinical procedures identified for such privileging mechanisms. The process outlined in this section shall be followed:

(1) A request shall be submitted to the Medical/Dental Staff Office;

(2) The Medical/Dental Staff Office shall notify the appointee/applicant that his request will not be processed until a determination has been made regarding whether the procedure/service or treatment will be offered by the Medical Center;

(3) The Credentials Committee shall incorporate the recommendation(s), the appropriate Chiefs of Service, the Chief Medical Officer and Medical Center Administration and develop threshold credentialing criteria to determine the qualifications for individuals who will be eligible to request the Clinical Privileges to perform the new procedure/service at the Medical Center. In developing the criteria, the Credentials Committee shall conduct research and may consult with specialty organizations, accredited training programs, external department chairpersons, credentialing consultants and/or experts via an ad hoc task force of multi-specialty physicians whose charge is to develop recommendations regarding (1) the minimum education, training and experience necessary to perform the procedure or service; (2) the extent of monitoring and supervision that should occur if the Privileges are granted; (3) the number and types of references required; (4) the re-privileging requirements, such as continuing medical education or documented competence; and (5) a listing of any associated required resources, equipment, personnel to provide the procedure or service;

(4) The Credentials Committee shall forward its recommendations to the Medical Executive Committee and the Medical Executive Committee shall then forward its recommendation to the Board of Directors for final action. The Board of Directors shall then approve the

minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question; and

(5) Once the foregoing steps are completed, specific requests from eligible Medical/Dental Staff appointees/applicants who wish to perform the procedure or service shall be handled in accordance with the procedures for requesting an increase in Clinical Privileges.

SECTION E: CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

(1) Requests for Clinical Privileges that traditionally have been exercised at the Medical Center only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privileges in question.

(2) The Credentials Committee shall conduct research and consult with experts, via an ad hoc task force which may consist of Medical/Dental Staff members, Chiefs of Service (including the Chiefs of Service or designees of potentially impacted departments), individuals with special expertise or interest and those outside the Medical Center.

(3) The Credentials Committee shall develop recommendations regarding (a) the minimum education, training, and experience necessary to perform the Clinical Privileges in question, and (b) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the Privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board for final action.

SECTION F: SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for Clinical Privileges for dentists and oral surgeons are processed in the same manner as all other privilege requests. All dental inpatients must receive a basic medical appraisal by a member of the Medical/Dental Staff, unless the basic medical appraisal has been performed by the attending dentist or oral surgeon and such dentist or oral surgeon has been granted Privileges to perform such appraisal.

Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence. A physician appointee of the Medical/Dental Staff will also be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization. This physician will have the responsibility for the overall medical care of the patient and any surgical procedure performed must be with his knowledge and concurrence.

SECTION G: SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONALS

A health professional may, subject to any licensure requirements or other limitations, exercise judgment only within the areas of his professional competence and participate directly in the medical management of patients under the supervision/collaboration of a physician member of the Medical/Dental Staff. An Allied Health Professional can be granted only those Privileges possessed by his supervising/collaborating physician.

SECTION H: REQUESTS FOR ADDITIONAL PRIVILEGES OR MODIFICATION TO EXISTING PRIVILEGES

Any Medical/Dental Staff member either in connection with reappointment or at any other time, may request modification of Clinical Privileges or additional Privileges by submitting a written request to the Medical/Dental Staff Office. The request for additional Privileges or

modification in Privileges will be submitted, along with, if required, supporting documentation demonstrating additional education, training and current clinical competence and experience which justifies the change in the specific Privileges requested, to the Chief of Service. The request will be processed as delineated in Article II of this manual and the procedures defined in the Professional Practice Evaluation Policy and Procedure.

(1) When approved by the Board of Directors, the applying physician will be notified in writing and may then exercise the privilege(s).

SECTION I: FAILURE TO UTILIZE MEDICAL CENTER PRIVILEGES

After two (2) consecutive years in which a member of the Staff fails to regularly care for patients in the Medical Center or its affiliates, or be regularly involved in Medical/Dental Staff functions as reasonably determined by the Medical/Dental Staff Bylaws, Rules and Regulations, this Credentialing Procedures Manual, the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Manual or any other relevant Medical/Dental Staff Policies and Procedures, or those of the Medical Center, the Staff member may, upon a finding by the Chief of Service and the Credentials Committee with the recommendation of the MEC and the approval of the Board of Directors, be transferred to the appropriate Medical/Dental Staff category for which the member is qualified, or removed from the Medical/Dental Staff, or have Privileges reduced, without any procedural or hearing rights as outlined in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review Manual. Such an action is not reportable.

SECTION J: TEMPORARY PRIVILEGES

CONDITIONS: Temporary Privileges may be granted only in the circumstances described below, only to an appropriately licensed practitioner, only upon written request and when verified information supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the Privileges requested and only after the practitioner has satisfied the professional liability insurance requirement established by the Board of Directors.

(1) The Chief of Service responsible for supervision may impose special requirements of consultation and reporting. Temporary Privileges will not be granted unless the practitioner has agreed in writing to abide by the Medical/Dental Staff Bylaws, Rules and Regulations and policies of the Medical/Dental Staff and all applicable policies, procedures and rules and regulations of the Medical Center in all matters relating to his temporary Privileges.

All requests for temporary Privileges must include a completed application for temporary Privileges, verification of current licensure, relevant training or experience, current competence, ability to perform the Privileges requested, results of a National Practitioner Data Bank query and a statement from the applicant that there is no current or previously successful challenge to licensure or registration, applicant has not been subject to voluntary or involuntary termination of Medical/Dental staff membership at another organization or has not been subject to voluntary or involuntary limitation, reduction, denial or loss of Clinical Privileges at another organization; all positive professional references and positive attestation of ability to perform the Privileges requested.

(2) **CIRCUMSTANCES**: Upon written concurrence of the Chief of Service, the President of the MEC and the Chief Medical Officer, the CEO or designee(s) may grant temporary Privileges in the following circumstances

PENDENCY OF APPLICATION: After receipt of a completed application for staff appointment that raises no concerns, including a written request for specific temporary Privileges, upon verification of the following: current license, relevant training or experience, current competence, ability to perform the Privileges requested, a query and evaluation of the National Practitioner Data Bank information, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of Medical/Dental staff membership at another institution and no subjection to involuntary limitation, reduction denial or loss of Clinical Privileges. Such temporary Privileges may be granted for a period of not more than 120 days.

Such requests will not be processed until the application has been reviewed and supported by the Chief of Service as necessary for the ongoing care of patients serviced by the sponsoring department, recommended by the Credentials Committee and is awaiting review and approval by the Medical Executive Committee and the Board of Directors. If such temporary Privileges are granted, the applicant shall act under the supervision of the Chief of Service of the department in which the applicant has requested primary Privileges

OR

IMPORTANT PATIENT CARE, TREATMENT AND SERVICE NEED: Upon receipt of a request, whether written, via telephone or verbal, temporary Privileges may be granted when there is an important patient care, treatment or service need as determined by the Chief Medical Officer or his designee. Specifically, temporary Privileges may be granted: for the care of one or more specific patients from a practitioner who is or is not an applicant for Staff appointment, or to an individual serving as a locum tenens for a Staff appointee, upon verification of current licensure and current competence; all subject to review by the Chief Medical Officer or his designee. The time period for these temporary Privileges will be granted for only that to meet the need, and not to cumulatively exceed 120 days in a twelve month period. Repeated issuance of temporary Privileges for the same practitioner is strongly discouraged and the number granted in a 12 month period will be at the joint discretion of the CMO and President of the Medical/Dental Staff.

Such Privileges shall be restricted to the care of the specific patient(s) or performance of the specific procedure(s) or service(s) or replacement coverage for a Medical/Dental Staff member for a specified period of time.

Information collected and verified in this instance will minimally include:

- New York State license and all other active licenses
- Proof of professional liability insurance
- Query and response from AMA or AOA Physician Master File
- Query and response from National Practitioner Data Bank
- Query and response from OIG Sanctions Data Bank
- Written or verbal reference from a peer attesting to the current competence of the individual

(3) **PERIOD OF TEMPORARY PRIVILEGES**: Temporary Privileges may not be granted for longer than 120 days in a 12 month period.

(4) **TERMINATION OF TEMPORARY PRIVILEGES**: For any or no reason, or upon the discovery of any information relative to the endangerment of a patient’s life or well being or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary Privileges granted, the CEO or his designee, upon consultation with the appropriate Chief of Service and the Medical/Dental Staff President, may terminate

any or all of a practitioner's temporary Privileges. In the event of any such termination, the practitioner's patients then in Erie County Medical Center Corporation will be assigned to a Medical/Dental Staff member with appropriate Clinical Privileges by the Chief of Service. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

(5) **RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES**: The approval of temporary Privileges is wholly discretionary and is a revocable license which does not confer upon a practitioner any right or expectation. A practitioner is not entitled to the procedural rights afforded by the fair hearing procedures because his request for temporary Privileges is refused or because all or any part of his temporary Privileges are terminated or suspended.

(6) **EMERGENCY PRIVILEGES**: In case of an emergency, any Medical/Dental Staff appointee is authorized, to the degree authorized by his license, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of departmental affiliation, staff category, or level of Privileges. A practitioner exercising emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up. There are no emergency Privileges available to practitioners who are not Medical/Dental Staff appointees.

For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

SECTION K: TELEMEDICINE PRIVILEGES

(1) **DEFINITIONS:**

a. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care from a distance.
b. “Telemedicine Practitioner” means the licensed independent practitioner(s) who have either total or shared responsibility for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.
c. “Interpretive Services” means official readings of images, tracings or specimens through a telemedicine link.
d. “Originating Site” means the site where the patient is located at the time the service is provided.
e. “Distant Site” means the site where the practitioner providing the professional service is located.

(2) **CREDENTIALING AND PRIVILEGING TELEMEDICINE PRACTITIONERS:**

The originating site, has the responsibility to credential and privilege telemedicine practitioners through one of the following mechanisms:

a. The Medical Center may fully credential and privilege the practitioner according to the process outlined in the credentialing procedures **OR**

b. The Medical Center may privilege telemedicine practitioners by using the credentialing information from the distant site provided the distant site is accredited by the Joint Commission as a hospital or ambulatory care organization which has made its decision using the process outlined in the Joint Commission’s standards for hospitals **OR**

c. The Medical Center may use the credentialing and privileging decision from the

distant site to make a final privileging decision provided the distant site is accredited by the Joint Commission as a hospital or ambulatory care organization which has made its decision using the process outlined in the Joint Commission's standards for hospitals.

When utilizing the credentialing format outlined in Section (2)b. or Section (2)c. above, the originating site assures that the distant-site telemedicine entity furnishes services in accordance with all related Medicare Conditions of Participation, Joint Commission Standards and applicable state law.

(3) **CLINICAL SERVICES:** The Credentials Committee shall recommend to the Medical Executive Committee, which shall in turn, recommend to the Board of Directors which clinical services would be appropriately delivered via telemedicine links and which services shall be approved by the Board. The clinical services offered via telemedicine links shall be consistent with commonly accepted quality standards.

SECTION L: DISASTER PRIVILEGES

(1) **CONDITIONS:** Disaster Privileges (Policy MS-004) may be granted to volunteers eligible to be licensed independent practitioners, by the President of the Medical/Dental Staff, CEO or Chief Medical Officer or their designee(s) when the Medical Center's emergency management plan has been activated and the Medical Center is unable to handle the immediate patient care needs. Disaster Privileges may be granted to licensed independent practitioners upon the provision of a valid government issued photo identification issued by a state or federal agency and at least one of the following:

a. A current picture hospital ID card that clearly identifies professional designation;
b. A current license to practice;
c. Primary source verification of the license;
d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), or The Emergency System for Advance Registration of Volunteer Health Professionals Program (ESAR-VHP), or other recognized state or federal organizations or groups;
e. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or
f. Identification by current hospital or Medical/Dental Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

(2) **VERIFICATION:** Primary source verification of licensure should begin as soon as the immediate situation is under control or be completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization or as soon as practicable. Verification of the credentials of any such individuals shall be a high priority and the Medical/Dental Staff Office shall begin the verification process of the credentials and Privileges of individuals who have been granted disaster Privileges as soon as the immediate situation is under control. In the extraordinary circumstance when there is no means of communication or a lack of resources, documentation should be maintained of why the primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and an attempt to rectify the situation as soon as possible. The verification process shall be identical to the process used to grant temporary Privileges based on an important patient care need.

(3) **OVERSIGHT:** To the extent practicable, the Medical/Dental Staff shall oversee the professional practice and performance of volunteer licensed independent practitioners through direct observation, mentoring and/or clinical record review, and will provide a mechanism to readily identify volunteer practitioners who have been granted disaster Privileges.

(4) **TERMINATION OF DISASTER PRIVILEGES:** Upon deactivation of the Medical Center's emergency management plan, or upon the action of the Chief Medical Officer or the CEO, an individual's disaster Privileges shall terminate.

(5) **RIGHTS OF THE PRACTITIONER WITH DISASTER PRIVILEGES:** The approval of disaster Privileges is wholly discretionary and is a revocable license which does not confer upon a practitioner any right or expectation. A practitioner is not entitled to invoke the fair hearing procedures following a denial of his request for disaster Privileges or following the termination or suspension of any part of his disaster Privileges.

SECTION M: TRAINING CLINICAL PRIVILEGES

(1) **REQUEST:** A request for Training Clinical Privileges to receive training must be made in writing by the appropriate Chief of Service. Applicable situations include but are not limited to fellows in non-accredited programs. Such privileges will be granted upon the written concurrence of the President of the Medical/Dental Staff and the Chief Medical Officer, who shall review and consider the clinical competency of the applicant. The granting of training privileges does not confer any rights or privileges of Membership on the Medical/Dental Staff. In the event the applicant's request for Training Clinical Privileges is denied or the privileges are terminated, such an action would not constitute facts or circumstances which would be considered a limitation of privileges resulting in a report to the Office of Professional Medical Conduct (OPMC) or the equivalent regulatory body of the state in which the applicant is licensed.

The request must include a copy of the practitioner's current NYS license (or other state license as allowed by the New York State Education Department), as well as satisfactory evidence of adequate professional liability insurance coverage, a copy of the practitioner's CV, documentation of the practitioner's current privileges and verification of a recent health review with PPD test and results.

ARTICLE V: REAPPLICATION AND MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES AND EXHAUSTION OF REMEDIES

SECTION A: REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION

Except as otherwise determined by the MEC or Board of Directors, in light of exceptional circumstances, a Practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or Clinical Privileges to avoid a potential adverse decision is not eligible to reapply to the Medical/Dental Staff for a period of at least five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal unless special consideration has been provided by the MEC. Any such application is processed in accordance with the procedures set forth in Article II of this manual as an initial application. As part of the reapplication, the practitioner must submit such additional information as the Medical/Dental Staff and/or Board of Directors requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

If an appointee has received an adverse decision based on the following situations, then a reapplication will not be accepted unless there is a change in circumstances:

(a) On the basis of the Medical Center's present inability as supported by documented evidence to provide adequate facilities or supportive services for the applicant and his patients;
(b) On the basis of inconsistency with the Medical Center's management plan including the mix of patient care services to be provided, as currently being implemented;
(c) On the basis of professional contracts the Medical Center has entered into for the provision of services within various departments; or
(d) On the basis of his failure to achieve specialty board certification within the time period defined by the appropriate specialty board or within four (4) years of appointment to the Medical/Dental Staff (unless an exception applies).

No Practitioner may submit or have more than one application for initial appointment or reappointment at any given time.

SECTION B: RESIGNATION OF STAFF APPOINTMENT

A Practitioner may resign his staff appointment and/or Clinical Privileges by providing written notice, through the Medical/Dental Staff Office, to the Chief of Service. The resignation shall specify the reason for the resignation and the effective date. A Practitioner who resigns his staff appointment and/or Clinical Privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation and may be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and so is reportable to the National Practitioner Data Bank pursuant to Health Care Quality Improvement Act of 1986. Notwithstanding the above, the Chief Medical Officer may be required to report to the New York State Department of Health, Office of Professional Medical Conduct and to the Medical Licensing Board of the Office of the Professions any voluntary or involuntary termination of Privileges in the event it is to avoid the imposition of disciplinary measures, when and as required by applicable state law or the Health Care Quality Improvement Act of 1986.

SECTION C: EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every Practitioner agrees that when corrective action is initiated or taken according to the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures, or when an adverse action or recommended action as defined in the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures is proposed or made, will exhaust all of the administrative remedies afforded in the various sections of the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

SECTION D: REPORTING REQUIREMENTS

The CEO or his designee shall be responsible for assuring that the Medical Center satisfies its obligations under the relevant New York State laws and under the Health Care Quality Improvement Act of 1986 and its successor statutes.

ARTICLE VI: LEAVE OF ABSENCE

SECTION A: LEAVE STATUS

(1) A staff appointee may request a voluntary leave of absence (for any period longer than eight (8) weeks) by providing written notice to the Chief of Service for transmittal through the Medical/Dental Staff Office, to the Medical Executive Committee and the Board of Directors. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed two (2) years, except for military service. Members of the Medical/Dental Staff or individuals with Clinical Privileges must report to the Chief Medical Officer any time they are away from the Medical Center and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical/Dental Staff, may trigger an automatic leave of absence.

(2) The Chief Medical Officer shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Chief Medical Officer shall consult with the President of the Medical/Dental Staff and the relevant Chief of Service.

(3) During the leave of absence, the individual shall not exercise any Clinical Privileges or prerogatives except the obligation to pay dues shall continue unless waived by the Medical Executive Committee. In addition, the individual shall be excused from all Medical/Dental Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period and prerogatives and responsibilities are inactive. Adequate insurance coverage as may be required by the Board of Directors must remain in effect during any leave.

SECTION B: TERMINATION OF LEAVE

At the conclusion of the leave, the individual may request reinstatement by sending a written notice to the Chief of Service through the Medical/Dental Staff Office, to the Medical Executive Committee. In no circumstance shall the staff member's appointment to the Medical Dental Staff extend beyond two years. Should the leave extend beyond the re-appointment date, the staff member may choose to re-appoint while on leave with the understanding that he/she may be required to undergo FPPE on return. The staff appointee may be required submit a written summary of relevant professional activities. The staff appointee must also provide any other information as may be requested by the Credentials and Medical Executive Committees. The Medical Executive Committee makes a recommendation to the Board of Directors concerning reinstatement, and the applicable procedures are followed.

If the leave of absence was for health reasons, then the individual must submit a report from his attending physician indicating that the individual is physically and/or mentally capable of resuming a Medical Center practice and exercising the Clinical Privileges requested. The individual shall also provide such other information as may be requested by the Medical Center at that time. After considering all relevant information, the Credentials and Medical Executive Committees shall then make a recommendation to the Board of Directors for final action.

In acting upon the request for reinstatement, the Board of Directors may approve reinstatement either to the same or a different staff category, and may limit or modify the Clinical Privileges to be extended to the individual upon reinstatement.

ARTICLE VII: PRACTITIONER HEALTH

SECTION A: PRACTITIONER HEALTH FUNCTION

The MEC and ECMCC Board of Directors, in support of the Provider Health and Wellness Policy, has established provisions for a Professional Development and Wellness Committee, which supports an established, referral, monitoring and counseling process in which a practitioner who is determined to be impaired by drugs, alcohol or other substance or chemical abuse or who is known to have a physical, mental or emotional impairment or illness which affects his ability to perform the Privileges requested, shall be required to participate. A description of the roles and responsibilities of this committee as well as the procedures to be followed is found in the Medical/Dental Staff Rules and Regulations Part II Manual. As appropriate to the particular conditions and circumstances involved and as necessary to protect the health and safety of the Medical Center's patients, this Committee provides a resource to the Credentials Committee, Medical Executive Committee and Board of Directors as it applies to privileging of providers.

SECTION B: FOR KNOWN OR SUSPECTED PHYSICAL/MENTAL HEALTH IMPAIRMENTS OR SUSPECTED SUBSTANCE ABUSE

A Practitioner who is known to have or who is suspected of having a physical/mental health impairment or who is suspected of having a drug, alcohol or other chemical or substance abuse problem shall be required to provide such information, to obtain such examinations, or to submit to such tests from such practitioner as designated, including random on-the-spot tests, as may reasonably be requested by any two of: the Medical/Dental Staff President, the Chief Medical Officer, a Chief of Service, or the CEO.

SECTION C: COMPLIANCE WITH NEW YORK STATE DEPARTMENT OF HEALTH MANDATES

All credentialed providers will comply with New York State requirements regarding documentation of health status, including but not limited, to the following:

1. Upon Initial Appointment:
    a. Provision of a physical examination and recorded medical history, of sufficient scope to ensure the provider is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties or granted clinical privileges.
    b. Certification of immunity against rubella by one of the following
        i. Evidence of immunization
        ii. Serologic evidence of rubella antibodies
        iii. Evidence of immunization/serologic evidence of rubella antibodies received from a prior employer or the school attended by the provider.
    c. Certification of immunity against measles by one of the following:
        i. Evidence of immunization
        ii. Serologic evidence of measles antibodies
        iii. Documentation of having had measles, by the provider who diagnosed the provider's measles.
        iv. Evidence of immunity as received from a prior employer or the school attended by the provider.
    d. An initial tuberculosis (TB) risk assessment, symptoms evaluation and TB test (either tuberculin skin test or FDA approved blood assay for the detection of latent tuberculosis infection). Any positive findings should be

addressed by the provider's primary care provider or by contacting ECMCC's Center for Occupational & Environmental Medicine (COEM). Documented outcomes following referral for high risk or positive findings should be provided to the Medical Dental Staff Office.

e. Documentation of vaccination against influenza or declination, indicating education and consent to wear a procedure mask.
f. Documentation of any other vaccinations required by federal or New York state law.

2. Annually thereafter, the Provider agrees to submit:
   a. Provision of a Medical Evaluation Statement, completed by a licensed independent practitioner not related to the Provider by blood or marriage:
      i. Includes documentation that the applicant is free from physical or mental impairment including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of duties or would impose a potential risk to patients or personnel.
      ii. Includes an appropriate tuberculosis risk assessment screening tool, indicating that the provider is deemed low risk, annual screening is recommended.
      iii. Documentation may be accepted from another qualifying institution if all of the requirement elements are met and documented appropriately.
      iv. Should the tuberculosis risk assessment identify the need for PPD testing and if any additional testing/treatment is needed, the provider may seek consult/treatment from his/her primary care provider or ECMC's Center for Occupational & Environmental Health Office, and will provide documentation of same to the Medical Dental Staff Office.
   b. Evidence of annual flu vaccine or declination.
   c. Documentation of any other vaccinations required by federal or New York state law.
3. These requirements apply to all credentialed medical staff providers, with the exception of those physicians who are practicing medicine from a remote location, as a condition of affiliation.
4. Failure to comply with these requirements will be addressed through the ECMC Bylaws, Rules & Regulations.

ARTICLE VIII: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

SECTION A: EXCLUSIVITY POLICY

The Medical Center may enter into contracts with physicians, groups of physicians or other health care providers for the performance of clinical services at the Medical Center. To the extent that any such contract confers the exclusive right to perform specified services at the Medical Center on any individual or group of individuals, no other individual may exercise Clinical Privileges to perform the specified services while the contract is in effect. Individuals performing specified professional services pursuant to contracts with the Medical Center must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of appointment as any other applicant or staff appointee. Application for initial appointment or for Clinical Privileges related to the Medical Center's 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 Medical Center.

ARTICLE IX: MEDICO-ADMINISTRATIVE OFFICERS

SECTION A: DEFINITION

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

A medico-administrative officer must achieve and maintain Medical/Dental Staff appointment and Clinical Privileges appropriate to his clinical responsibilities, and discharge Staff obligations appropriate to his staff category, in the same manner applicable to all other Staff members. Physicians, dentists, podiatrists and Allied Health Professionals employed in a purely administrative capacity with no clinical duties are subject to the Medical Center's Human Resource policies and are not required to be Medical/Dental Staff members or hold Clinical Privileges.

SECTION B: EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN APPOINTMENT STATUS OR CLINICAL PRIVILEGES

(1) Where a contract exists between the officer and the Medical Center, its terms govern any of the following matters that are addressed in it:

(a) The effect of removal from the medico-administrative office on the Officer's staff appointment and Clinical Privileges; and
(b) The effect of an adverse change in the officer's Staff appointment or Clinical Privileges on his remaining in office.

In the absence of a contract or where the contract is silent on the matter, upon termination of the contractual arrangement, the Medical/Dental Staff membership or Privileges of the Medico-Administrative Official may be terminated without hearing and appellate review, except for instances in which the practitioner may be entitled to request a hearing under the Collegial Intervention, Peer Review, Fair Hearing and Appellate Review procedures.

ARTICLE X: PERIOD REVIEW, ADOPTION AND AMENDMENT

SECTION A: REVIEW PERIOD

The Credentials and Medical Executive Committees will review this Credentials Procedures Manual at least every three (3) years.

SECTION B: AMENDMENT

This Credentials Procedures Manual will be initially adopted by resolution of the Credentials Committee, Medical Executive Committee, the Active Medical/Dental Staff and the Board of Directors. Thereafter, it may be amended or repealed, in whole or in part, by a resolution of the Credentials and Medical Executive Committees as recommended to and adopted by the Board of Directors.

SECTION C: CORRECTIONS

The Credentials Committee may correct non-substantive typographical, spellings or other

obvious errors in this manual without other approval or voting. The Medical Executive Committee may also make any changes specifically required by law, state regulation or Joint Commission standards, to be approved by the Board of Directors.

SECTION D: RESPONSIBILITIES AND AUTHORITY

The procedures outlined in the Medical/Dental Staff and Erie County Medical Center Corporation's Corporate Bylaws regarding Medical/Dental Staff responsibility and authority to formulate, adopt and recommend Medical/Dental Staff bylaws and amendments thereto apply as well to the formulation, and adoption of this Credentials Procedures Manual. In the event of any conflict or inconsistency among such documents, the following priority shall control: 1) the Medical Center's Corporate Bylaws; 2) Medical/Dental Staff Bylaws; and 3) Credentials Manual.

The Medical/Dental Staff shall comply with all applicable laws and regulations governing the credentialing and privileging of healthcare providers, including without limitation, New York Public Health Law §§ 2801-b, 2805-j and 2805-k, and JC standards. Notwithstanding anything herein to the contrary, the Medical/Dental Staff and the Board shall not refuse to act upon an application for Staff Privileges, or deny or withhold Staff Privileges, or exclude, expel, terminate or curtail the Privileges of a qualified Practitioner without stating the reason(s) therefore, or for reasons that are unrelated to standards of patient care, patient welfare, the objectives of the Medical Center or the character or competency of the applicant.

ARTICLE XI: USE OF TERMS

(1) Words used in this Credentials Procedures Manual shall be read as the masculine or feminine gender and as the singular or plural as the context and circumstances require. The captions or headings in this Credentials Procedures Manual are for convenience only and are not intended to limit or define the scope or effect of any provision of this Manual.

(2) When used herein the terms "Relevant peer review/Practice Improvement committee," "Credentials Committee", "President", "Chief of Service", "Chief Medical Officer ", "CEO" and "Board of Directors" are construed to include their "designee".

(3) "All supporting documentation," means the application form and its' accompanying information, the reports and recommendations of the Chief of Service, Credentials Committee, MEC and all dissenting views, if any.

(4) "Adverse recommendation" from the MEC or an "adverse action" by the Board of Directors as referred to in the appointment process means a clinical assignment to reduce staff category without his consent; or to deny or restrict requested Clinical Privileges. *The term "applicant" as used in these Sections shall be read, as "staff appointee."

(5) "Adverse action" by the Board of Directors means action to deny appointment, reappointment or to deny or restrict requested Clinical Privileges, or any change in staff category without the staff appointee's consent.

(6) "Special notice" written correspondence sent by certified mail, return receipt requested or other delivery method capable of verified receipt.

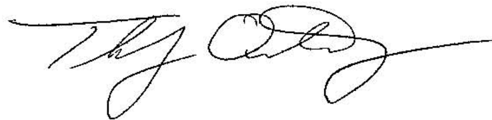
ADOPTION AND APPROVAL

ADOPTION:

Adopted by the Medical/Dental Staff:

Jennifer Pugh, MD
Medical/Dental Staff President
Date: 1/25/2023

Approved by the Board of Directors:



Thomas Quatroche, Jr., PhD
CEO, Erie County Medical Center Corporation
Date: 1/25/2023

REVISIONS:

Medical Executive Committee: Revised: November 21, 2011, July 23, 2012, April 28, 2014, May 18, 2015, November 16, 2015, May 23, 2016, May 20, 2019, January 27, 2020, March 22, 2021; November 22, 2021, October 24, 2022

Board of Directors Committee: Ratified: December 6, 2011, July 31, 2012, April 29, 2014, May 26, 2015, December 15, 2015, May 31, 2016, July 30, 2019, January 28, 2020, March 30, 2021; November 23, 2021, January 25, 2023