Erie County Medical Center Corporation

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January 2026

Medical Dental Staff Bylaws

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

MEDICAL/DENTAL STAFF BYLAWS

Adopted by the Medical Executive Committee on November 24, 2025
Adopted by the Medical/Dental Staff on December 10, 2025
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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in all the Medical/Dental Staff documents are set forth in the Medical/Dental Staff Credentials & Procedural Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Administrative Leadership, by a Medical/Dental Staff member, or by a Medical/Dental Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Medical Center employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of these Medical/Dental Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee or individual that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under these Bylaws is unavailable or unable to perform that function, one or more of the Medical/Dental Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of these Bylaws, technical or minor deviations from the procedures set forth within these Bylaws do not invalidate any review or action taken.

ARTICLE 2

CATEGORIES OF THE MEDICAL/DENTAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical/Dental Staff contained in the Credentials & Procedural Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix A** to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff will consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are regularly involved in patient care at the Medical Center, as evidenced by being involved in at least 36 patient contacts per appointment term; and

(b) have contributed or expressed a willingness to contribute to Medical/Dental Staff functions and/or demonstrated a commitment to the Medical/Dental Staff and Medical Center through service on committees, service in Medical/Dental Staff leadership, and/or active participation in performance improvement or peer review functions.

For purposes of this Article, "patient contacts" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Medical Center or its hospital-based clinics. Patient contacts do not include referrals for diagnostic or laboratory tests or imaging studies.

Guidelines:

If at the time of reappointment questions arise about whether an individual's relationship to the Medical Center fits within the specified purpose of this category, the Credentials Committee has the discretion to assign the individual to another Medical/Dental Staff category that is more appropriate. This means that unless an Active Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the requirements of this category:

* A member who has fewer than 36 patient contacts during his or her appointment term may not be eligible to request Active Staff status at the time of his or her reappointment.

** The member may be transferred to another staff category that best reflects his or her relationship to the Medical/Dental Staff and the Medical Center (options – Associate or Courtesy, Refer, and Follow).

2.A.2. Prerogatives:

Active Staff members:

(a) may admit patients and otherwise exercise such clinical privileges as are granted to them;

(b) may attend and participate in Medical/Dental Staff and applicable department, division/clinical service, and committee meetings (with vote);

(c) may hold Medical/Dental Staff office and serve as Chiefs of Service, Associate Chiefs of Service, Physician Advisors, and chairs of standing Medical/Dental Staff committees;

(d) may be appointed to Medical/Dental Staff committees (with vote);

(e) will be required to participate on the Emergency Department on-call schedule and to respond promptly (in accordance with the applicable Medical/Dental Staff policies) when called to render clinical services within their area of specialization;

(f) will pay applicable fees, dues, and assessments, as set by the Medical Center and the MEC; and

(g) will perform the basic responsibilities set forth in Section 2.B.1 of the Credentials & Procedural Policy and other assigned duties, as applicable.

2.B. ASSOCIATE STAFF

2.B.1. Qualifications:

The Associate Staff will consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) provide consultations, specialty coverage, or other services not otherwise available or in limited supply on the Active Staff;

(b) are involved in at least one, but fewer than 36, patient contacts per appointment term; and

(c) meet all the same threshold eligibility criteria as other Medical/Dental Staff members.

At each reappointment time, Associate Staff members must provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

If at the time of reappointment questions arise about whether an individual's relationship to the Medical Center fits within the specified purpose of this category, the Credentials Committee has the discretion to assign the individual to another Medical/Dental Staff category that is more appropriate. This means that unless an Associate Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the requirements of this category:

* Any member who has no patient contacts during his or her appointment term may be transferred to the Courtesy, Refer, and Follow staff category unless an exception is granted.

** Any member who has 36 or more patient contacts during his or her appointment term may be transferred to Active Staff status.

*** Any member who is only providing coverage for another member, group, or specialty at the Medical Center may not be eligible to request reappointment if he or she no longer provides such coverage or if such service should otherwise become readily available on the Active Staff.

2.B.2. Prerogatives and Responsibilities:

Associate Staff members:

(a) may admit patients and otherwise exercise such clinical privileges as are granted to them;

(b) may attend and participate in Medical/Dental Staff, department, and division/clinical service meetings (without vote);

(c) may not hold Medical/Dental Staff office or serve as a Chief of Service, Associate Chief of Service, Physician Advisor, or chair of a Medical/Dental Staff committee;

(d) may be appointed to Medical/Dental Staff committees (with vote);

(e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

(1) will respond to the Emergency Department (either personally or through his or her designated coverage) whenever contacted about one of their patients who presents to the Emergency Department and assist in guiding that patient's care, including the provision of any applicable consultations,

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) will be required to serve on the Emergency Department on-call schedule for his or her specialty if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(f) will pay applicable fees, dues, and assessments, as set by the Medical Center and the MEC; and

(g) will perform the basic responsibilities set forth in Section 2.B.1 of the Credentials & Procedural Policy and other assigned duties, as applicable.

2.C. COURTESY, REFER, AND FOLLOW STAFF

2.C.1. Qualifications:

The Courtesy, Refer, and Follow Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

(a) desire to be associated with, but who do not intend to establish clinical practice at, the Medical Center;

(b) meet the eligibility criteria set forth in the Credentials & Procedural Policy except for those criteria in Section 2.A.1 that are related to an inpatient clinical practice; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership of the Courtesy, Refer, and Follow Staff as outlined in Section 2.C.2.

The primary purpose of the Courtesy, Refer, and Follow Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Medical Center services for their patients by referring patients to the Medical Center for admission and care.

2.C.2. Prerogatives and Responsibilities:

Courtesy, Refer, and Follow Staff members:

(a) may ***not***: admit patients, attend patients, exercise clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Medical Center;

(b) may attend meetings of the Medical/Dental Staff and applicable departments or divisions/clinical services (without vote);

(c) may not hold Medical/Dental Staff office or serve as a Chief of Service, Associate Chief of Service, Physician Advisor, or chair of a Medical/Dental Staff committee;

(d) may be appointed to Medical/Dental Staff committees (with vote);

(e) may attend educational activities sponsored by the Medical/Dental Staff and the Medical Center;

(f) may refer patients to the Medical Center for admission and/or care;

(g) are encouraged to submit their relevant outpatient records for inclusion in the Medical Center's medical records for any patients who are referred;

(h) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(i) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(j) may submit history and physical examinations performed in the office and have those reports entered into the Medical Center's medical records;

(k) may be asked to accept referrals from the Emergency Department for follow-up care of patients treated and released from the Emergency Department;

(l) may refer patients to the Medical Center's diagnostic facilities and order such tests;

(m) will pay applicable fees, dues, and assessments, as set by the Medical Center and the MEC; and

(n) will perform the basic responsibilities set forth in Section 2.B.1 of the Credentials & Procedural Policy and other assigned duties, as applicable.

2.D. ADMINISTRATIVE STAFF

2.D.1. Qualifications:

The Administrative Staff will consist of Practitioners who provide administrative services to the Medical Staff and Medical Center but who do not have any clinical practice at the Medical Center.

2.D.2. Prerogatives and Responsibilities:

Administrative Staff members:

(a) do not intend to establish a clinical practice at this Medical Center, are not seeking and will not be granted clinical privileges, and are not subject to focused professional practice evaluation and ongoing professional practice evaluation;

(b) may attend and participate in Medical/Dental Staff, department, and division/clinical service meetings (without vote);

(c) may not hold Medical/Dental Staff office or serve as a Chief of Service, Associate Chief of Service, Physician Advisor, or chair of a Medical/Dental Staff committee;

(d) may be appointed to Medical/Dental Staff committees (with vote);

(e) may attend educational activities of the Medical Staff and the Medical Center; and

(f) will pay applicable fees, dues, and assessments, as set by the Medical Center and the MEC.

2.E. EMERITUS STAFF

2.E.1. Qualifications:

(a) The Emeritus Staff will consist of physicians, dentists, oral surgeons, and podiatrists of outstanding professional and personal reputation who the MEC has chosen to honor in recognition of distinguished service to the Medical Center and/or the community or for distinguished professional achievement by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their long-standing service to the Medical Center.

(b) Once an individual is appointed to the Emeritus Staff, that status is ongoing unless revoked by the Board. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.E.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) may not admit patients or otherwise exercise clinical privileges at the Medical Center;

(b) may attend Medical/Dental Staff and department and division/clinical service meetings when invited to do so (without vote);

(c) may be appointed to Medical/Dental Staff committees (with vote);

(d) may attend educational activities sponsored by the Medical/Dental Staff and the Medical Center;

(e) may not hold Medical/Dental Staff office or serve as a Chief of Service, Associate Chief of Service, Physician Advisor, or chair of a Medical/Dental Staff committee; and

(f) are not required to pay application fees, dues, or assessments.

2.F. ALLIED HEALTH PROFESSIONAL STAFF

2.F.1. Qualifications:

The Allied Health Professional Staff will consist of practitioners who satisfy the qualifications and conditions for appointment contained in the Credentials & Procedural Policy.

2.F.2. Prerogatives and Responsibilities:

Allied Health Professional Staff members:

(a) may exercise such clinical privileges as are granted to them, but may not admit patients;

(b) may attend meetings of the Medical/Dental Staff and applicable department and division/clinical service meetings (with vote);

(c) may be appointed to Medical/Dental Staff committees (with vote);

(d) may not hold Medical/Dental Staff office or serve as a Chief of Service, Associate Chief of Service, Physician Advisor, or chair of a Medical/Dental Staff committee;

(e) may attend educational activities sponsored by the Medical/Dental Staff and the Medical Center;

(f) will pay applicable fees, dues, and assessments, as set by the Medical Center and the MEC; and

(g) will perform the basic responsibilities set forth in Section 2.B.1 of the Credentials & Procedural Policy and other assigned duties, as applicable.

2.G. CLINICAL PRIVILEGES WITHOUT APPOINTMENT

The following types of affiliations with the Medical Center include a grant of clinical privileges only. Practitioners who are granted clinical privileges but who are not considered to be members of the Medical/Dental Staff include, but are not limited to:

(1) moonlighting physicians in training;

(2) temporary privileges (important patient care need);

(3) locum tenens providers; and

(4) distant-site telemedicine providers.

Practitioners who have been granted clinical privileges without appointment may exercise such clinical privileges as are granted to them but will generally have no Medical/Dental Staff prerogatives or responsibilities. However, such practitioners may be invited to serve on committees (with vote), when they are willing and able. Any privileges granted to an individual in this category pursuant to a contractual arrangement will expire when the agreement is terminated, not renewed, or expires, without the right to a hearing or appeal.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical/Dental Staff will be the Medical/Dental Staff President, Medical/Dental Staff President-Elect, Secretary, Treasurer, and Immediate Past Medical/Dental Staff President.

3.B. ELIGIBILITY CRITERIA

(1) Only those members of the Medical/Dental Staff, who satisfy the following criteria initially and continuously, as determined by the Leadership Council, will be eligible to serve as an officer of the Medical/Dental Staff, unless an exception is recommended by the Leadership Council and approved by the MEC. They must:

(a) be appointed in good standing to the Active Staff, and have served on the Medical/Dental Staff for at least two years;

(b) not currently be under investigation by the MEC, and are not currently subject to, and never have been subject to, any adverse recommendations concerning Medical/Dental Staff appointment or clinical privileges at the Medical Center;

(c) not currently be participating in a voluntary improvement plan developed through the Medical/Dental Staff;

(d) not presently be serving as a Medical/Dental Staff officer or Board member at any other hospital and will not so serve during their term of office;

(e) be willing to faithfully discharge the duties and responsibilities of the position;

(f) have experience in a leadership position or other involvement in performance improvement functions at this or other hospitals;

(g) agree to attend continuing education relating to Medical/Dental Staff leadership, credentialing, and/or peer review functions prior to or during the term of the office, when requested by the MEC;

(h) have demonstrated an ability to work well with others; and

(i) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the

Medical Center or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. The Leadership Council and MEC will assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

(2) All Medical/Dental Staff Officers must maintain such qualifications during their term of office. Failure to do so will automatically create a vacancy in the office involved, unless an exception is recommended by the MEC and approved by the Board.

3.C. DUTIES

3.C.1. Medical/Dental Staff President:

The Medical/Dental Staff President will:

(a) act in coordination and cooperation with Medical Center administration in matters of mutual concern involving the care of patients in the Medical Center;

(b) attend meetings of the Board;

(c) represent and communicate the views, policies and needs, and report on the activities, of the Medical/Dental Staff to the CEO and the Board;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical/Dental Staff and the MEC;

(e) work with the CMO to address Medical/Dental Staff issues, as described in these Bylaws and the policies of the Medical/Dental Staff;

(f) chair the MEC and Leadership Council (with vote), as necessary and be a member of all other Medical/Dental Staff committees, *ex officio*, without vote;

(g) oversee adherence to the Bylaws, policies, Rules and Regulations of the Medical/Dental Staff and to the policies and procedures of the Medical Center; and

(h) perform all functions authorized in all applicable policies, including collegial efforts and progressive steps as referenced in the Credentials & Procedural Policy and other relevant Medical/Dental Staff policies.

3.C.2. Medical/Dental Staff President-Elect:

The Medical/Dental Staff President-Elect will:

(a) assume all duties of the Medical/Dental Staff President and act with full authority as Medical/Dental Staff President when the Medical/Dental Staff President is unavailable within a reasonable period of time;

(b) serve on the MEC and the Leadership Council, with vote;

(c) assume all such additional duties as are assigned to him or her by the Medical/Dental Staff President or the MEC; and

(d) become Medical/Dental Staff President upon completion of his or her term.

3.C.3. Secretary:

The Secretary will:

(a) serve on the MEC and the Leadership Council, with vote;

(b) oversee the preparation of accurate and complete minutes of all MEC and general Medical/Dental Staff meetings;

(c) act as parliamentarian and attend to necessary correspondence; and

(d) assume all such additional duties as are assigned to him or her by the Medical/Dental Staff President or the MEC.

3.C.4. Treasurer:

The Treasurer will:

(a) serve on the MEC and the Leadership Council;

(b) be responsible for overseeing the collection of dues and assessments;

(c) keep financial transactions and make financial disbursements as designated by the MEC;

(d) make a financial report of all Medical/Dental Staff funds collected and disbursed during the year at the annual Medical/Dental Staff meeting; and

(e) assume all such additional duties as are assigned to him or her by the Medical/Dental Staff President or the MEC.

3.C.5. Immediate Past Medical/Dental Staff President:

The Immediate Past Medical/Dental Staff President will:

(a) serve on the MEC and Leadership Council, with vote;

(b) serve as an advisor to other Medical/Dental Staff leaders; and

(c) assume all duties assigned by the Medical/Dental Staff President or the MEC.

3.D. NOMINATIONS

(1) The Leadership Council will convene at least 45 days prior to the election and will submit the names of at least one qualified nominee for any vacant office. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees will be provided to the Medical/Dental Staff at least 14 days prior to the election.

(2) Additional nominations may also be submitted in writing by petition signed by at least five members of the Voting Staff at least 14 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Leadership Council, and be willing to serve.

(3) Nominations from the floor will not be accepted.

3.E. ELECTION

(1) Elections will be held at the annual meeting of the Medical/Dental Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Voting Staff present and voting at that meeting will be elected, subject to Board confirmation, which confirmation will signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical/Dental Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election will be held promptly between the two candidates receiving the highest number of votes.

(2) In the alternative, and in the discretion of the MEC, elections may be held by written or electronic ballot returned to the Medical/Dental Staff Office in the manner as indicated on the ballot at the time it is distributed. Ballots will be provided to all members of the Voting Staff and completed ballots must be received in the Medical/Dental Staff Office by the date indicated on the ballot. Those who receive a majority of the votes cast will be elected, subject to Board confirmation, which confirmation will signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical/Dental Staff leadership role.

3.F. TERM OF OFFICE

(1) Officers will serve for a term of two years or until a successor is elected or appointed. The term of office will commence on the first day of the Medical/Dental Staff year following the election.

(2) No Officer may serve more than two consecutive terms in a particular office.

3.G. REMOVAL FROM OFFICE OR MEMBERSHIP ON THE MEDICAL EXECUTIVE COMMITTEE

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, a two-thirds vote of the Voting Staff, or by the Board. Grounds for removal will be:

(a) failure to maintain compliance with the eligibility criteria outlined in Section 2.A.1 of the Medical/Dental Staff Credentials & Procedural Policy;

(b) failure to maintain compliance with the eligibility criteria outlined in Section 3.B of these Bylaws;

(c) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(d) failure to perform the duties of the position held;

(e) conduct detrimental to the interests of the Medical Center and/or its Medical/Dental Staff; or

(f) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual will be given written notice of the date of the meeting at which action is to be considered. The individual will be afforded an opportunity to speak to the MEC, the Voting Staff, or the Board, as applicable, prior to a vote on removal. No removal will be effective until approved by the Board.

3.H. VACANCIES

A vacancy in the office of Medical/Dental Staff President will be filled by the Medical/Dental Staff President-Elect, who will serve until the end of the Medical/Dental Staff President's unexpired term. In the event there is a vacancy in the Medical/Dental Staff President-Elect, Secretary, or Treasurer position, the MEC will appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC. Any such appointment will be subject to Board confirmation,

which confirmation will signify that the individual is entitled to legal protection and indemnification by the Board for acting in a Medical/Dental Staff leadership role.

3.I. ADDITIONAL OFFICERS

The Board may, after considering the advice and recommendations of the MEC, 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 or she must become and remain a member of the Medical/Dental Staff. In all events, he or 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.

3.J. AUTHORITY AND DUTIES OF THE CHIEF MEDICAL OFFICER ("CMO")

The Board has vested in the CMO, 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 Medical Center and accordingly the oversight of the Medical/Dental Staff. One or more Associate Medical Directors may serve to assist the CMO, and in the temporary absence of the CMO, will assume the duties and have the authority of the CMO. They may also perform such additional duties as may be requested by the CEO, the MEC, or the Board.

ARTICLE 4

CLINICAL DEPARTMENTS AND DIVISIONS/CLINICAL SERVICES

4.A. ORGANIZATION

The Medical/Dental Staff will be organized into departments and divisions/clinical services as determined by the MEC and listed in the Organization Manual. In conjunction with the CEO, the MEC may create new departments, eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure, in accordance with the amendment provisions contained in these Bylaws documents.

4.B. ASSIGNMENT TO DEPARTMENTS AND DIVISIONS/CLINICAL SERVICES

(1) Upon initial appointment to the Medical/Dental Staff, each Medical/Dental Staff member will be assigned to a clinical department and division/clinical service, if applicable. Such assignment will be based on an individual's primary area of board certification, as confirmed by the Credentials Committee, and will establish the Medical/Dental Staff member's voting rights within the department.

(2) Assignment to a particular department or division/clinical service does not preclude a Medical/Dental Staff member from seeking and being granted clinical privileges typically associated with another department.

(3) A Medical/Dental Staff member may request a change in department or division/clinical service assignment to reflect a change in his or her clinical practice.

(4) Department or division/clinical service assignment may be transferred at the discretion of the MEC.

4.C. FUNCTIONS OF DEPARTMENTS

Medical/Dental Staff departments will be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges in a given department, and (iii) to arrange for emergency call coverage within the department.

4.D. QUALIFICATIONS OF ELECTED CHIEFS OF SERVICE AND ASSOCIATE CHIEFS OF SERVICE

Each Chief of Service and Associate Chief of Service must:

(1) meet the eligibility criteria in Section 3.B of these Bylaws, except for the two year requirement outlined in (1)(a); and

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process.

4.E. APPOINTMENT, DUTIES, EVALUATION, REMOVAL AND VACANCIES OF CHIEFS OF SERVICE

(1) Appointment.

(a) Each Chief of Service will be appointed by the Board on the recommendation of the CMO with advice from the MEC for a term of one to three years.

(b) Each Chief of Service may be reappointed for additional terms at the discretion of the Board.

(2) Duties.

Chiefs of Service will work in collaboration with other Medical/Dental Staff Leaders and Medical Center personnel to collectively be responsible for the following:

(a) all clinically-related activities of the department;

(b) all administratively-related activities of the department, unless otherwise provided for by the Medical Center;

(c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) the integration of the department into the primary functions of the Medical Center;

(g) the coordination and integration of interdepartmental and intradepartmental services, including (directly, or through a designee), as needed and at the request of the CMO participating in the design and functioning of Medical Center service lines and on Medical Center committees and task forces. Assists the CMO in ensuring compliance by practitioners within his or her

department with Medical Center policies and guidelines especially those related to documentation, corporate compliance and utilization review;

(h) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services, including those related to Emergency Department coverage and consultations;

(i) determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

(j) recommendations for a sufficient number of qualified and competent persons to provide care or services;

(k) continuous assessment and improvement of the quality of care and services provided;

(l) be an active participant in the maintenance of quality monitoring programs, as appropriate;

(m) recommendations for space and other resources needed by the department;

(n) assessing and recommending off-site sources for needed patient care services not provided by the department or the Medical Center;

(o) the orientation and continuing education of all persons in the department;

(p) coordinating functions of the department with Associate Chiefs of Service, as applicable;

(q) serving as voting members of the MEC;

(r) accounting to the MEC on quality review functions within the department and report minimally on a quarterly basis the performance improvement activities within his or her department, including written recommendations, actions, and follow-up;

(s) delegating functions to other qualified members of the department, when appropriate;

(t) working collaboratively within the practice improvement process with the Leadership Council and the Quality Executive Committee to foster a culture of clinical excellence and collegiality among practitioners;

(u) providing for the orientation and continuing education of all persons in the department or service, including medical students and residents assigned by

the State University of New York at Buffalo and other academic institutions, as appropriate;

(v) being responsible for the teaching, education and research programs in his or her department. Work collaboratively with Medical Center administration to ensure Medical Center compliance with any and all affiliation agreements which the Medical Center has in place with external educational institutions;

(w) developing and maintaining a schedule that provides for admission and treatment of Service Patients as defined in the Medical/Dental Staff Rules and Regulations;

(x) developing and maintaining schedules to ensure that emergency coverage is provided to Medical Center patients by his or her department on a 24 hours/7 days per week schedule; and

(y) performing all other functions described in Medical/Dental Staff policy, including those related to focused professional practice evaluation ("FPPE") and ongoing professional practice evaluation ("OPPE").

(3) Evaluation.

(a) The Medical/Dental Staff President, CEO, a majority of the MEC, or a majority of the Voting Staff in the relevant Clinical Service may, for good cause, request that the CMO review the performance of a Chief of Service at any time. 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 will be sent to the applicable Chief of Service and to the Medical/Dental Staff President and the CMO.

(b) If the request is deemed valid by the CMO, he or she will conduct a special review of the applicable Chief of Service. Upon completion of the review, the CMO will formulate a recommendation which will be forwarded to the MEC.

(c) The MEC will confirm it agrees or disagrees with the CMO's recommendation. If it disagrees, the MEC will state its reasons and recommendations concerning the Chief of Service under review.

(d) The recommendations of the CMO and MEC will then be sent to the CEO and Board for final determination.

(4) Removal.

A Chief of Service may be removed by a two-thirds vote of the department, by a two-thirds vote of the MEC, or by the Board (either of its own accord or after receiving a recommendation from the CMO or MEC as described in (2) of this Section) after reasonable notice and opportunity to be heard. Grounds for removal will be:

(a) failure to maintain compliance with the eligibility criteria outlined in Section 2.A.1 of the Medical/Dental Staff Credentials & Procedural Policy;

(b) failure to maintain compliance with the eligibility criteria outlined in Section 3.B of these Bylaws;

(c) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(d) failure to perform the duties of the position held;

(e) conduct detrimental to the interests of the Medical Center and/or its Medical/Dental Staff; or

(f) an infirmity that renders the Medical/Dental Staff member incapable of fulfilling the duties of that office.

Prior to the initiation of any removal action, the Chief of Service will be given written notice of the date of the meeting at which such action will be taken at least 10 days prior to the date of the meeting. The Chief of Service will be afforded an opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on such removal being taken. No removal will be effective until approved by the Board.

(5) Vacancies.

Upon a vacancy in the office of Chief of Service, the Associate Chief of Service or Assistant Director of the department will become Chief of Service for the remainder of the term or until another individual is appointed Chief of Service by the Board.

4.F. APPOINTMENT, DUTIES, REMOVAL, AND VACANCIES OF ASSOCIATE CHIEFS OF SERVICE

(1) Appointment.

(a) Each Associate Chief of Service will be appointed by the Board on the recommendation of the applicable Chief of Service, with the endorsement of the CMO and the MEC, for a term of one to three years.

(b) The Chief of Service in conjunction with the Chief Medical Officer will decide the need for an Associate Chief of Service.

(c) Each Chief of Service and Associate Chief of Service may be reappointed for additional terms at the discretion of the Board.

(2) Duties.

Associate Chiefs of Service will carry out the duties requested by Chiefs of Service. Upon request, these duties may include:

(a) assisting with the review of applications for initial appointment, reappointment, and clinical privileges, including interviewing applicants;

(b) evaluation of individuals to assist with ongoing professional practice evaluation and focused professional practice evaluation;

(c) participation in the development of criteria for clinical privileges;

(d) reviewing and reporting on the professional performance of individuals practicing within the section; and

(e) serving in the absence of the Chief of Service.

Note: As a general rule, an Associate Chief of Service does not have voting privileges on the MEC, except by proxy in the absence of the Chief of Service. However, the MEC, in its sole 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 MEC as members at large.

(3) Removal.

(a) An Associate Chief of Service may be removed by the Chief of Service for any of the following reasons:

(i) failure to maintain compliance with the eligibility criteria outlined in Section 2.A.1 of the Medical/Dental Staff Credentials & Procedural Policy;

(ii) failure to maintain compliance with the eligibility criteria outlined in Section 3.B of these Bylaws;

(iii) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(iv) failure to perform the duties of the position held;

(v) conduct detrimental to the interests of the Medical Center and/or its Medical/Dental Staff; or

(vi) an infirmity that renders the Medical/Dental Staff member incapable of fulfilling the duties of that office.

(b) No removal will be effective until approved by the Board.

(4) Vacancies.

Upon a vacancy in the office of Associate Chief of Service, the Chief of Service will 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.

4.G. DIVISIONS/CLINICAL SERVICES

4.G.1. Division/Clinical Service Requirements:

The MEC may recognize any group of practitioners who wish to organize themselves into a division/clinical service. Divisions/Clinical Services will generally have no meeting, attendance, or minutes requirements. Only when divisions/clinical services are making formal recommendations to a department or the MEC will a report be required.

4.G.2. Division/Clinical Service Activities:

Divisions/Clinical Services may perform any of the following activities:

(a) continuing education;

(b) performance improvement opportunities;

(c) grand rounds;

(d) discussion of policy or equipment needs; and/or

(e) development of recommendations for the relevant Chief of Service or MEC.

4.G.3. Division/Clinical Service Directors:

When the MEC recognizes a Division/Clinical Service, it will appoint a Division/Clinical Service Director who will be responsible for calling special meetings to discuss specific issues as necessary and may also be involved with peer review and credentialing issues, as

requested. In these circumstances, the Division/Clinical Service Director must follow the processes and procedures outlined in the Medical/Dental Staff Bylaws documents and policies and treat all such activities and documentation in a strictly confidential and privileged manner. Any documentation that is created by a Division/Clinical Service Director in this regard will be maintained in the practitioner's confidential Medical/Dental Staff file.

4.H. PHYSICIAN ADVISORS

Liaison or resource physicians for clinical specialties may be appointed by the CMO 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 will not have the title or responsibilities traditionally granted to Chiefs of Service.

4.I. SERVICE LINES

(1) The Medical Center may also establish multi-disciplinary service lines to facilitate the delivery of quality, safe, and effective patient care.

(2) When service lines exist, a physician will be designated to serve as a Service Line Director who will have responsibility for the day-to-day operations of the service line. This physician will work closely with an individual designated by the Medical Center to assist with day-to-day operations and overall management of the service line.

(3) Notwithstanding the creation of services lines, the primary responsibility for activities related to credentialing, privileging, and the evaluation of professional practice related to the practitioners who function within the service line will remain the responsibility of the relevant Chief of Service or other appropriate Medical/Dental Staff Leader or Medical/Dental Staff committee.

(4) Service Line Directors may participate in credentialing, privileging, and evaluation of professional practice activities if requested by a Medical/Dental Staff Leader or Medical/Dental Staff committee. In these circumstances, the Service Line Directors must follow the processes and procedures outlined in the Medical/Dental Staff Bylaws documents and policies and treat all such activities and documentation in a strictly confidential and privileged manner. Any documentation that is created by a Service Line Director in this regard will be maintained in the practitioner's confidential Medical/Dental Staff file.

ARTICLE 5

MEDICAL/DENTAL STAFF COMMITTEES

5.A. MEDICAL/DENTAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical/Dental Staff Organization Manual outline the Medical/Dental Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical/Dental Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

Unless otherwise indicated in the Medical/Dental Staff Bylaws documents:

(1) all Medical/Dental Staff committee chairs and members will be appointed by the MEC for an initial term of two years, with the ability to be reappointed for additional terms. All chair appointments will be subject to approval by the Board;

(2) all appointed chairs and members of a Medical/Dental Staff committee may be removed and vacancies filled by the MEC;

(3) members of the Allied Health Professional Staff may also be appointed to serve as voting members of Medical/Dental Staff committees;

(4) all Medical Center and administrative representatives on a Medical/Dental Staff committee will be appointed by the CEO. All such representatives will serve on the committees, without vote; and

(5) the CMO and the CEO will be members, *ex officio*, without vote, on all Medical/Dental Staff committees.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC will consist of the following ***voting*** members:

(1) the Officers of the Medical/Dental Staff, with the Medical/Dental Staff President serving as chair;

(2) the 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;

(3) the Associate Chiefs of Service for Internal Medicine-Specialty Care, Internal Medicine-Hospitalist Service, and Internal Medicine-Ambulatory Care;

(4) the Associate Chief of Service, representing Chemical Dependency;

(5) three members-at-large of the Medical/Dental Staff, elected for a two-year term at the Annual Meeting of the Medical/Dental Staff;

(6) two Allied Health Professionals-at-large, elected for a two-year term at the annual meeting of the Medical/Dental Staff;

(7) Chair, Credentials Committee; and

(8) additional at-large members, as determined by the MEC.

(b) The ***non-voting*** members of the MEC include: the CEO, the CMO, Associate Medical Directors, the Chief Operating Officer, the Senior VP of Nursing, and the Director of Medical/Dental Staff Services.

(c) Other individuals (e.g., other Medical/Dental Staff members, Medical Center personnel, legal counsel, etc.) may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals should be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

(d) Voting on all motions, resolutions, and other business of the MEC will be conducted on the principle of one member, one vote. No member will be entitled to more than one vote, regardless of any other positions or roles they may hold.

(e) A voting member who is unable to attend a meeting may designate another Medical/Dental Staff member to serve as their proxy for that meeting. The designation of a proxy must be provided to the Medical/Dental Staff President in advance of any such meeting and is valid for only the specific meeting or meetings for which it was designated.

5.C.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical/Dental Staff and performance improvement activities regarding

the professional services provided by Medical/Dental Staff members with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical/Dental Staff in the intervals between Medical/Dental Staff meetings;

(b) making recommendations to the Board regarding Medical/Dental Staff matters, including, but not limited to, the following:

(1) the Medical/Dental Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical/Dental Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical/Dental Staff in Medical Center performance improvement activities and the quality of professional services being provided by the Medical/Dental Staff;

(6) the mechanism by which Medical/Dental Staff appointment may be terminated; and

(7) hearing procedures;

(c) consulting with the CEO on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical/Dental Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) setting annual Medical/Dental Staff dues, which may vary depending upon staff category;

(j) reviewing, or delegating to the Bylaws Committee the responsibility to review, at least once every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical/Dental Staff and recommending such changes as may be necessary or desirable; and

(k) performing such other functions as are assigned to it by these Bylaws, the Credentials & Procedural Policy, the Board, or other applicable policies.

5.C.3. Meetings:

The MEC will meet at least ten times a year or more often if necessary to fulfill its functions and will maintain a permanent record of its proceedings and actions.

5.D. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical/Dental Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual Medical/Dental Staff member, a standing committee, or a special task force will be performed by the MEC.

5.E. SPECIAL COMMITTEES

Special committees may be appointed by the MEC to perform a specific task or function (e.g., study and develop recommendations for a new protocol or policy). Such committees will confine their activities to the purpose for which they were appointed and will report to the MEC as directed.

ARTICLE 6

MEETINGS

6.A. MEDICAL/DENTAL STAFF YEAR

The Medical/Dental Staff year is January 1 to December 31.

6.B. MEDICAL/DENTAL STAFF MEETINGS

6.B.1. Annual Staff Meeting:

The annual meeting of the Medical/Dental Staff will be held during the last quarter of the year. All elections of Medical/Dental Staff Officers and any at-large members of the MEC will be held. Additional meetings may be scheduled as needed, at the discretion of the MEC.

6.B.2. Special Meetings:

Special meetings of the Medical/Dental Staff may be called by the Medical/Dental Staff President, the MEC, the Board, or by a petition signed by not less than 20 members of the Voting Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Department Meetings:

Except as otherwise provided in these Bylaws or in the Medical/Dental Staff Organization Manual, each department will meet as often as necessary to fulfill its responsibilities, at times set by the Chief of Service.

6.C.2. Regular Committee Meetings:

Except as otherwise provided in these Bylaws or in the Medical/Dental Staff Organization Manual, each committee will meet as often as necessary to fulfill its responsibilities, at times set by the chair.

6.C.3. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer (e.g., Chief of Service or committee chair, as applicable), the Medical/Dental Staff President, or by a petition signed by not less than 33% of the voting members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical/Dental Staff members will be provided notice of all regular meetings of the Medical/Dental Staff and regular meetings of departments and committees at least 14 days in advance of the meetings. Notice of meetings will generally be provided by e-mail but may also be provided by mail, hand delivery, posting in a designated electronic or physical location, or telephone/verbally at least 14 days prior to the meetings. All notices will provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical/Dental Staff is called, all of the provisions in paragraph (a) will apply except that the notice period will be reduced to 48 hours. When a special meeting of a department or a committee is necessary, the notice period may be reduced further where a matter is urgent and adequate notice is provided to the department or committee members, as determined by the Presiding Officer.

(c) The attendance of any individual Medical/Dental Staff member at any meeting will constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical/Dental Staff, department, or committee, those voting members present (but not fewer than two) will constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC and Leadership Council, the presence of at least 50% of the voting members of the committee will constitute a quorum; and

(2) for amendments to these Medical/Dental Staff Bylaws, at least 50 members of the Voting Staff will constitute a quorum.

(b) The Presiding Officer may permit some members of the Medical/Dental Staff or a department or committee that is meeting in person to participate in the meeting via telephone, videoconference, or other approved mode of communication. All such individuals will count for purposes of calculating the quorum and for voting.

(c) As an alternative to an in-person meeting, at the discretion of the Presiding Officer, meetings of the Medical/Dental Staff, a department, or a Medical/Dental Staff committee may be conducted entirely by telephone or videoconference or the voting members may also be presented with a question by mail, e-mail, hand delivery, website posting, or telephone and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws (which requires a quorum of 50 members of the Voting Staff) and actions

by the MEC and Leadership Council (which require a quorum of 50%), a quorum for purposes of these votes will be the number of responses returned to the Presiding Officer by the date indicated. The question raised will be determined in the affirmative if a majority of the responses returned has so indicated.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical/Dental Staff or a department or committee, an individual who has recused himself or herself from participation in the vote will not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) Recommendations and actions of the Medical/Dental Staff, departments, and committees will be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be by written or electronic ballot at the discretion of the Presiding Officer.

6.D.3. Agenda:

The Presiding Officer for the meeting will set the agenda for any regular or special meeting of the Medical/Dental Staff, department, or committee.

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections but will not be binding. Specific provisions of these Bylaws and Medical/Dental Staff, department, or committee custom will prevail at all meetings, and the Presiding Officer will have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical/Dental Staff, departments, and committees will be prepared and will include a record of the attendance of Medical/Dental Staff members and the recommendations made and the votes taken on each matter. The minutes will be approved in accordance with Medical/Dental Staff, department, or committee custom.

(b) Unless otherwise indicated, a summary of all recommendations and actions of the Medical/Dental Staff, departments, and committees will be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical/Dental Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings will be maintained by the Medical Center.

6.D.6. Confidentiality:

All Medical/Dental Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical/Dental Staff who have access to, or are the subject of, credentialing and/or peer review documents and information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review information contained therein must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials & Procedural Policy or other applicable Medical/Dental Staff or Medical Center policy. A breach of confidentiality with regard to any Medical/Dental Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Each member of the Medical/Dental Staff or a Medical/Dental Staff department or committee is encouraged, but not required, to attend and participate in all Medical/Dental Staff meetings and applicable department and committee meetings each year.

(b) Attendance at meetings of the MEC, the Leadership Council, and the Credentials Committee will be periodically reviewed by the CMO, who will make recommendations on whether failure to attend the required number of meetings should result in replacement of a member.

(c) Participation at a meeting by telephone, video conference, or other approved modes of communication may constitute attendance at the discretion of the Presiding Officer.

ARTICLE 7

LEGAL PROTECTIONS FOR PRACTITIONERS
PERFORMING MEDICAL/DENTAL STAFF FUNCTIONS

Practitioners have significant personal legal protections from various sources when they perform functions pursuant to these Bylaws, the Credentials & Procedural Policy, the Medical/Dental Staff Organization Manual, and all other policies of the Medical/Dental Staff and Medical Center, as long as they maintain confidentiality and act in accordance with these Bylaws and related policies. The sources of these legal protections include:

(a) As set forth in Section 2.C.2 of the Credentials & Procedural Policy, all practitioners agree, as a condition of applying for appointment, reappointment, and/or clinical privileges, to release from liability, extend immunity to, and not sue other practitioners for any actions, recommendations, communications, and/or disclosures made or taken in the course of credentialing and peer review activities.

(b) All applicants for appointment, reappointment, and clinical privileges sign an application form by which they release from liability and agree not to sue other practitioners who participate in credentialing and peer review activities.

(c) Protections are also available under New York Education Law §6527, N.Y. Public Health Law § 2805-m(1), and the federal Health Care Quality Improvement Act ("HCQIA") for practitioners who participate in credentialing and peer review activities. The Medical/Dental Staff Bylaws and related policies have been structured to take full advantage of these legal protections.

(d) The Medical Center will indemnify practitioners who perform lawful functions under these Bylaws and related policies for any claims made against the practitioner that are not completely covered by an applicable insurance policy, in accordance with the Medical Center's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials & Procedural Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical/Dental Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials & Procedural Policy.

8.B. PROCESS FOR PRIVILEGING

Requests for clinical privileges are provided to the Chief of Service, who evaluates the quality and efficiency of services ordered or performed by the individual and reviews the individual's education, training, and experience. The Credentials Committee then reviews the Chief of Service's report and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant clinical privileges is favorable, it is forwarded to the Board (or its designee) for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the Chief of Service, who evaluates the quality and efficiency of services ordered or performed by the individual and reviews the individual's education, training, and experience. The Credentials Committee then reviews the Chief of Service's report and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board (or its designee) for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. TEMPORARY PRIVILEGING

Temporary privileges may be granted by the CEO to (i) applicants for initial appointment, (ii) individuals seeking privileges when there is an important patient care, treatment, or

service need, and (iii) for locum tenens providers. In these situations, the grant of temporary privileges will not exceed 120 days, 60 days, and 180 days, respectively.

8.E. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO, CMO, or Medical/Dental Staff President (or their designees) may use a modified credentialing process to grant disaster privileges as described in the Medical Staff Disaster Credentialing and Privileging Policy.

8.F. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) satisfy threshold eligibility criteria;

(ii) notify the Medical Center of changes in information pertaining to qualifications;

(iii) provide requested information;

(iv) attend a mandatory meeting to discuss issues or concerns;

(v) complete and comply with educational or training requirements;

(vi) comply with a request for fitness for practice evaluation; or

(vii) comply with a request for competency assessment;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form;

(d) remains absent on leave for longer than one year, unless an extension is granted; or

(e) is involved in other activities that may trigger an automatic relinquishment under Medical/Dental Staff policy.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

8.G. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical/Dental Staff Officer or relevant Chief of Service, acting in conjunction with the CMO or the CEO, is authorized to suspend or restrict all or any portion of an individual's clinical privileges as a precaution pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO or the MEC.

(3) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.H. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Medical Center or the Medical/Dental Staff; or (d) conduct that is considered lower than the standards of the Medical/Dental Staff or is disruptive to the orderly operation of the Medical Center or its Medical/Dental Staff.

8.I. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, the individual may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL/DENTAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by at least 20 members of the Voting Staff, by the MEC, or the Board.

(2) In the discretion of the MEC, amendments to the Bylaws will be presented to the Medical/Dental Staff in one of the following two ways:

(a) Amendments Subject to Vote at a Meeting: The MEC will report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical/Dental Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 50 members of the Voting Staff must be present, and (ii) the amendment must receive a majority of the votes cast by the Voting Staff at the meeting.

(b) Amendments Subject to Vote via Written or Electronic Ballot: The MEC will present proposed amendments to the Voting Staff by written or electronic ballot, to be returned by the date and in the manner indicated on the ballot, which date will be at least 14 days after the proposed amendment was provided to the Voting Staff. Along with the proposed amendments, the MEC will provide a written report on the amendments either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 50 members of the Voting Staff, and (ii) the amendment must receive a majority of the votes cast.

(3) The MEC will have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

(4) All amendments will be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical/Dental Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical/Dental Staff. Such conference will be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical/Dental Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request for same submitted by the Medical/Dental Staff President.

(6) Neither the Medical/Dental Staff nor the Board will unilaterally (without seeking the advice of the other party) amend these Bylaws.

9.B. OTHER MEDICAL/DENTAL STAFF DOCUMENTS

(1) In addition to the Medical/Dental Staff Bylaws, there will be policies and rules and regulations that are applicable to members and other individuals who have been granted clinical privileges.

(2) An amendment to the Medical/Dental Staff Credentials & Procedural Policy, Medical/Dental Staff Organization Manual, and Medical/Dental Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments to these documents will be provided to each member of the Voting Staff at least 14 days prior to the vote by the MEC. Any voting member of the Medical/Dental Staff may submit written comments on the proposed amendments to the MEC. The Appendices to the Medical/Dental Staff Credentials & Procedural Policy may be amended by a majority vote of the MEC without prior notice to the Medical Staff.

(3) Other policies of the Medical/Dental Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(4) The present Medical/Dental Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rules and Regulations are inconsistent with these Bylaws, they are of no force or effect. Furthermore, the MEC and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical/Dental Staff. Notice of provisionally adopted amendments will be provided to each member of the Voting Staff as soon as possible. The Voting Staff members will have 30 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical/Dental Staff and the MEC, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

(5) Adoption of and changes to Medical Staff policies, procedures and rules and regulations will become effective only when approved by the Board.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical/Dental Staff and the MEC with regard to:

(a) proposed amendments to the Medical/Dental Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical/Dental Staff to discuss the conflict may be called by a petition signed by at least 20 members of the Voting Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC will forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Voting Staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical/Dental Staff.

(4) Nothing in this section is intended to prevent individual Medical/Dental Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical/Dental Staff Bylaws, the Medical/Dental Staff Rules and Regulations, or other Medical/Dental Staff policies directly to the Board. Communication from Medical/Dental Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Medical/Dental Staff President of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical/Dental Staff member(s).

ARTICLE 10

ADOPTION

These Medical/Dental Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical/Dental Staff Bylaws, Rules and Regulations, policies, manuals or Medical Center policies pertaining to the subject matter thereof.

Medical/Dental Staff President
Michael Manka, MD Date: 12/10/2025

Approved by the Board of Directors:

Chief Executive Officer Date: 1/27/2026
Erie County Medical Center Corporation Thomas Quatroche, PhD

REVISIONS:

Medical Executive Committee: November 24, 2025

Medical/Dental Staff: December 10, 2025

Board of Directors: January 27, 2026

APPENDIX A

MEDICAL/DENTAL STAFF CATEGORIES SUMMARY

	Active	Associate	Courtesy, Refer, and Follow	Administrative	Emeritus	AHP
Basic Requirements						
Number of patient contacts per appointment term	≥ 36	1-35	NA	NA	NA	NA
Rights & Responsibilities						
May admit patients	Y*	Y*	N	N	N	N*
May exercise clinical privileges	Y	Y	N	N	N	Y
May attend Medical Staff meetings	Y	Y	Y	Y	Y	Y
May vote at Medical Staff meetings	Y	N	N	N	N	Y
May attend department meetings	Y	Y	Y	Y	Y	Y
May vote at department meetings	Y	N	N	N	N	Y
May serve on committees (w/vote)	Y	Y	Y	Y	Y	Y
May serve as a Medical Staff Officer, Chief of Service, or committee chair	Y	N	N	N	N	N
May be required to serve on ED call	Y	N**	N	N	N	N
Subject to OPPE & FPPE	Y	Y	N	N	N	Y
Pay Medical Staff dues	TBD	TBD	TBD	TBD	N	TBD

Y = Yes
N = No
NA = Not Applicable
TBD = To be determined
* = When permitted by the individual's granted delineation of privileges
** = Unless the MEC makes a determination that there are an insufficient number of Active Staff members to provide coverage, considering recommendation by relevant Chief of Service

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(1) Every patient will have a complete history taken and physical examination performed by a qualified practitioner within 30 days before or within 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 record 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 24 hours following admission.

(2) 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 record 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 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.

(3) For details 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.

Medical Dental Staff Rules & Regulations

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

MEDICAL/DENTAL STAFF RULES AND REGULATIONS

Adopted by the Medical Executive Committee on November 24, 2025
Adopted by the Medical/Dental Staff on December 10, 2025
Approved by the Board of Directors on January 27, 2026

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RULES AND REGULATIONS OF THE MEDICAL/DENTAL STAFF OF 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 Medical Center 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 Medical Center. 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 regarding 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 Medical Center, 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 Medical Center 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 Medical Center 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 MEC 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 Medical Center's Ethics Committee and CMO 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 CMO. 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;

(b) the necessary treatment falls outside the scope of the attending Staff Member's privileges; or

(c) a consultation is indicated for the clinical specialty in admission to special care units.

3. Any individual with clinical privileges can be asked for an inpatient consultation within his or her area of expertise. Practitioners who are asked to provide an inpatient consultation are expected to respond in accordance with the following patient care guidelines, unless (i) another time frame is required under an approved Medical Staff policy, or (ii) another time frame is agreed upon by the requesting and consulting practitioners.

   If a consult is requested, STAT, it is requested 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 60 (sixty) minutes.

   When a ROUTINE consult is requested, the referring practitioner should enter the reasons for the consultation request in the EMR, as well as make every attempt to personally contact the consulting practitioner to discuss the request. Routine consults are expected to be completed and included in the patient's medical record within 24 (twenty-four) hours of the request for such a consultation. Bi-directional communication is expected between the referring and the consulting services. If the report is dictated, but not yet available, a brief note should be placed in the chart and a verbal/secure electronic communication made to the referring service.

4. When providing an inpatient consult, the Consulting Practitioner will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the Consulting Practitioner will be directly communicated to the Requesting Practitioner through a note in the EMR or by phone call or secure text message.

5. Once the consultant is involved in the care of the patient, the requesting attending Staff Member and consultant are expected to review each other's notes in the patient's medical record on a regular basis to assure continuity of care until such time as the consultant has signed off on the case or the patient is discharged. The requesting attending Medical Staff member is also expected to act on any orders issued by the consultant during this time.

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 Medical Center to accommodate.

II.B. Admission of Patients

1. Authority to Admit. Patients may be admitted to the Medical Center 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 Medical Center 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 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 set forth above. In the event of an unauthorized patient discharge, the responsible practitioner shall obtain, where practicable, a written release from the patient absolving ECMCC 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 Medical Center 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 Medical Center, 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 Medical Center 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 Medical Center. 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. In accordance with the laws of the state of New York and the Joint Commission's accreditation standards, ECMCC is not required to privilege those practitioners from outside organ procurement organizations designated by the Secretary of the U.S. Department of Health and Human Services who are engaged at the Medical Center in the harvesting of tissues and/or other body parts for transplantation, therapy, research, or educational purposes pursuant to the Federal Anatomical Gift Act and New York law.

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. The required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of the Medical/Dental Staff Bylaws. See also policy and procedure: "Hybrid Medical Record Requirements", HIM -030, for detail regarding minimum requirements for the content of the Hx and Px.

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.

    i. 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 MEC, 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.

ii. Delinquent Records. Providers are routinely notified by Health Information Records of incomplete charts, including, but not limited to, electronic signatures, procedure notes, discharge summaries, orders, etc. They are also notified in advance when those charts are about to become delinquent. Providers who have charts more than 30 days old, who have been notified by Health Information Records that they are now delinquent, will receive notification from the office of the CMO that they have 30 days to complete the records that are now delinquent.

Persistent violation of these Rules & Regulations will result in disciplinary action, including but not limited to an Administrative Time-out, referral to the MEC for disciplinary action, delayed/denied reappointment to the Medical/Dental Staff.

Time frames for completion of specific elements of the medical record are dictated by regulatory authorities, this document as well as ECMC Policy.

Failure to complete operative/procedure notes in accordance with policy are also subject to referral to the Leadership Council and/or the MEC as appropriate.

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.

5. 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.

6. 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.

7. 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

1. 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.

2. Student privileges shall be limited to those delineated and conferred by the State University of New York at Buffalo 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

1. 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.

2. Documentation of attending Staff Member supervision of the patient care provided by residents must include, at a minimum, a 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.

3. 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

Medical/Dental 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.

SECTION VI. AMENDMENTS

These Rules and Regulations may be amended as described in the amendment provisions of the Medical/Dental Staff Bylaws.

Adopted by the Medical/Dental Staff:

Medical/Dental Staff President
Michael Manka, MD Date: 12/10/2025

Approved by the Board of Directors:

Chief Executive Officer Date: 1/27/2026
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

MOST RECENT REVISIONS:

Medical Executive Committee: November 24, 2025

Medical/Dental Staff: December 10, 2025

Board of Directors: January 27, 2026

Medical Dental Staff Organization Manual

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

MEDICAL/DENTAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Executive Committee on November 24, 2025
Adopted by the Medical/Dental Staff on December 10, 2025
Approved by the Board of Directors on January 27, 2026

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in all the Medical/Dental Staff documents are set forth in the Medical/Dental Staff Credentials & Procedural Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Administrative Leadership, by a Medical/Dental Staff member, or by a Medical/Dental Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Medical Center employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical/Dental Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee or individual that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Manual is unavailable or unable to perform a necessary function, one or more of the Medical/Dental Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Manual, technical or minor deviations from the procedures set forth within this Manual do not invalidate any review or action taken.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments will be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors will be considered in determining whether a clinical department should be created:

(a) there exists a number of members of the Medical/Dental Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in this Manual and in the bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish organizational functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) it has been determined by the Medical/Dental Staff leadership and the CEO that there is a clinical and administrative need for a new department; and

(e) the voting Medical/Dental Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors will be considered in determining whether the dissolution of a clinical department is warranted:

(a) there is no longer an adequate number of members of the Medical/Dental Staff in the clinical department to enable it to accomplish the functions set forth in this Manual or in the Bylaws;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

(c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department; or

(e) a majority of the voting members of the department vote for its dissolution.

2.B. LIST OF CLINICAL DEPARTMENTS

The following clinical departments are established by the Medical/Dental Staff:

(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 Orthopedic 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

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and Chiefs of Service are set forth in the Medical/Dental Staff Bylaws.

ARTICLE 3

MEDICAL/DENTAL STAFF COMMITTEES

3.A. MEDICAL/DENTAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical/Dental Staff committees of the Medical Center that carry out peer review and other performance improvement functions that are delegated to the Medical/Dental Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical/Dental Staff Bylaws.

(3) This Article details the standing members of each Medical/Dental Staff committee. However, other individuals (e.g., other Medical/Dental Staff members, Medical Center personnel, legal counsel, Employer representatives, etc.) may be invited to attend a particular Medical/Dental Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical/Dental Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Medical Center and Medical/Dental Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions, and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.D. BYLAWS COMMITTEE

3.D.1. Composition:

The Bylaw Committee will consist of:

(a) a Chair appointed by the Medica/Dental Staff President;

(b) three (3) members of the Medical/Dental Staff, with vote;(may be members of the Leadership Council or designees);

(c) CMO, *ex officio*, without vote;

(d) Director, Medical Dental Staff Services, *ex officio*, without vote; and

(e) Medical Center Legal Counsel, as needed; without vote.

3.D.2. Duties:

The Bylaws Committee will perform the following functions:

(a) review (at least every three years) and maintain the Medical/Dental Staff Bylaws, and related documents upon written request of the MEC, Credentials Committee, or any member of the Active Staff;

(b) recommend revisions to all documents, as appropriate and necessary, to the MEC; and

(c) 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.

3.E. CANCER COMMITTEE

3.E.1. Composition:

(a) The Cancer Committee will consist of:

(1) a Chair appointed by the Medica/Dental Staff President;

(2) the Cancer Liaison Physician;

(3) a multi-disciplinary membership will include 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; and

(4) 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.

(b) Required Coordinator roles will be defined by the most recent Commission on Cancer standards and may include: Cancer Registrar, Quality & Patient Safety, Psychosocial Services, Clinical Research, Multidisciplinary Tumor Board, Survivorship Program Director, and Prevention and Screening.

(c) 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.E.2. Duties:

The Cancer Committee will perform the following functions:

(a) establishes program goals; plans, initiates, implements and monitors program activity; and evaluates patient outcomes;

(b) establishes, implements and monitors all Commission on Cancer standards to achieve and/or maintain CoC accreditation status annually; and

(c) ensures eligibility requirements by:

(1) monitoring, assessing and identifying changes needed yearly;

(2) delegating responsibilities (involving appointed coordinators in the process) to CoC workgroups or subcommittees and monitors progress and outcomes; and

(3) reviewing and documenting the assessment of all eligibility requirements in the Committee Minutes annually.

3.E.3. Meetings, Reports, and Recommendations:

The Cancer Committee will meet as often as necessary to perform its duties, but at a minimum quarterly, and will maintain a permanent record of its findings, proceedings, and actions. The Cancer Committee reports to the Medical Executive Committee via minutes of the proceedings presented for adoption.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

(a) The Credentials Committee will consist of:

(1) a Chair appointed by the Medica/Dental Staff President;

(2) at least five members of the Active Staff all of whom will not be department chairs of the State University of New York at Buffalo, with vote;

(3) two members of the Allied Health Professional Staff, with vote;

(4) CMO, *ex officio*, without vote;

(5) Director, Medical Dental Staff Services, *ex officio*, without vote; and

(6) Medical Center Legal Counsel, as needed, ex officio, without vote.

(b) Members of the Credentials Committee will have served at least two 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.

(c) 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 reappointed for additional terms without limit.

3.F.2. Duties:

The Credentials Committee will perform the following functions:

(a) receive and analyze applications and recommendations for initial appointment, reappointment, clinical privileges and changes therein and recommend action to the MEC;

(b) review and recommend qualifications and criteria for granting clinical privileges;

(c) review and report on matters referred by the Medical/Dental Staff President or the MEC regarding the qualifications, conduct, professional character or competence of any licensed independent practitioner, applicant or Medical/Dental Staff member; and

(d) 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.

3.F.3. Meetings, Reports, and Recommendations:

The Credentials Committee will meet as often as necessary to perform its duties, but at a minimum 10 times a year, and will maintain a permanent record of its findings, proceedings, and actions. The Credentials Committee reports to the Medical Executive Committee via minutes of the proceedings presented for adoption.

3.G. MEDICAL/DENTAL STAFF LEADERSHIP COUNCIL ("LEADERSHIP COUNCIL")

3.G.1. Composition:

(a) The Leadership Council will be comprised of the following voting members:

(1) Medical/Dental Staff President, who will serve as Chair;

(2) Medical/Dental Staff President-Elect;

(3) Treasurer of the Medical/Dental Staff;

(4) Secretary of the Medical/Dental Staff;

(5) CMO;

(6) Chair of the Quality Executive Committee;

(7) Immediate Past Medical/Dental Staff President; and

(8) Chair, Credentials Committee.

(b) A Medical/Dental Staff Office representative will serve as a non-voting member to facilitate the Leadership Council's activities and to perform functions on behalf of the Council between meetings.

(c) The Leadership Council is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The Leadership Council makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical/Dental Staff Bylaws documents, possesses disciplinary authority.

(d) Between meetings of the Leadership Council, the Medical/Dental Staff President as Chair, in conjunction with the CMO or another Leadership Council member, may take steps as necessary to implement and operationalize the decisions of the Leadership Council. By way of example and not limitation, this may include providing clarifications to a practitioner regarding the Leadership Council's decisions or expectations, reviewing and approving communications with the practitioner, and similar matters.

3.G.2. Duties:

The Leadership Council will perform the following functions:

(a) review issues identified from, among other sources: the Practice Improvement (PI) process, including electronically submitted occurrence events, referrals from Service Line Directors and Chiefs of Service, Office of the CMO, Medical Center Administration, Professional Development and Wellness Committee, Utilization Review Committee, Credentials Committee;

(b) determine the appropriate avenue of review for all administratively complex issues (or facilitate the review of the same);

(c) discuss and coordinate quality issues;

(d) recommend and facilitate leadership development for the Medical/Dental Staff;

(e) act as the Nominating Committee as described in Article 3 of the Medical/Dental Staff Bylaws;

(f) work collegially with the Professional Development and Wellness Committee to address issues arising from the policies related to conduct, professionalism, health or wellness;

(g) request the assistance of the Professional Development and Wellness Committee or other practitioners, 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;

(h) facilitate external review for clinical issues when necessary;

(i) assist the Quality Executive Committee in the development, facilitation and oversight of voluntary improvement plans;

(j) initiate voluntary improvement plans for conduct when indicated; and

(k) assist with or provide collegial counseling when indicated.

3.G.3. Meetings, Reports, and Recommendations:

The Leadership Council will meet as often as necessary to perform its duties, but at a minimum of six times a year, and will maintain a permanent record of its findings, proceedings, and actions. The Leadership Council should provide reports to the MEC on at least an annual basis or as otherwise requested. Such reports should include summary and aggregate information regarding the committee's activities. These reports should not include the details of any reviews or findings regarding specific practitioners unless the Leadership Council determines such information is necessary for the MEC to address a matter.

3.H. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.C of the Medical/Dental Staff Bylaws.

3.I. PROFESSIONAL DEVELOPMENT AND WELLNESS COMMITTEE

3.I.1. Composition:

(a) The Professional Development and Wellness Committee will consist of:

(1) a Chair appointed by the Medica/Dental Staff President;

(2) no fewer than three additional members of the Active Staff, with vote; and

(3) at least two members of the Allied Health Professional Staff.

(b) 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.

(c) Consultant/additional members may be asked to join the group as needed for their expertise concerning a particular issue or problem.

3.I.2. Duties:

The Professional Development and Wellness Committee will perform the following functions:

(a) 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;

(b) be accessible to members of the Medical-Dental Staff for collegial support and to inspire leadership development;

(c) ongoing engagement with the organized medical staff for feedback as to how the committee can best support its needs;

(d) recommend to the MEC educational programs and resources that promote the purpose of the committee and support the staff;

(e) partner with the Administrative Leadership and the Board to proactively address practitioner issues to ensure timely intervention and successful outcomes;

(f) 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.

Activities supporting the aforementioned infrastructure include:

- 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; and

(g) 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 MEC, the CEO and the Board, where appropriate.

3.J. QUALITY EXECUTIVE COMMITTEE

3.J.1. Composition:

(a) The Quality Executive Committee ("QEC") will consist of members who include representatives with diverse clinical expertise including, but not limited to:

(1) Surgical Specialties (recommended a minimum of two representatives);

(2) Medical Specialties (recommended a minimum of two representatives);

(3) Anesthesia Services (recommended a minimum of one representative);

(4) Radiology Services (recommended a minimum of one representative);

(5) Behavioral Health Specialties (recommended a minimum of one representative); and

(6) Allied Health Professionals (recommended a minimum of one representative).

(b) The committee will be chaired by the Immediate Past Medical/Dental Staff President. If that is not possible, the Chair will be appointed by the Medical/Dental Staff President.

(c) The Medical/Dental Staff President will serve as an *ex officio* member, without a vote.

(d) Non-physician administrative and ancillary services members including, but not limited to, the Practice Improvement Coordinator and Practice Improvement Specialists are appointed by the CEO or his or her designee.

(e) The QEC is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The QEC makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical/Dental Staff Bylaws documents, possesses disciplinary authority.

(f) Between meetings of the QEC, the QEC Chair, in conjunction with the CMO or another QEC member, may take steps as necessary to implement and operationalize the decisions of the QEC. By way of example and not limitation, this may include providing clarifications to a practitioner regarding the QEC's decisions or expectations, reviewing and approving communications with the practitioner, and similar matters.

3.J.2. Duties:

The QEC will perform the following functions:

(a) utilize collegial efforts and progressive steps, facilitate a systematic process to evaluate Medical/Dental Staff professional practice and identify opportunities to improve the quality of medical care provided;

(b) establish program goals and plan, initiate, implement and monitor program activity and evaluates patient outcomes;

(c) 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"); and

(d) work collegially with the Leadership Council, the Chiefs of Service, the Resource Utilization Committee, the CMOs and the MEC to oversee the Peer Review Process in accordance with the Bylaws, Rules & Regulations and related policies.

3.J.3. Meetings, Reports, and Recommendations:

The QEC will meet as often as necessary to perform its duties, but at a minimum of 10 times a year, and will maintain a permanent record of its findings, proceedings, and actions. The QEC should provide reports to the MEC on at least an annual basis or as otherwise requested. Such reports should include summary and aggregate information regarding the committee's activities. These reports should not include the details of any reviews or findings regarding specific practitioners unless the QEC determines such information is necessary for the MEC to address a matter.

3.K. QUALITY IMPROVEMENT COMMITTEE

3.K.1. Composition:

The Quality Improvement Committee will consist of:

- CMO (or designee), Chair;
- Medical-Dental Staff members of the MEC; and
- 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 by the Medical/Dental Staff President.

3.K.2. Duties:

The Quality Improvement Committee will perform the following functions:

(a) 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;

(b) 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;

(c) identify information to be included on the Medical Center's quality dashboard and affiliated documents and assign accountability for presentation to the MEC; and

(d) ensure compliance with regulatory and accreditation requirements, providing leadership to assure compliance with appropriate Medical/Dental Staff standards.

3.K.3. Meetings, Reports, and Recommendations:

The Quality Improvement Committee will meet no less than as part of the confidential portion of each MEC meeting, and will maintain a permanent record of its findings, proceedings, and actions. The Quality Improvement Committee reports to the MEC.

3.L. RESOURCE UTILIZATION COMMITTEE

3.L.1. Composition:

The Resource Utilization Committee will consist of:

(a) a Chair appointed by the Medical/Dental Staff President;

(b) members of the Active Medical Staff, with vote; and

(c) Quality Information Personnel, as staff, without vote.

3.L.2. Duties:

The Resource Utilization Committee will perform the following functions:

(a) report findings and recommendations to the MEC, COO, CMO, and Senior Vice President of Nursing;

(b) review third-party payor denials, make recommendations and/or take appropriate actions;

(c) collect and analyze data necessary to carry out its responsibilities; and

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

3.M. SURGICAL EXECUTIVE COMMITTEE

3.M.1. Composition:

The Surgical Executive Committee will consist of:

- Chief of the Department of Surgery, Chair;
- Medical Staff members appointed by the MEC, to include at least five active surgeons and at least one anesthesia provider, who shall serve three-year terms and may be reappointed for additional terms;
- CMO;
- COO or designee;
- Vice President of Surgical Services; and
- Ad hoc members (without vote).

Additional members may be appointed upon assessment of need by the Committee.

3.M.2. Duties:

The Surgical Executive Committee will perform the following functions:

(a) guide the MEC in the evaluation of existing programs, services, and operative facilities, recommending continuation, expansion, abridgement, or termination of each;

(b) establish program goals, initiate, implement, and monitor programs;

(c) evaluate personnel and other resources needed for beginning a new program or service, for construction of new facilities or for acquiring new or replacement capital equipment;

(d) evaluate and make recommendations on OR productivity reports, block time requests, efficiencies, and revenue generating initiatives; and

(e) work with the MEC, Executive Leadership Team, the Physician Leadership Council, the Resource Utilization Committee, the Chief Medical Officer and the Quality Executive Committee to meet its defined goals.

3.M.3. Meetings, Reports, and Recommendations:

The Surgical Executive Committee will meet as often as necessary to fulfill its responsibilities. The Surgical Executive Committee reports to the MEC.

ARTICLE 4

PERFORMANCE IMPROVEMENT FUNCTIONS OF THE MEDICAL/DENTAL STAFF

The Medical/Dental Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(a) sentinel events;

(b) patient safety;

(c) pain assessment, pain management, and safe opioid prescribing through participating in the establishment of protocols and quality metrics and reviewing performance improvement data;

(d) the Medical Center's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(e) accurate, timely and legible completion of medical records;

(f) review of findings of the assessment process that are relevant to an individual's performance;

(g) communicate findings, conclusions, recommendations, and actions to improve performance to appropriate practitioners and the Board;

(h) appropriate resource utilization; and

(i) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of the Medical/Dental Staff Bylaws.

ARTICLE 5

AMENDMENTS

This Manual may be amended as described in the amendment provisions of the Medical/Dental Staff Bylaws.

ARTICLE 6

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical/Dental Staff or Medical Center policies pertaining to the subject matter thereof.

Michael Manka, MD

Medical/Dental Staff President
Michael Manka, MD Date: 12/10/2025

Approved by the Board of Directors:

Chief Executive Officer, Date: 1/27/2026
Erie County Medical Center Corporation Thomas Quatroche, PhD

REVISIONS:

Medical Executive Committee: November 24, 2025

Medical/Dental Staff: December 10, 2025

Board of Directors: January 27, 2026

Medical Dental Staff Credentials & Procedural Policy

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

CREDENTIALS & PROCEDURAL POLICY

Adopted by the Medical Executive Committee on November 24, 2025
Adopted by the Medical/Dental Staff on December 10, 2025
Approved by the Board of Directors on January 27, 2026

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the following definitions will apply to terms used in the Medical/Dental Staff Bylaws, this Policy, and the Medical/Dental Staff Organization Manual:

(1) "ADMINISTRATIVE LEADERSHIP" means the CEO, Chief Medical Officer, Chief Operating Officer, or any administrator on call at the Medical Center, or their respective designee.

(2) "ALLIED HEALTH PROFESSIONAL" or "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 or her area of professional competence. Allied Health Professionals are divided into three categories based on the required level of supervision/collaboration:

- Independent – means a type of Allied Health Professional who is permitted by law and by the Medical Center to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. See **Appendix A** of this Policy for a list of Allied Health Professionals who are permitted to practice at the Medical Center independently.

- Independent/Collaboration – means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Medical Center to exercise some or all those clinical privileges in collaboration with a physician pursuant to a collaborative agreement. See **Appendix B** of this Policy for a list of Allied Health Professionals who are permitted to practice at the Medical Center independently/in collaboration with a physician.

- Dependent/Supervision – means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Medical Center to exercise some or all of those clinical privileges under the direction of a physician pursuant to a supervision agreement. See **Appendix C** of

this Policy for a list of Allied Health Professionals who are permitted to practice at the Medical Center under the supervision of a physician**.**

(3) "APPOINTMENT" means the granting of membership to the Medical/Dental Staff by the Board to one of the defined categories outlined in Article 2 of the Medical/Dental Staff Bylaws.

(4) "AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION" of appointment and/or clinical privileges are administrative actions that occur by operation of this Policy or other applicable Medical/Dental Staff policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the practitioner to a hearing or appeal.

(5) "BOARD" means the Board of Directors of the Medical Center or any of its designated subcommittees that have been established to perform certain functions outlined in this Policy.

(6) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the Royal College of Physicians and Surgeons of Canada, the AOA, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, the Bureau of Osteopathic Specialists, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Podiatric Surgery, as applicable.

(7) "CHIEF EXECUTIVE OFFICER" or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.

(8) "CHIEF MEDICAL OFFICER" or "CMO" means the individual appointed by the Board to act as the chief medical officer or those with similar positions and titles.

(9) "CHIEF OF SERVICE" means the applicable head of a Medical/Dental Staff department at the Medical Center or his or her designated Associate Chief of Service. The Chiefs of Service are accountable to the MEC for all professional, administrative, clinically-related and quality review functions within their clinical department.

(10) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, for which the Medical/Dental Staff leaders and Board have developed eligibility and other credentialing criteria and FPPE and OPPE standards. There are several types of clinical privileges, including, but not limited to, telemedicine privileges, temporary privileges, and disaster privileges.

(11) "CONFIDENTIAL FILE" means any file, paper or electronic, containing credentialing, privileging, PPE/Peer Review, or quality information related to a practitioner.

(12) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical/Dental Staff leaders and Board to require closely related skills and experience.

(13) "DAYS" unless otherwise indicated means calendar days.

(14) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(15) "INVESTIGATION" means a non-routine, formal process to review questions or concerns pertaining to a practitioner. Only the MEC has the authority to initiate and conduct an investigation. By contrast, the processes that address issues of clinical performance, professional conduct, and health involving practitioners that utilize collegial efforts or progressive steps do not constitute investigations.

(16) "KALEIDA HEALTH" means the hospitals and related facilities and entities of Kaleida Health.

(17) "MEDICAL CENTER" means Erie County Medical Center Corporation and any outpatient facilities that bill under the Medical Center's Medicare certification number.

(18) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the executive committee of the Medical/Dental Staff. Its composition and duties are described in Article 5 of the Medical/Dental Staff Bylaws.

(19) "MEDICAL/DENTAL STAFF" means all physicians, dentists, oral surgeons, podiatrists, and allied health professionals who are credentialed through the Medical/Dental Staff and designated as a member of the Medical/Dental Staff by the Medical Center's Medical/Dental Staff and Board.

(20) "MEDICAL/DENTAL STAFF BYLAWS DOCUMENTS" means the Medical/Dental Staff Bylaws, the Credentials & Procedural Policy, and the Medical/Dental Staff Organization Manual. These documents are implemented in conjunction with the supporting policies, procedures, rules and regulations of the Medical/Dental Staff.

(21) "MEDICAL/DENTAL STAFF LEADER" means any Medical/Dental Staff Officer, Chief of Service, Associate Chief of Service, or Medical/Dental Staff committee chair.

(22) "MEDICAL/DENTAL STAFF MEMBER" means any physician, dentist, oral surgeon, podiatrist, or allied health professional who has been granted appointment by the Board at the Medical Center.

(23) "MEDICAL/DENTAL STAFF OFFICE" means the Medical/Dental Staff Office at the Medical Center or any delegated Credentials Verification Office ("CVO").

(24) "NOTICE" means written communication by regular U.S. mail, Medical Center mail, hand delivery, e-mail, website, or other electronic method.

(25) "ORAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed an accredited residency program in oral and maxillofacial surgery as provided herein.

(26) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule which permits the Medical Center and Medical/Dental Staff to use joint notice of privacy practices information when patients are admitted to the Medical Center. Practically speaking, being part of an OHCA allows the members of the Medical/Dental Staff to rely upon the Medical Center's notice of privacy practices and therefore relieves Medical/Dental Staff members of their responsibility to provide a separate notice when members consult or otherwise treat inpatients at the Medical Center.

(27) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(28) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(29) "PRACTITIONER" means any individual who has been granted clinical privileges and/or appointment by the Board, including, physicians, dentists, oral surgeons, podiatrists, and allied health professionals.

(30) "REAPPOINTMENT" means the granting of continued appointment to the Medical/Dental Staff by the Board.

(31) "RESTRICTION" means a professional review action that:

(a) is recommended by the MEC as part of an investigation or agreed to by the practitioner while he or she is under investigation or in exchange for the MEC not conducting an investigation or taking an adverse professional review action; and

(b) limits the individual's ability to independently exercise his or her clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring

requirement in which the proctor must be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the MEC or by any other Medical/Dental Staff committee:

(a) general consultation requirements, in which the practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the practitioner agrees to have a proctor present to observe his or her provision of care; and

(c) other collegial performance improvement efforts, including informational letters, educational letters, or voluntary improvement plans that are suggested by the Medical/Dental Staff leadership and voluntarily agreed to by the practitioner as a part of the routine PPE process.

(32) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(33) "SPECIAL PRIVILEGES" means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(34) "VOTING STAFF" means those practitioners who have been given the right to vote in all general and special meetings of the Medical/Dental Staff. Voting rights are defined in the prerogatives of each Medical/Dental Staff category in Article 2 of the Medical/Dental Staff Bylaws.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of the Administrative Leadership, by a Medical/Dental Staff member, or by a Medical/Dental Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Medical Center employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee or individual that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical/Dental Staff leaders may perform

the function personally or delegate it to another appropriate individual as set forth above.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

1.D. CONDITIONS FOR AHPs

Unless specified otherwise, practitioners who seek permission to practice as a member of the Allied Health Professional Staff will be subject to the same terms and conditions of appointment and reappointment as specified for Medical/Dental Staff members, including the procedural rights as described in Article 7. Applications for appointment or reappointment for Allied Health Professionals will be submitted and processed in the same manner as outlined for Medical/Dental Staff members in this Policy.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, and/or clinical privileges and as a condition of maintaining ongoing appointment and/or clinical privileges, individuals must satisfy the applicable eligibility criteria:

(a) All Practitioners:

(1) have a current, unrestricted license to practice in the State of New York (or a Limited Permit necessary to achieve or pending full licensure) that is not subject to any restrictions, conditions or probationary terms;

(2) not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency, and have never voluntarily surrendered a license while under investigation by any state licensing agency;

(3) where applicable to their practice, have a current, unrestricted DEA registration and state-controlled substance license and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended;

(4) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Medical Center (the Medical Center should be listed on the Certificate of Insurance as the certificate holder, unless otherwise designated through a contractual agreement with the Medical Center);

(5) not be under any criminal investigation or indictment and have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(6) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(7) have not been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(8) have not had appointment or clinical privileges denied, suspended, revoked, or terminated by any health care facility or health plan, including this Medical Center, for reasons related to clinical competence or professional conduct;

(9) have not resigned appointment or relinquished clinical privileges during a Medical/Dental Staff investigation or in exchange for not conducting such an investigation at any health care facility, including this Medical Center;

(10) not currently facing pending criminal charges or indictment and have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence, or (vii) abusing the practitioner-patient relationship;

(11) have appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed practitioner with appropriate specialty-specific privileges as determined by the Credentials Committee) with other practitioners for those times when the individual will be unavailable;

(12) demonstrate recent clinical activity in their primary area of practice during the last two years;

(13) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

(14) if applying for clinical privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(15) agree to comply with all policies, training and educational protocols, and orientation requirements adopted by the MEC or the Medical Center, including, but not limited to, those involving electronic medical records, the privacy and security of protected health information, infection control, patient safety initiatives, clinical protocols, and Medical/Dental Staff functions;

(16) document compliance with any immunization, vaccination, and/or health screening requirements as may be adopted by the MEC or the Medical Center (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures); and

(17) have not been separated from employment with the Medical Center or any of its subsidiaries for issues related to clinical performance or professionalism.

(b) Additional Criteria for Medical/Dental Staff Members (Physician, Dentist, Oral Surgeon, and Podiatrist):

(1) have successfully completed a residency program accredited by one of the following (as applicable:

(i) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges; or

(ii) a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or

(iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(2) agree to serve on the Emergency Department on-call roster for their specialty, as may be requested during the term of their appointment and consistent with their Medical/Dental Staff category;

(3) satisfy the following board certification requirements:

(i) are certified in their primary area of practice at the Medical Center by an approved board as defined in this Policy; or

(ii) are within six years of completion of residency or fellowship training and achieve board certification in their primary area of practice within six years from the date of completion of their residency or fellowship training[1]; and

(iii) maintain board certification in their primary area of practice at the Medical Center on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so.

[1] At the discretion of the MEC, the six-year time frame for an initial applicant to obtain board certification may be extended for an additional appointment term, not to exceed three years, in order to permit the individual an additional opportunity to obtain board certification. Failure to do so within that additional term will result in the individual being ineligible for ongoing appointment and clinical privileges, unless a waiver is granted as described in Section 2.A.2 of this Policy.

(Board certification status may be assessed at any time throughout the course of appointment but will be affirmatively assessed at reappointment.)

(c) Additional Criteria for Advanced Practice Professionals:

(1) 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 ("ABPP") or any other nationally recognized board certification entity approved by the MEC; and

(2) as applicable based on the type of Allied Health Professional, have a supervision/collaborative agreement with a physician that meets all applicable requirements of New York state law and Medical Center policy.

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any applicant for appointment or reappointment who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating (i) that the applicant is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is a demonstrated Medical Center or Medical/Dental Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver will be submitted to the Credentials Committee for consideration, along with the application form and any additional information submitted by the applicant. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Chief of Service, and the best interests of the Medical Center and the communities it serves. The Credentials Committee will forward its recommendation to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The Board's determination regarding whether to grant a waiver is final. No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank, nor does it provide the right to a hearing under this Policy.

(e) A determination to grant a waiver does not mean that the appointment or clinical privileges will be granted, only that processing of the application can begin.

(f) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(g) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.

2.A.3. Factors for Evaluation:

The ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the assessment of the initial grant or renewal of clinical privileges at time of appointment and reappointment, as reflected in the following factors:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work professionally with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Medical Center's and Medical/Dental Staff's commitment to quality care and a recognition that

interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment or Clinical Privileges:

No individual is entitled to receive an application or to be granted appointment, reappointment, or particular clinical privileges merely because the individual:

(a) is employed by the Medical Center or its subsidiaries or has a contract with the Medical Center;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical/Dental Staff appointment, permission to practice as an Allied Health Professional, or clinical privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Medical Center; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

Credentialing decisions will not be based on an applicant's age, sex, gender identification, sexual orientation, race, creed, color, ethnic/national identity or origin, religion, or the patient type (e.g., Medicaid or high-risk populations) in which the individual specializes.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment, and/or clinical privileges, and as a condition of maintaining ongoing appointment and/or clinical privileges, every practitioner specifically agrees to the following:

(a) to abide by all Bylaws, policies, rules, and regulations of the Medical/Dental Staff and the Medical Center in force during the time the individual is appointed;

(b) to participate in Medical/Dental Staff affairs through committee service, participation in quality improvement and peer review activities, and/or by

performing such other Medical/Dental Staff duties and responsibilities as may be assigned;

(c) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(d) to be involved in the educational process at it relates to students, interns, residents, fellows, or other health care professionals;

(e) to actively participate in the Medical/Dental Staff's peer review and performance improvement processes, including those related to the Medical Center's malpractice prevention program and the quality assurance program;

(f) consistent with his or her clinical privileges and Medical/Dental Staff category, to serve on the Emergency Department on-call roster for their specialty, provide consultations, and care for unassigned patients;

(g) to comply with clinical practice or evidence-based medicine protocols that (1) are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or (2) may be adopted by the Medical/Dental Staff or the Medical/Dental Staff leadership, or to clearly document the clinical reasons for variance;

(h) to submit to a competency evaluation or to obtain, when requested, an appropriate health assessment, which may include diagnostic testing (e.g., blood, urine, or hair testing) or a complete physical, psychiatric, or behavioral evaluation, as set forth in this Policy or other Medical/Dental Staff policy;

(i) to meet with Medical/Dental Staff leaders and/or members of the Administrative Leadership upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical/Dental Staff leaders and/or members of the Administrative Team as may be requested;

(j) to appear for personal, phone, or virtual interviews in regard to an application for initial appointment or reappointment, if requested;

(k) to maintain and monitor a current professional e-mail address (e.g., an ECMC, Kaleida Health or a group practice e-mail account) or other approved electronic communication channel (e.g., secure portal or text), which will be the primary mechanism used by the Medical/Dental Staff Office to communicate all Medical/Dental Staff information to the practitioner;

(l) to provide a valid mobile phone number, with secure texting capability, in order to facilitate practitioner-to-practitioner communication;

(m) to provide upon request access to copies of the practitioner's office charts and records relating to the treatment of patients receiving care in the Medical Center if deemed necessary for the review of the practitioner's professional activities and current clinical competence;

(n) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;

(o) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(p) to not deceive patients as to the identity of any individual providing treatment or services and to always wear proper Medical Center identification of their name and status;

(q) to seek consultation whenever required or necessary;

(r) to complete in a timely and legible manner all medical and other required records, containing all information required by the Medical Center, and to utilize the electronic medical record system for patients referred or admitted to the Medical Center;

(s) to cooperate with all care management activities;

(t) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(u) to promptly pay any applicable Medical/Dental Staff dues and application fees;

(v) to attend and participate in any applicable orientation programs at the Medical Center before participating in direct patient care;

(w) to participate in an Organized Health Care Arrangement with the Medical Center and abide by the terms of the Medical Center's Notice of Privacy Practices with respect to health care delivered in the Medical Center; and

(x) if practicing as an allied health professional, comply with any applicable supervision or collaboration agreement.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of producing information deemed adequate by the Medical Center for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information

to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees have been paid. An application will become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If an application continues to be incomplete 30 days after the individual has been notified of the additional information required, the application will be deemed to be withdrawn and the individual may not submit another application for appointment or clinical privileges for a period of three years.

(d) The individual seeking appointment, reappointment and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying the Medical/Dental Staff Office of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, promptly but no later than ten days after becoming aware of the change occurring, and includes, but is not limited to:

(1) any information on the application form;

(2) any threshold eligibility criteria for appointment or clinical privileges;

(3) complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA registration or state-controlled substance license;

(4) changes in professional liability insurance coverage;

(5) the filing of a professional liability lawsuit against the individual;

(6) the filing of any lawsuit or administrative complaint or proceeding by any government agency related to the individual's professional practice;

(7) a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;

(8) exclusion or preclusion from participation on any private health insurance panel of providers or in Medicare, Medicaid, or any other federal or state healthcare program, or any sanctions imposed with respect to the same;

(9) changes in status (e.g., appointment, clinical privileges, or employment) at any medical group or health care entity because of issues with clinical competence or professional conduct; and

(10) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health).

2.C. APPLICATION

2.C.1. Information:

(a) Forms approved by the Medical Center will be used as the application for requests for appointment, reappointment, and clinical privileges. The application may be supplemented to address requests for specific clinical privileges and other information concerning the individual's professional qualifications.

(b) The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

(c) In addition to other information, the applications shall seek a copy of a government-issued photo identification.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Medical Center or any of

its affiliates or subsidiaries, or any of their Boards, Board members, practitioners, employees, officers, representatives or agents, or any third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Medical Center, its Medical/Dental Staff, Medical/Dental Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical/Dental Staff and/or clinical privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes these third parties to release this information to the Medical Center, its Medical/Dental Staff, Medical/Dental Staff leaders, and their authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Medical Center.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes the Medical Center, its Medical/Dental Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Medical Center that are assessing the individual's professional qualifications, competence, or health pursuant to a review that the individual has been notified is occurring under applicable Medical Center or Medical/Dental Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any peer review information in response to such inquiries does not waive any associated privilege, and any and all disclosures will be made with the understanding that the receiving entity will only use such peer review information for peer review purposes.

(d) Authorization to Share Information with Affiliated Entities:

The practitioner specifically authorizes the Medical Center and any entity affiliated with it, including Kaleida Health, to share with each other any and all credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct in accordance with any information sharing agreement or policy. This information may be shared as outlined in any such agreement or policy, but generally will occur at the time of initial appointment, reappointment, or at any other time during the individual's affiliation with the Medical Center.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Medical Center.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she will reimburse the Medical Center, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff members or other practitioners, authorized representatives, agents, and employees who are involved in the action for all fees, costs, and out-of-pocket expenses incurred in defending such legal action, including, but not limited to, reasonable attorney's fees, court costs, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Medical Center's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical/Dental Staff or no longer exercises his or her clinical privileges at the Medical Center; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

2.C.3. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Credentials Committee to explain the misstatement or omission. The Credentials Committee will review the response and determine whether appointment and privileges should be deemed to be automatically relinquished pursuant to this Policy.

(c) If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply for a period of at least three years.

(d) No action taken pursuant to this Section will entitle the applicant or member to a hearing or appeal.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment and clinical privileges will be submitted in accordance with current Medical Center protocol (i.e., on approved forms or submitted through an approved portal/website).

(b) An individual seeking initial appointment and clinical privileges will be provided access to information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for any clinical privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final six months of their training may apply to the Medical/Dental Staff. Such applications may be processed, but final action on the applications will not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical/Dental Staff Office.

(b) As a preliminary step, the application will be reviewed by the Medical/Dental Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) The Medical/Dental Staff Office will oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be

contained in the application, obtained from peer references (two peer references are required from the same discipline, where practicable), and/or obtained from other available sources who may have knowledge about the applicant's education, training, experience, and ability to work with others (e.g., residency/fellowship training director, the applicant's past or current Chiefs of Service at other health care entities, etc.).

(b) An interview(s) with the applicant may be conducted as a part of the credentialing process. The purpose of the interview is to discuss and review any aspect of the applicant's application, experience, qualifications, and requested clinical privileges. This interview may be conducted by any of the following (individually or in combination): the Chief of Service, Associate Chief of Service, the Credentials Committee (or its representative(s)), the MEC (or its representative(s)), the CMO, and/or the CEO. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

3.A.4. Chief of Service Procedure:

(a) The Medical/Dental Staff Office will make the application packet available to the relevant Chief of Service(s) in which the applicant seeks clinical privileges. The Chief of Service will review the application packet and make a recommendation on whether the applicant satisfies all of the qualifications for appointment and the clinical privileges being requested.

(b) The Chief of Service will be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the recommendation of that individual.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee will review the application packet, including the recommendation of the relevant Chief of Service, before making a recommendation to the MEC.

(b) The Credentials Committee may use the expertise of the Chief of Service or any member of the department, any Medical/Dental Staff committee, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) If, after determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee has any questions about the applicant's ability to safely practice, it may require the applicant to provide information regarding his or her health status and/or to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. Failure of an applicant to undergo an examination within a reasonable

time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application will cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions on appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than three years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, as pertinent, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

(a) At its next regular meeting after receipt of the findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint and grant clinical privileges, the recommendation will be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC will forward its recommendation to the CEO, who will promptly send special notice to the applicant. The CEO will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

(a) Expedited Review: The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges

if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or clinical privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for ratification at its next meeting.

(b) Full Board Review: When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Medical Center for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Medical/Dental Staff President, as Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO will promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.A.9. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to this Policy will be for a duration of not more than three years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in Medical/Dental Staff policy.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to admit or treat patients at the Medical Center. Each practitioner who has been granted appointment is entitled to exercise only those clinical privileges specifically granted by the Board. Clinical privileges, once granted, may be exercised in person or via technology-enabled direct communication and evaluation (i.e., telemedicine) when that modality of treatment is available and has not been otherwise limited in the relevant delineation of privileges.

(b) A request for privileges will be processed only if an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived and the waiver process outlined in Article 2 will be followed.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Board has determined to close a specific specialty area at the Medical Center.

(d) The granting of clinical privileges may include the responsibility to serve on the on-call roster for their specialty.

(e) Recommendations for clinical privileges should be based on consideration of the following, as applicable:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused peer review and other performance improvement activities, as applicable;

(5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Medical Center's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital or health care facility;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(f) Core privileges, special privileges, clinical privilege delineations, and/or the criteria for the same will be developed or endorsed by the relevant Chief of Service and will be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(h) The report of the Chief of Service(s) in which clinical privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Requests for Limited Privileges Within a Core or Specialty:

(a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)

(b) An individual may request an exception to this requirement (i.e., for limited clinical privileges within a core or specialty). The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

(c) A request for limited clinical privileges will be reviewed by the relevant Chief of Service, Credentials Committee, MEC, and Board.

(d) The following factors, among others, may be considered in deciding whether to grant limited privileges:

(1) the Medical Center's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(2) the effect of the request on the Medical Center's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(3) the expectations of other Medical/Dental Staff members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

(5) fairness to other Medical/Dental Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and

(6) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(e) No one is entitled to be granted limited clinical privileges, and denial of such a request does not trigger a right to a hearing or appeal.

4.A.3. Resignation of Limited Clinical Privileges:

A request to resign limited clinical privileges, whether or not part of the core, must provide a basis for the request. All such requests will be processed in the same manner as a request for limited clinical privileges, as described above.

4.A.4. Resignation of Appointment and Clinical Privileges:

A request to resign appointment and all clinical privileges should be provided with at least 30 days' notice and should specify the desired date of resignation, and be accompanied by

evidence that the individual will be able to accomplish the following by the specified end date:

(a) completion of all medical records;

(b) as applicable, the appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(c) as applicable, the completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

Any such request should be submitted to the Medical/Dental Staff Office and the resignation request will be forwarded to the MEC for action. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

4.A.5. Clinical Privileges for New Procedures:

(a) General. Requests for clinical privileges to perform either a procedure not currently being performed at the Medical Center or a new technique to perform an existing procedure (hereafter, "new procedure") will not be processed until (1) an initial administrative review is completed to determine that the procedure will be offered by the Medical Center, and (2) the Credentials Committee has developed criteria to be eligible to request those clinical privileges.

(b) Initial Administrative Review. As an initial step in the process, the practitioner seeking to perform the new procedure will contact the relevant administrative leader (e.g., service line chair, dyad leader, etc.) to discuss the following, as relevant to the new procedure being requested:

(1) appropriate education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Medical Center currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

Medical Center administration will review this report and consult with the relevant specialty committee, the CMO, the Medical/Dental Staff President, the Chief of Service, and/or the Credentials Committee (any of which may be asked to conduct additional research) as may be necessary to make a determination as to whether the new procedure should be offered to the community.

(c) Credentials Committee Review Procedures. If the Medical Center administration supports the request for a new procedure, the Credentials Committee will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a "new procedure," the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Medical Center. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the appropriate threshold eligibility criteria, including education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the manner of addressing the most common complications that may arise in the performance of the new procedure;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and

(5) the manner in which the procedure would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities.

(d) MEC and Board Review Procedures. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the MEC. The MEC will then make a recommendation to the Board for final action. The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question based on the recommendations of the Credentials Committee. Once the foregoing steps are completed, specific requests from eligible practitioners who wish to perform the procedure or service may be processed.

(e) 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.

4.A.6. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously at the Medical Center have been exercised 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.

(b) As an initial step in the process, the practitioner seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care. The Administrative Leadership will confirm the request is permissible under any existing exclusive contracts or Board directives regarding a closed service that are in place at the Medical Center before the request is forwarded to the Credentials Committee.

(c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical/Dental Staff (e.g., Chiefs of Service, individuals on the Medical/Dental Staff with special interest and/or expertise) and those outside the Medical Center (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the committee may develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;

(2) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(4) the manner in which the privileges would be reviewed as part of the Medical Center's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(5) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action. The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible practitioners who wish to exercise the privileges in question may be processed.

4.A.7. Clinical Privileges for Dentists and Oral Surgeons:

(a) 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 clinical privileges to perform such appraisal.

(b) 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 or her knowledge and concurrence.

4.A.8. Post-Graduate Trainees (Residents and Fellows):

(a) Residents in a Training Program.

Physicians in residency training will not hold appointments to the Medical/Dental Staff and will not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member will be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Medical Center. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Moonlighting Trainees.

(1) Physicians who are in a fellowship or their final year of a residency program at the Medical Center and who wish to moonlight outside of their training program may be granted specific privileges in accordance with the review process described in this Policy. In order to be eligible for moonlighting privileges, an individual must meet all relevant eligibility criteria for the clinical privileges requested (or be granted a waiver) and must:

(i) have a license to practice in the state of New York;

(ii) provide the written confirmation of his or her program chair recognizing the provisions of moonlighting services and the hours approved; and

(iii) where applicable to their practice, have a current, unrestricted DEA registration.

(2) A resident who is moonlighting must comply with the institutional and program training requirements. Failure to comply with these requirements or termination from the residency program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.9. Telemedicine Privileges for Distant-Site Practitioners:

(a) A qualified individual providing services from a distant-site location may be granted telemedicine privileges regardless of whether the individual is Appointed to the Medical/Dental Staff.

(b) Requests for initial or renewed telemedicine privileges by distant-site practitioners will be processed through one of the following options, as determined by the CEO in consultation with the Medical/Dental Staff President:

(1) A request for telemedicine privileges may be processed through the same process for Medical/Dental Staff applications, as set forth in this Policy. In such case, the distant-site practitioner must satisfy all qualifications and requirements set forth in this Policy, except those relating to response times, coverage arrangements, and emergency call responsibilities.

(2) If the distant-site practitioner is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Medical Center must ensure, through a written agreement, that the

distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the distant-site practitioner is licensed in the state of New York;

(ii) a current list of clinical privileges granted to the distant-site practitioner;

(iii) information indicating that the distant-site practitioner has actively exercised the relevant clinical privileges during the previous 12 months and has done so in a competent manner;

(iv) confirmation that the distant-site practitioner satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) confirmation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other confirmation, attestations, or information required by the agreement or requested by the Medical Center.

This information will be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Medical Center may determine that a distant-site practitioner is ineligible for appointment or clinical privileges if the individual fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Telemedicine privileges, if granted, will be for a period of not more than three years.

(d) Distant-site practitioners who have been granted telemedicine privileges will be subject to the Medical Center's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the distant-site practitioner by patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Medical/Dental Staff President and the Credentials Committee or its Chair, and after considering the evaluation of the Chief of Service; and

(5) temporary privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Important Patient Care Need. The CEO, upon recommendation of the Medical/Dental Staff President and the applicable Chief of Service, may also grant temporary privileges in other limited situations when there is an important patient care, treatment, or service need (e.g., the temporary privileges are needed for the care of a specific patient; when a proctoring or consulting practitioner is needed, but is otherwise unavailable; or when necessary to prevent a lack or lapse of services in a needed specialty area. In these situations, the following factors will be considered and/or verified prior to the granting of temporary privileges:

(1) current New York state licensure and DEA or state-controlled substance authorization, if applicable;

(2) relevant training or experience;

(3) current competence (e.g., verification of good standing at the individual's most recent hospital affiliation and peer references);

(4) current professional liability coverage acceptable to the Medical Center; and

(5) a query to the National Practitioner Data Bank, and from OIG queries.

The grant of clinical privileges in these situations will not exceed 60 days; however, in exceptional situations, this period of time may be extended in the discretion of the CEO and the Medical/Dental Staff President.

Any individual seeking temporary privileges for an urgent patient care need who is currently appointed in good standing at a Kaleida Health hospital with a grant of clinical privileges relevant to the request for temporary privileges may be immediately authorized to exercise temporary privileges upon verification of good standing by the Medical/Dental Staff Office and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for such grants of privileges will generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges.

(c) Locum Tenens. The CEO may grant temporary privileges to an individual serving as a locum tenens for a practitioner who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous year), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the applicant has received a favorable recommendation from the Medical/Dental Staff President and/or Credentials Committee Chair, after considering the evaluation of the Chief of Service;

(5) the applicant will be subject to any focused professional practice requirements established by the Medical Center; and

(6) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify the Medical/Dental Staff Office at least 10 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform the Medical/Dental Staff Office of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

(d) Automatic Expiration. All grants of temporary privileges will automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary privileges by the relevant Chief of Service, the Chair of the Credentials Committee, the Medical/Dental Staff President, and the CEO.

(e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical/Dental Staff and the Medical Center.

(f) FPPE. Individuals who are granted temporary privileges will be subject to the Medical Center policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The CEO may withdraw temporary privileges at any time, after consulting with the Medical/Dental Staff President, the Chair of the Credentials Committee, the Chief of Service or the CMO. Clinical privileges will then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the Chief of Service, the Medical/Dental Staff President, or the CMO may immediately withdraw all temporary privileges. The Chief of Service or the Medical/Dental Staff President will assign to another practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a practitioner may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the Chief of Service, Associate Chief of Service, or the Medical/Dental Staff President to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

Disaster privileging will be carried out in accordance with the Medical Staff Disaster Credentialing and Privileging Policy.

4.E. PRIVILEGES FOR OTHER HEALTH CARE PROFESSIONALS

(1) Licensed or registered health care professionals who are not members of the Medical/Dental Staff or the Allied Health Professional Staff but who, in accordance with the state of New York and federal law, may perform specific clinical services independently at the Medical Center, may be granted clinical privileges to do so. Current health care professionals permitted to make such requests include the following:

Category of Provider	**Eligible Clinical Privileges**
Clinical Pharmacist	*Managing Drug Therapies*

(2) Any request for clinical privileges by such a health care professional will be reviewed through the same process used for all other requests for clinical privileges, as set forth in this Policy. When making such a request, the individual must satisfy

all the qualifications and/or training requirements set forth in the applicable privilege delineation form.

(3) Any clinical privileges granted to such a health care professional pursuant to this Policy will supplement the individual's hospital practice, as described in his or her job description.

4.F. EXCLUSIVE ARRANGEMENTS

4.F.1. General Principles Applicable to All Exclusive Arrangements:

(a) Types of Exclusive Arrangements. The Medical Center may enter into arrangements with practitioners and/or groups of practitioners for the exclusive performance of clinical and administrative services at the Medical Center. The Medical Center may accomplish this by:

(1) entering into a contract that confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(2) passing a Board resolution that limits those who may exercise clinical privileges in a clinical specialty to employees of the Medical Center or its affiliates.

(b) Credentialing Requirements. All such practitioners must obtain and maintain clinical privileges at the Medical Center in accordance with the terms and processes outlined in this Policy.

(c) Effect on Applicants for Clinical Privileges. Only practitioners who are authorized by an exclusive arrangement are eligible to apply for the clinical privileges that are covered by the exclusive arrangement at the time of initial appointment or reappointment.

(d) Effect on Existing Clinical Privileges and Medical/Dental Staff Appointment.

(1) Practitioners who were granted clinical privileges prior to an exclusive arrangement being established will no longer be eligible to exercise the clinical privileges covered by an exclusive arrangement unless they are parties to it or an exception has been granted to them;

(2) A practitioner who leaves a group that maintains an exclusive arrangement with the Medical Center will no longer be eligible to exercise the clinical privileges covered by the arrangement upon the effective date of his or her departure from the group;

(3) If the Medical Center establishes a new exclusive arrangement that replaces an existing exclusive arrangement, the practitioners who were part of the

former exclusive arrangement will no longer be eligible to exercise the applicable clinical privileges, unless they join the new exclusive provider or an exception has been granted to them; and

(4) If ***all*** of an individual's clinical privileges are covered by an exclusive arrangement to which he or she is not a party, the individual will be deemed to have voluntarily resigned from the Medical/Dental Staff unless an exception is offered that allows them to continue to exercise their clinical privileges at the Medical Center. However, such Practitioners will be afforded the notice provisions outlined in Section 4.F.2 of this Policy before such a voluntary resignation takes place.

(e) No Hearing and No Reporting Obligations. The inability of a practitioner to exercise clinical privileges because of an exclusive arrangement is not a matter that entitles the practitioner to request a hearing as outlined in Article 7 or requires a report to the state licensure board or to the National Practitioner Data Bank.

(f) Contract Provisions Control. Except as provided in (b) above (i.e., requirement that all practitioners to be fully credentialed), in the event of any conflict between this Policy or the Medical/Dental Staff Bylaws and the terms of any exclusive contract, the terms of the contract will control.

4.F.2. Process for Exclusive Arrangements in ***New*** Specialty Areas:

(a) MEC Review. Prior to the Medical Center establishing an exclusive arrangement in a ***new*** specialty area (i.e., no prior exclusive arrangement), the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Medical/Dental Staff President) will review the quality of care and service implications of the proposed exclusive arrangement and provide a report of its findings and recommendations to the Board within 30 days of the Board's request.

As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Medical Center administration. However, the actual terms of any such exclusive arrangement, and any financial information related to it, including but not limited to the remuneration to be paid to the practitioners who may be a party to the arrangement, are not relevant and will neither be disclosed to the MEC nor discussed as part of the MEC's review.

(b) Meeting with Board or Board Committee. After receiving the MEC's report, the Board will determine whether or not to proceed with an exclusive arrangement in the new specialty area. If the Board determines to do so, and if that determination would have the effect of preventing an existing practitioner from exercising clinical privileges that had previously been granted, the affected practitioner is entitled to

the following notice and review procedures (*Note*: If more than one practitioner in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(1) The affected practitioner will be given at least 30 days' advance notice of the anticipated effective date of the exclusive arrangement and will have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the exclusive contract being signed by the Medical Center or the Board resolution becoming effective. Any such meeting must be requested by the affected practitioner and held within 30 days of the notice, unless this time frame is extended by mutual agreement.

(2) At the meeting, the affected practitioner will be entitled to present any information that he or she believes is relevant to the Board's determination to enter into the exclusive arrangement.

(3) If, following this meeting, the Board confirms its initial determination to enter into the exclusive arrangement, the affected practitioner will then be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive arrangement, as described in Section 4.F.1(c) above.

(4) The affected practitioner will not be entitled to any procedural rights beyond those outlined in this Section with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) satisfied all Medical/Dental Staff responsibilities, including payment of dues and completing medical records;

(b) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

(c) if applying for renewal of clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Medical Center must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, peer evaluations, clinical information from the individual's private office practice if appropriate or comparable to privileges requested, and/or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further; and

(d) paid the reappointment processing fee, if any.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical/Dental Staff and the Medical Center;

(b) participation in Medical/Dental Staff duties, including committee assignments, serving on the on-call roster, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality

improvement, utilization activities, and peer review activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Medical Center's performance improvement and peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) any ongoing or focused professional practice evaluations;

(e) verified complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment will be made available to practitioners at least 120 days prior to the expiration of their current appointment term. A completed reappointment application must be submitted to the Medical/Dental Staff Office by the established deadline.

(b) Failure to submit a complete application at least three months prior to the expiration of the practitioner's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical/Dental Staff Office and the Medical/Dental Staff leaders. If an individual's privileges lapse due to a processing delay, subsequent action may be taken to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).

(c) Reappointment will be for a period of not more than three years.

(d) The application will be reviewed by the Medical/Dental Staff Office to determine that all relevant information has been received and verified and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) The steps outlined in Article 3 for the initial appointment process will then be followed for the reappointment process

5.A.4. Processing Applications for Reappointment:

(a) The Medical/Dental Staff Office will forward the application to the relevant Chief of Service and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent on a practitioner's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Conditional reappointments may also be used for low-volume practitioners (e.g., a requirement to complete additional FPPE).

(c) Reappointments may be recommended for periods of less than three years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than three years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(d) In addition, in the event the applicant for reappointment is the subject of an unresolved peer review concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than three years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

(a) If the Credentials Committee or MEC is considering a recommendation to deny reappointment or to revoke, reduce, or restrict clinical privileges, the chair will notify the practitioner of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the practitioner will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the practitioner will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the Credentials Committee's and/or MEC's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The practitioner will not have the right to be accompanied by legal counsel

at this meeting and no recording (audio or video) of the meeting will be permitted or made.

(e) If the Board determines to reject a favorable recommendation from the MEC, it should first discuss the matter with the Chair of the Credentials Committee and the Medical/Dental Staff President, as chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO will promptly send a special notice to the applicant that the applicant is entitled to request a hearing under this Policy.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 business days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in Medical/Dental Staff policy.

ARTICLE 6

REVIEW OF PRACTITIONER PERFORMANCE ISSUES

6.A. COLLEGIAL EFFORTS AND OTHER PROGRESSIVE STEPS

(1) This Policy outlines and encourages the use of collegial efforts and other progressive steps to address and resolve performance issues that may be identified about a member's clinical practice, health or behavior.

(2) Collegial efforts that may be taken by Medical/Dental Staff leaders and committees include activities such as:

(a) informal mentoring, coaching, or counseling by a Medical/Dental Staff leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming their practice to appropriate norms.

Brief documentation of these efforts (e.g., follow-up email to the practitioner or a note to file) is encouraged to help determine if a pattern may be developing that would recommend a more formal response. A copy of any such documentation will be maintained in the individual's confidential file.

(3) Other progressive steps that may be used by Medical/Dental Staff leaders and committees include, but are not limited to, the following actions:

(a) addressing minor performance issues through an informational letter (e.g., for delinquent medical records);

(b) sending an educational letter that describes opportunities for improvement and provides specific guidance and suggestions;

(c) facilitating a formal collegial intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical/Dental Staff leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a voluntary improvement plan that can be used to address a concern.

These progressive steps are to be documented and included in a practitioner's confidential file. The written response by the practitioner to any of these progressive steps will also be included in the individual's confidential file.

(4) The goal of these collegial efforts and other progressive steps is to arrive at voluntary, responsive actions by the member to resolve the questions that have been raised in a non-disciplinary way. All such efforts are a part of the Medical/Dental Staff's peer review functions and on behalf of its peer review committees. These efforts are fundamental and integral components of the Medical Center's peer review activities and are confidential and protected in accordance with state law.

(5) Collegial efforts and other progressive steps are encouraged, but are not mandatory. Nothing in this Policy will prohibit the referral of an issue to the MEC for its review and action at any time.

6.B. GUIDELINES FOR COLLEGIAL INTERVENTION

6.B.1. No Recording:

There will be no recording (audio or video) or transcript made of any meetings that involve initial collegial efforts or other progressive steps activities.

6.B.2. No Right to the Presence of Others:

(a) Credentialing and peer review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual is not entitled to bring any other individual when attending a meeting that takes place pursuant to this Article unless consented and agreed to by the committee or individual(s) calling the meeting.

(b) If the individual refuses to meet, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.3. No Right to Legal Counsel:

(a) Members do not have the right to be accompanied by legal counsel when the Medical/Dental Staff leaders and members of the Administrative Leadership engage in collegial efforts or other progressive steps.

(b) If the individual refuses to meet without their lawyer present, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.4. Involvement of Supervising Physician in Matters Pertaining to an Allied Health Professional:

If any peer review activity pertains to the clinical competence or professional conduct of an Allied Health Professional, the supervising/collaborating physician (if any) may be notified and may be invited to participate.

6.C. ADDITIONAL METHODS FOR PROGRESSIVE STEPS

6.C.1. Mandatory Meeting:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, an authorized Medical/Dental Staff leader or committee, the CMO, or the CEO may require the individual to attend a mandatory meeting.

(b) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(c) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.C.2. Health Assessment:

(a) Emergent Need. An individual may be requested to immediately submit to a health assessment to determine their ability to safely practice. Such a request for an immediate evaluation may be made when two Medical/Dental Staff leaders (or one Medical/Dental Staff leader and one member of the Administrative Leadership) have a reasonable belief that the individual poses an immediate threat to patients, the individual themselves, or others. Such belief may be based on the review of a reported concern and/or after a personal assessment of the practitioner.

(b) Other Requests. A request for a health assessment may also be made as follows:

(1) of an applicant during the initial appointment or reappointment processes when requested by the Credentials Committee;

(2) of a member during a Medical/Dental Staff investigation or during a review pursuant to another Medical/Dental Staff policy; or

(3) of a member seeking reinstatement from a leave of absence.

(c) Under both paragraphs (a) and (b), the Medical/Dental Staff leaders, members of the Administrative Leadership, or committee that requests the evaluation will:

(1) identify the health care professional(s) to perform the evaluation;

(2) inform the individual of the time period within which the evaluation must occur; and

(3) provide the individual with all appropriate releases and/or authorizations to allow the Medical/Dental Staff leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical/Dental Staff leaders or relevant committee.

(d) An individual who has been asked to obtain an assessment described in this Policy will be responsible for any costs related to the assessment that are not covered by their insurance.

(e) Failure to obtain the requested evaluation may result in an automatic relinquishment of appointment and privileges as set forth below.

6.D. LEAVES OF ABSENCE

6.D.1. Initiation:

(a) A practitioner may request a leave of absence by submitting a written request to the Medical/Dental Staff Office. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

(b) The CMO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CMO will consult with the Medical/Dental Staff President and the relevant Chief of Service. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Leaves for Health Issues. Except for maternity leaves, practitioners must report to the Medical/Dental Staff Office any time they are away from Medical/Dental Staff 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. Upon becoming aware of such circumstances (whether by report of the practitioner or otherwise), the CEO and/or CMO, in consultation with the Medical/Dental Staff President, may trigger an automatic medical leave of absence at any point after becoming aware of the practitioner's absence from patient care. The practitioner will be sent special notice informing him or her that a leave of absence has been enacted.

6.D.2. Duties of Practitioners on Leave:

During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical/Dental Staff and clinical

responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.D.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Medical Center (e.g., current licensure, CME, etc.). Requests for reinstatement will then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical/Dental Staff member may immediately resume clinical practice at the Medical Center. If, however, the Leadership Council has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for normal maternity leaves, which are not required to be processed for reinstatement as a leave for a health issue), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. Before acting on a practitioner's request for reinstatement, the Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the practitioner to undergo a health assessment conducted by a physician or entity chosen by the Leadership Council in order to obtain a second opinion on the practitioner's ability to practice safely and competently.

(c) Absence for longer than one year will result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the CMO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Center.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges will lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner will be deemed a voluntary resignation of appointment and clinical privileges.

(f) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.E. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.E.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical/Dental Staff Officer or relevant Chief of Service or Associate Chief of Service, acting in conjunction with the CMO or the Medical/Dental Staff President is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed or (2) suspend or restrict all or any portion of an individual's clinical privileges. The process defined below will apply regardless of the option used in this paragraph.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, reasonable efforts will be made to meet with the individual in question and review the concerns and afford the individual an opportunity to respond.

(c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the CEO, the CMO, and the Medical/Dental Staff President. A precautionary suspension will remain in effect unless it is modified by the MEC, the CEO or the Board.

(e) Special notice will be given at least three days following the imposition of a precautionary suspension. The special notice will provide the individual with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The relevant supervising physician (if any) will be notified when the affected individual is an Allied Health Professional.

(f) Upon the imposition of a precautionary suspension, the Medical/Dental Staff President will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.E.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension or restriction, the MEC will review the reasons for the action.

(b) As part of this review, the individual will be invited to meet with the MEC. In advance of the meeting, the individual may submit a written statement and other information to the MEC.

(c) At the meeting, the individual may provide information to the MEC and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, to protect patients, employees or others while the matter is being reviewed. Neither the MEC nor the individual may be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting will be permitted or made; however, minutes of the meeting will be prepared.

(d) After considering the matters resulting in the suspension or restriction, and the individual's response, if any, the MEC will determine the appropriate next steps, which may include, but are not limited to, commencing a focused review or a formal investigation, referring the matter for review pursuant to another policy, or recommending some other action that is deemed appropriate under the circumstances. The MEC will also determine whether the precautionary suspension or restriction should be continued, modified, or lifted during any further review process.

(e) If the MEC recommends that the suspension be continued, it will send the individual written notice of its recommendation, including the basis for it. If the MEC recommends that the suspension be modified, or lifted, this recommendation will be forwarded to the CEO for final action.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction. The procedures outlined above are deemed to be fair under the circumstances.

6.E.3. Care of Patients:

Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the Medical/Dental Staff President will assign to another individual with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or to aid in implementing the precautionary suspension, restriction, or agreement to refrain from practicing, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician but may not always be accommodated.

6.F. INVESTIGATIONS

6.F.1. Initial Review:

(a) Where collegial efforts or other progressive steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical/Dental Staff leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any practitioner, including the care, treatment or management of a patient or patients;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation by any practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Medical Center or the Medical/Dental Staff; and/or

(4) conduct by any practitioner that is considered lower than the standards of the Medical Center or disruptive to the orderly operation of the Medical Center or its Medical/Dental Staff, including the inability of the practitioner to work harmoniously with others,

the matter may be referred to the Medical/Dental Staff President, the relevant Chief of Service, the chair of a standing committee, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any practitioner, the matter will be referred to the Medical/Dental Staff President, the relevant Chief of Service, the chair of a standing committee, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred will conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, will forward it in writing to the MEC.

(d) No action taken pursuant to this Section will constitute an investigation.

6.F.2. Initiation of Investigation:

(a) When a question involving a practitioner's clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another Medical/Dental Staff policy (e.g., peer review policy, professionalism policy/code of conduct, practitioner health policy), or to proceed in another manner. Prior to making its determination, the MEC may discuss the matter with the individual. An investigation will begin only after a formal

determination by the MEC to do so. The MEC's determination will be recorded in the minutes of the meeting where the determination is made.

(b) The MEC will inform the individual that an investigation has begun. The notification will include:

(1) the date on which the investigation was commenced;

(2) the committee that will be conducting the investigation, if already identified;

(3) a statement that the physician will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and

(4) a copy of Section 6.F.3 of this Policy, which outlines the process for investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Medical Center or Medical/Dental Staff.

6.F.3. Investigative Procedure:

(a) Selection of Investigating Committee.

(1) Once a determination has been made to begin an investigation, the MEC will either investigate the matter itself or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8 and **Appendix D**. If the MEC elects to appoint an ad hoc committee, it may be necessary to appoint individuals who are not on the Medical/Dental Staff at the Medical Center. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, etc.).

(2) As an alternative to an ad hoc committee, in matters in which the underlying matter is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies, the MEC may elect to appoint an individual to conduct the investigation. This individual could be an attorney or other non-clinician, so long as no conflicts of interest exist.

(b) Investigating Committee's Review Process.

(1) The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview

individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee will also have available to it the full resources of the Medical/Dental Staff and the Medical Center, including the authority to arrange for an external review, if needed. An external review may be used whenever the Medical Center and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical/Dental Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under investigation will be notified of that decision and the nature of the external review. However, the individual under investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual will be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

(3) The investigating committee may require the individual under investigation to obtain a health or clinical competency assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the assessment the reasons for the assessment; and (ii) the health care professional(s) conducting the assessment to discuss and provide documentation of the results of such assessment directly to the investigating committee. The cost of the assessment will be borne by the Medical Center.

(c) Meeting with the Investigating Committee.

(1) The individual under investigation will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written

responses to specific questions related to the investigation and/or a written explanation of his or her perspective on the events that led to the investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings will apply. No recording (audio or video) or transcript of the meeting will be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview will be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the investigation, the investigating committee will prepare a report of the investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Medical Center, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.F.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the investigation, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension or restriction of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) If a recommendation by the MEC would entitle the individual to request a hearing in accordance with Section 7.A.1, the recommendation will be forwarded to the CEO, who will promptly inform the individual by special notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) A determination by the MEC that does not entitle the individual to request a hearing will take effect immediately. All such determinations will be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification that would entitle the individual to request a hearing, the

CEO will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

(d) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical/Dental Staff leaders on an ongoing basis through the Medical Center's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.G. AUTOMATIC RELINQUISHMENT/ACTIONS

6.G.1. General:

An automatic relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of the Medical Center to file a report with the National Practitioner Data Bank or any state licensing agency. It takes effect immediately without the right to the procedural rights outlined in this Policy (i.e., there is no right to a hearing or appeal). Any request for reinstatement of appointment and clinical privileges will be reviewed in accordance with the procedures outlined in this Section.

6.G.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Policy will result in the automatic relinquishment of appointment and clinical privileges unless a waiver is granted pursuant to Section 2.A.2 of this Policy.

6.G.3. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony, or to any misdemeanor involving the following will result in an automatic relinquishment: (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, or (vii) the abuse of the practitioner-patient relationship.

6.G.4. Failure to Provide Required Notification to the Medical/Dental Staff Office:

Practitioners must notify the Medical/Dental Staff Office, in writing, within 10 days of the occurrence of any of the following events:

(a) changes in the practitioner's licensure status or DEA or state-controlled substance authorization;

(b) changes in the practitioner's appointment or clinical privileges at another hospital or health care facility because of issues related to clinical competence or professional conduct, including the practitioner's resignation while under investigation;

(c) changes in the practitioner's employment status at any medical group or hospital because of issues related to clinical competence or professional conduct;

(d) the practitioner's arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter (other than a misdemeanor traffic citation);

(e) the practitioner's exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

(f) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues;

(g) the practitioner's participation in a state practitioner health program (Note: active participation with the Medical Staff leadership to address an impairment issue satisfies this requirement and does not require a separate notice to the Medical/Dental Staff Office); and

(h) any charge of, or arrest for, driving under the influence ("DUI").

Failure of a practitioner to provide this notification will result in the automatic relinquishment of appointment and clinical privileges.

6.G.5. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's professional qualifications, clinical care, or professionalism, in response to a written request from the Credentials Committee, the MEC, the Leadership Council, the Quality Executive Committee, the CMO, the CEO, or any other committee authorized to request such information, will result in the automatic relinquishment of appointment and clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party.

6.G.6. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by any other authorized Medical/Dental Staff committee or the CMO or CEO after appropriate notice has been given will result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.G.7. Failure to Comply with Request for a Health or Competency Assessment:

(a) Failure of an applicant to undergo a requested health or competency assessment or to execute any of the required releases (i.e., to allow the Medical/Dental Staff leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical/Dental Staff leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested health or competency assessment or to execute any of the required releases (i.e., to allow the Medical/Dental Staff leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical/Dental Staff leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.G.8. Request for Reinstatement:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 60 days of the relinquishment, the individual may request to be reinstated.

(b) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by the Medical/Dental Staff Office. If any questions or concerns are noted, the Medical/Dental Staff Office will refer the matter for further review in accordance with (c) below.

(c) All other requests for reinstatement following a relinquishment of appointment and clinical privileges will be reviewed by the Leadership Council. If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice at the Medical Center. If, however, the Leadership Council has any questions or concerns, those questions will be noted, and the reinstatement request will be forwarded to the Credentials Committee, MEC, and Board for review and recommendation.

(d) If an individual seeks reinstatement prior to the resolution of the matter that triggered the automatic relinquishment, the individual bears the burden of demonstrating that the underlying matter does not raise concerns about the individual's professional qualifications or ability to completely and safely exercise clinical privileges. The MEC, in its sole discretion, will make a recommendation to the Board regarding whether the individual has met this burden.

(e) Failure to resolve a matter leading to an automatic relinquishment and to be reinstated as set forth above within 60 days of the relinquishment will result in an automatic resignation of appointment and clinical privileges.

6.H. ACTION AT ANOTHER AFFILIATED HOSPITAL

(1) The Medical Center and participating Kaleida Health hospitals will share information regarding the implementation or occurrence of any of the following actions that occur at a participating hospital where an individual maintains appointment, clinical privileges, or any other permission to care for patients:

(a) **automatic relinquishment or resignation** of appointment or clinical privileges for failure to meet any **threshold eligibility criteria** for appointment or clinical privileges or for any of the **other occurrences** set forth in Medical Staff policy;

(b) **voluntary agreement to modify clinical privileges** or **to refrain from exercising** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;

(c) any **denial, suspension, revocation, or termination** of appointment and/or clinical privileges;

(d) participation in a **voluntary improvement plan**;

(e) a grant of **conditional appointment or clinical privileges** (either at initial appointment or reappointment), or conditional continued appointment or clinical privileges; and/or

(f) any other event which, in the sole discretion of the Medical Center or a participating Kaleida Health hospital making the notification, raises a **significant concern about the practitioner's clinical competence, professional conduct, health/ability to safely practice, or utilization practices**.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) above have occurred at the Medical Center or any participating Kaleida Health hospital, that action will either:

(a) automatically and immediately take effect at the Medical Center or participating Kaleida Health hospital receiving the notice; or

(b) be cause for the Medical Center or participating Kaleida Health hospital receiving the notice to determine that the individual no longer satisfies the eligibility criteria for appointment and/or clinical privileges and has therefore automatically relinquished his or her appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural rights (including advance notice, additional peer review, formal investigation, hearing, or appeal) other than what occurred at the Medical Center or participating Kaleida Health hospital taking the original action. All other information that is shared pursuant to Paragraph (1) above will be reviewed by Medical/Dental Staff leaders at the Medical Center or participating Kaleida Health hospital receiving the information to determine whether additional steps may be necessary.

(3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the Medical Center or participating Kaleida Health hospital receiving the information, following its review of the MEC's recommendation. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

(a) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or hospital operations; and

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Medical Center or participating Kaleida Health hospital where the action first occurred. The burden is on the affected practitioner to provide evidence showing that a waiver is appropriate.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) Members of the Medical/Dental Staff and Allied Health Professional Staff are entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment;

(2) denial of reappointment;

(3) revocation of appointment;

(4) denial of requested clinical privileges, whether at the time of initial appointment, reappointment, or during the course of appointment;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension which entitles an individual to the procedures outlined in Section 6.E of this Policy, which are deemed fair under the circumstances);

(7) a restriction of clinical privileges for more than 30 days; or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations will entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" will be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

(a) determination that an applicant for appointment fails to meet the threshold eligibility qualifications or criteria for appointment;

(b) ineligibility to request appointment or privileges, or to continue privileges, because a relevant specialty is closed under a Medical/Dental Staff development plan or is covered under an exclusive provider agreement;

(c) determination that an applicant for clinical privileges fails to meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

(e) determination that an application will not be processed due to a misstatement or omission;

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of appointment and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(h) issuance of an informational letter, educational letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the acceptance of a voluntary improvement plan;

(l) any requirement to complete a competency or health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than three years;

(o) restriction or suspension of clinical privileges for 30 days or less;

(p) precautionary suspension;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

(r) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(s) removal from the on-call roster or any other reading panel;

(t) withdrawal of temporary privileges;

(u) requirement to appear for a mandatory meeting;

(v) termination of any contract with or employment by the Medical Center; and

(w) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request will be in writing to the CEO and will include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The CEO will schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members (or Hearing Officer) and Presiding Officer, if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Medical/Dental Staff President, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members and may include any combination of:

(i) any member of the Medical/Dental Staff or other practitioner, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians, other practitioners, or laypersons not connected with the Medical Center (i.e., physicians not on the Medical/Dental Staff or laypersons not affiliated with the Medical Center).

(2) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, the Medical Center or an affiliate will not preclude an individual from serving on the Panel.

(4) The Panel will not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Hearing Panel will not include any individual who is professionally associated with, related to, or involved in a significant referral relationship with, the individual requesting the hearing.

(6) The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(7) In addition, the appointment of the Hearing Panel will comply with the guidelines set forth in the conflict of interest provisions found in Article 8 and **Appendix D** of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Medical/Dental Staff President, will appoint a Presiding Officer who will be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Medical Center in any legal matters. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence; and

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

(3) The Presiding Officer may be advised by legal counsel to the Medical Center with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but will not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Medical/Dental Staff President, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, will be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Medical/Dental Staff President and must include the basis for the objection. The Medical/Dental Staff President will be given a reasonable opportunity to comment. The CEO will rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.5. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

(a) The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in any portion of the pre-hearing or hearing processes.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Medical Center employees or Medical/Dental Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Medical Center has been notified and has contacted the individuals about their willingness to be interviewed. The Medical Center will advise the individual who has requested the hearing once it has contacted such employees or Medical/Dental Staff members and confirmed their willingness to meet. Any employee or Medical/Dental Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical/Dental Staff member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

(d) The hearing will last no more than 15 hours, with each side being afforded approximately seven and one-half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(a) the pre-hearing conference will be scheduled at least 14 days prior to the hearing;

(b) the parties will exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information will not waive any privilege under the state peer review protection statutes.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical/Dental Staff.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party will provide the other party with its proposed exhibits. All objections to documents or witnesses will be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

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

7.C.5. Pre-Hearing Conference:

The Presiding Officer will require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which will be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination and will resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

The parties and their counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel, who will be at each party's own expense, who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the post-hearing statement referenced in this Article, following the close of the hearing session(s).

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned by the MEC's representative or the Hearing Panel/Hearing Officer.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Medical Center. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding, the Medical/Dental Staff President, and the CEO. In addition, administrative personnel may be present as requested by the CEO or the Medical/Dental Staff President.

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone but will be permitted only by the Presiding Officer or the CEO on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.2. Deliberations and Recommendation of the Hearing Panel:

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

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel will deliver its report to the CEO. The CEO will send by special notice a copy of the report to the individual who requested the hearing. The CEO will also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical/Dental Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf of the Chair) will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Medical Center, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Medical Center and the quality of care provided.

(c) The Board will render its final decision in writing, including specific reasons, and will send special notice to the individual. A copy will also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board will be effective immediately and will not be subject to further review. If the matter is referred for further action and recommendation, such recommendation will be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical/Dental Staff will be entitled to more than one hearing and one appellate review on any matter.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PEER REVIEW ACTIVITIES

(a) All those involved in credentialing, privileging, and peer review activities (referred to collectively as "Medical/Dental Staff Functions" in this Article) must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical/Dental Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) An assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. Conflict of Interest Guidelines, which are attached as **Appendix D**, may be used as guidance in addressing potential conflict of interest situations, including whether and how an individual may participate.

(d) When performing a function outlined in this Policy, or any other Medical/Dental Staff policy, if a member has or reasonably could be perceived as having a conflict of interest or a bias, that member should not participate in the final discussion or voting on the matter and should recuse themself from the meeting during that time. However, the member may provide relevant information and answer any questions concerning the matter before leaving the meeting. See Rules for Recusal in **Appendix D**.

(e) Any member with knowledge of the existence of an actual or potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Medical/Dental Staff President (or Medical/Dental Staff President-Elect if the Medical/Dental Staff President is the person with the conflict), CMO, or applicable committee chair.

(f) Additionally, members are obligated to notify the Medical/Dental Staff President, CMO, or applicable committee chair of any known or suspected conflicts of interest of those who are involved in reviewing a matter. Any potential conflict of interest that is not timely raised will be deemed to be waived.

(g) The Medical/Dental Staff President or applicable committee chair will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee.

(h) The fact that an individual is in the same specialty as an individual whose request is being considered or performance is being reviewed does not automatically create a conflict.

(i) No individual has a right to compel disqualification of another individual based on an allegation of conflict of interest.

(j) The fact that an individual chooses to refrain from participation, or is excused from participation under these guidelines, will not be interpreted as a finding of an actual conflict of interest.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy will be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities will make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized practitioner or authorized Medical Center employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and peer review activities;

(2) when the disclosures are authorized by a Medical/Dental Staff or Medical Center policy; or

(3) when the disclosures are authorized, in writing, by the CMO, the CEO, or by legal counsel to the Medical Center.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO or the Medical/Dental Staff President (or the Medical/Dental Staff President-Elect if the Medical/Dental Staff President is the person committing the claimed breach).

9.B. PEER REVIEW PROTECTION

(1) All credentialing and peer review activities pursuant to this Policy and related Medical/Dental Staff documents will be performed by individuals and committees as described in the New York Education Law §6527 and N.Y. Public Health Law § 2805-m(1), for the purposes defined therein. These individuals and committees (hereinafter collectively referred to as "peer review committees") include, but are not limited to:

(a) all standing and ad hoc Medical/Dental Staff and Medical Center committees;

(b) all departments, divisions, and clinical sections;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to Chiefs of Service, Associate Chiefs of Service, Physician Advisors, committee chairs and members, officers of the Medical/Dental Staff, the CMO, all Medical Center personnel, and experts or consultants retained to assist in peer review activities.

(2) All credentialing, peer review, risk management, patient safety and similar activities of the Medical Center and its Medical Staff, including any activities conducted by any individuals or committees pursuant to this Policy and related Medical/Dental Staff documents,

(1) are integral components of the Medical Center's Quality Assurances and Performance Improvement ("QAPI") program required by state and federal law;

(2) constitute professional review activities as defined in the federal Health Care Quality Improvement Act;

(3) constitute functions of committees and individuals who are protected from discovery as described in the New York Education Law §6527 and N.Y. Public Health Law § 2805-m(1); and

(4) are part of the Medical Center's Patient Safety Evaluation System as that term is defined by the federal Patient Safety and Quality Improvement Act.

As such, all data and information related to those activities, including any documents, proceedings, records, recommendations, actions, and other evidence or information in oral, written or digital form that is submitted to, prepared for, or acquired or considered by the Medical Center or the committees or individuals referred to herein for or in the course of activities pursuant to this Policy including any communications, records and proceedings related thereto, are and shall be kept strictly confidential.

(3) All peer review committees will also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.*

ARTICLE 10

AMENDMENTS

This Policy may be amended as described in the amendment provisions of the Medical/Dental Staff Bylaws.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical/Dental Staff or Medical Center policies pertaining to the subject matter thereof.

By:

Michael Manka, MD

Medical/Dental Staff President
Michael Manka, MD Date: 12/10/2025

Approved by the Board of Directors:

Chief Executive Officer, Date: 1/27/2026
Erie County Medical Center Corporation Thomas Quatroche, PhD

REVISIONS:

Medical Executive Committee: November 24, 2025

Medical/Dental Staff: December 10, 2025

Board of Directors: January 27, 2026

APPENDIX A

Those individuals currently practicing as Independent Allied Health Professionals at the Medical Center are as follows:

- Doctor of Chiropractic
- Clinical Ph.D.
- Research Ph.D.

APPENDIX B

Those individuals currently practicing as Independent/Collaboration Allied Health Professionals at the Medical Center are as follows:

- Nurse Practitioner
- Nurse Midwife

APPENDIX C

Those individuals currently practicing as Dependent/Supervision Allied Health Professionals at the Medical Center are as follows:

- Physician Assistant
- Certified Registered Nurse Anesthetist
- RN First Assist (RNFA)

APPENDIX D

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
	Provide Information	Individual Reviewer	Committee Member					Hearing Panel
			Credentials Committee	Leadership Council	QEC	MEC	Investigating Committee	
Employment/contract relationship with Medical Center	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N
Relevant treatment relationship	Y	N	R	R	R	R	N	N
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N
Direct competitor	Y	Y	Y	Y	Y	R	N	N
Close friends	Y	Y	Y	Y	Y	R	N	N
History of conflict	Y	Y	Y	Y	Y	R	N	N
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N
Involvement in prior Voluntary PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N

Y – ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and Quality Executive Committee have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or Quality Executive Committee always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the practitioner under review.

N – ("No") – means the Interested Member should not serve in the indicated role.

R – ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The relevant Medical/Dental Staff leader should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The interested member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, relevant Medical/Dental Staff leader will note that the interested member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the interested member may provide information and answer any questions regarding the following: (i) any factual information for which the interested member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or are relevant to the matter under consideration; (iv) the interested member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The interested member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee. The minutes should reflect the fact that the interested member was excused from the meeting prior to deliberation and decision-making.