Medical Staff Bylaws

Novant Health Kernersville Outpatient Surgery

3/9/2021

NOVANT HEALTH

OVERVIEW

These are the medical staff bylaws for the medical staff of Novant Health Kernersville Outpatient Surgery. The bylaws explain the qualifications for medical staff members and advanced practice clinicians; the basic steps in the appointment, reappointment and clinical privileging processes; and how the medical staff reviews and investigates clinical competence and professional behavior concerns and the procedures used for hearings and appeals.

Organization of the bylaws

The bylaws are organized into the following articles:

Important concepts

- Only physicians, oral surgeons, podiatrists and general dentists who meet the qualifications in these bylaws are eligible to be members of the medical staff. Others, such as certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), and physician assistants (PAs), may hold clinical privileges but they are not eligible to be members of the medical staff.
- Being granted membership on the medical staff means the same thing as being appointed or reappointed to the medical staff.

- When the word “practitioner” is used, it refers both to members of the medical staff and to those individuals who hold clinical privileges but are not members, such as CRNAs, NPs, and PAs.
- It is a privilege to serve on the medical staff and to exercise clinical privileges. Members and those holding clinical privileges are afforded important rights but also must fulfill certain obligations and responsibilities such as providing quality care to patients and treating all patients, visitors and members of the healthcare team with respect, courtesy, and dignity.
- Terms of membership and clinical privileges cannot be for longer than two years, but they may be for two years or less. Members and those holding clinical privileges must apply for reappointment and renewal of clinical privileges at least every two years.
- The Board of Trustees, after considering the recommendation of the MEC, may waive any qualification or requirement in these bylaws for good cause when the Board determines the waiver is in the best interest of patients.
- Words used in these bylaws are to be read as the masculine or feminine gender, and as the singular or plural, as the content requires. Captions and headings are used for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.
- An abbreviated table of contents follows this overview. Detailed tables of contents are included at the beginning of each article.

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ARTICLE I – MEMBERSHIP ON THE MEDICAL STAFF

Article I explains the principles associated with medical staff membership. It addresses which practitioners are eligible to become members of the medical staff, and the basic qualification they must meet and continue to meet to remain on the medical staff. The leave of absence process, how practitioners may resign their medical staff membership and/or clinical privileges in good standing, and the criteria that trigger automatic termination of a practitioner's membership and/or clinical privileges are also explained in this Article.

ARTICLE I – MEMBERSHIP ON THE MEDICAL STAFF
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ARTICLE I – MEMBERSHIP ON THE MEDICAL STAFF

Section 1-1. Basic Qualifications for Membership

Membership on the medical staff is a privilege. Only physicians, oral surgeons, podiatrists and dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws and in policies adopted by the Board of Trustees are eligible to be members of the medical staff. The basic qualifications for medical staff membership that applicants must meet are described below, and medical staff members must continuously meet these qualifications in order to maintain their membership and clinical privileges.

Only individuals from the following disciplines who meet the qualifications are eligible to be members of the medical staff:

- *physicians,*
- *oral surgeons,*
- *podiatrists, and*
- *dentists.*

Others, such as CRNAs, NPs, and PAs, may hold clinical privileges, but they are not eligible to be members of the medical staff.

Applicants may have an application *in process* for a license, professional liability insurance or DEA registration when applying for membership or clinical privileges (*see* sections 1-1, A, G and I, below), but membership or clinical privileges will not be granted until the license, insurance coverage or DEA registration has been issued.

A. Licensure

Applicants for medical staff membership must have a current, active and unrestricted license to practice medicine, oral surgery, podiatry or general dentistry in North Carolina.

B. Board eligibility and board certification

Applicants for medical staff membership must be board eligible or board certified. Board eligibility is defined as the period of time between completion of an accredited residency program or fellowship and achievement of initial certification in a specialty. Applicants whose board certification is lapsed are not considered board eligible for initial medical staff membership purposes. Board certification must be achieved within the timeframe set by the specialty board or within five years of completing residency or fellowship training, *whichever is earlier*. When a medical staff member has a board certificate that contains an expiration date, recertification must be achieved no later than two years after the expiration date.

Board certification must be achieved within the timeframe set by the specialty board or within five years of completing residency or fellowship training, whichever is earlier. When recertification is required, recertification must be obtained within two years.

- Members who were appointed to the medical staff *before* January 1, 2001, and surgeons who were appointed to the medical staff *before* 1985 are ***exempt*** from the board eligibility and board certification requirement.

1. Physicians

   MD applicants must be board certified or board eligible in their primary specialty or subspecialty by an American Board of Medical Specialties (ABMS) member board. DO applicants must be board certified or board eligible in their primary specialty or subspecialty by the American Osteopathic Association (AOA) or an ABMS member board.

   MDs must be board certified or board eligible in their primary specialty or subspecialty by an ABMS member board.

2. Oral surgeons who are not physicians

   DDS and DMD applicants who are oral surgeons but *not* physicians must be board certified or board eligible by the American Board of Oral and Maxillofacial Surgery (ABOMS).

3. Podiatrists

   DPM applicants must be board certified or board eligible by the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

C. Current competence, experience, ethics and character

Applicants for medical staff membership must provide sufficient documentation of their background, experience, training and current clinical competence; adherence to the ethics of their profession; good reputation and character, including physical health and mental and emotional stability; and their ability to work harmoniously with others to convince the medical staff that all outpatient surgery center patients treated by them will receive quality care and that the medical staff and outpatient surgery center will be able to operate in an orderly manner.

D. Health status and ability to perform clinical privileges

Applicants for medical staff membership must be able to perform the clinical privileges requested.

E. Membership and privileges at Novant Health hospital

Applicants for medical staff membership must be members of the medical staff in good standing at Novant Health Forsyth Medical Center and have been granted clinical privileges for the surgical procedures he or she is requesting at the outpatient surgery center.

F. Geographic service area

Applicants for medical staff membership must be located (office and residence) within the geographic service area of the outpatient surgery center, as defined by the outpatient surgery center, close enough to provide timely care for their patients.

G. Professional liability insurance

Applicants for medical staff membership must have current and valid professional liability insurance coverage with limits of at least one million dollars for each claim and three million dollars in the aggregate for the clinical privileges requested from an insurance company that is licensed or approved to do business in North Carolina.

H. Federally-funded healthcare programs

Applicants for medical staff membership must be eligible to participate in Medicare, Medicaid and other federally-funded healthcare programs and cannot be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally-funded healthcare program.

I. Controlled substance registration

Applicants for medical staff membership, where applicable to their practice, must have a current, valid and unrestricted Federal Drug Enforcement Administration (DEA) registration.

J. Membership and privileges at other healthcare facilities

Applicants for medical staff membership must not have had medical staff membership or clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities.

Section 1-2. Rights of the Medical Staff

The rights of the medical staff are listed below. *See* section 2-4 on page 16 for the rights of APPs. Members of the medical staff have the right to:

A. The credentialing and hearing and appeal procedures described in Articles III, IV, and V of these bylaws; and

B. Meet with the medical director. If the issue is not resolved by working with the medical director, the member has the right to meet with the chief of staff and/or the credentials committee chairperson. If the issue is not resolved through that meeting, the member may, upon presentation of a written notice, meet with the MEC to discuss the issue.

Section 1-3. Basic Obligations of Practitioners

When an applicant applies for membership and/or clinical privileges, and for as long as a practitioner is a medical staff member and/or holds clinical privileges, the applicant or practitioner automatically agrees to fulfill the following obligations:

A. Treat all patients, visitors and members of the healthcare team with respect, courtesy, and dignity;

B. Provide appropriate care and supervision to his/her patients, seek consultation whenever necessary, and only delegate to those practitioners qualified to care for patients;

C. Abide by these bylaws, rules & regulations, and the policies and procedures of the medical staff and the outpatient surgery center, as well as the generally recognized ethics of his/her profession;

D. Successfully complete:

   1. patient safety education materials approved by the MEC;
   2. orientation; and
   3. any electronic health record training and associated competency validation, and use the electronic health record for all patient care documentation and order entry;

E. Satisfy all medical record documentation requirements;

F. Appear for any requested interview about an application, clinical performance or professional behavior and permit the medical staff and outpatient surgery center, and their agents, to obtain evaluations about clinical performance or behavior by a consultant;

G. Participate in on-going professional practice evaluations (OPPE), focused professional practice evaluations (FPPE) and peer review, as well as clinical improvement , risk management, and other improvement activities as requested;

H. Cooperate with the outpatient surgery center in matters involving accreditation, licensure surveys and the outpatient surgery center's fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third party payers;

I. Participate in an organized health care arrangement (OCHA) with the outpatient surgery center and follow Novant Health's Joint Notice of Privacy Practices and HIPAA policies while practicing in a Novant Health facility; and

J. Notify the medical staff office immediately in writing if he/she:

   1. is the subject of a complaint to, or under investigation by, his/her licensing board and of any actual or proposed disciplinary actions;
   2. is charged with any felony or misdemeanor, including DWI (but excluding minor traffic citations such as parking or speeding tickets);

3. has a significant medical condition that could adversely affect his/her ability to care for patients safely and competently;
4. is notified by his/her professional liability insurance carrier that it intends to cancel, not renew or impose any conditions on professional liability insurance coverage;
5. loses DEA registration;
6. is under investigation by Medicare or Medicaid or is excluded, voluntarily or involuntarily, from participating in Medicare, Medicaid or any other federally-funded healthcare program;
7. is under investigation by a hospital or health care facility; or
8. is referred to, contacts, or enters into a contract or agreement with any individual, group, program or impaired physician committee because of substance abuse or other disease.

Section 1-4. Leaves of Absence

The term "leave of absence" or "LOA" automatically includes "administrative leave" or "ALOA," which is a category of LOA, unless the context clearly requires otherwise.

Practitioners must request an LOA, or will be placed on LOA, if they:

- are away from patient care responsibilities for more than 60 days (> 60);
- develop a physical or mental health condition (*e.g.,* seizure, MI, TIA/stroke, addiction or substance abuse) that may affect their ability to care for patients safely and competently; or
- otherwise meet one of the LOA criteria described in section 1-4, B, below.

Practitioners cannot exercise clinical privileges while on LOA. If a practitioner's reappointment or renewal of clinical privileges occurs while on LOA, he/she must complete that process, even though he/she is on LOA.

LOAs are matters of courtesy, not of right. Determinations that a practitioner has not demonstrated good cause for an LOA or not to grant an extension are final and do not entitle the practitioner to exercise the hearing and appeals procedures of these bylaws.

A. Requesting an LOA

Requests for an LOA must be submitted in writing to the medical staff office and include the reason for the requested LOA and the proposed duration of LOA. LOA requests may ***not*** be for more than one year. The credentials committee forwards its recommendation on the LOA request to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges and are excused from membership responsibilities during LOA, but practitioners whose reappointment or renewal of clinical privileges period occurs during

a LOA *must* complete the reappointment and clinical privileges renewal requirements if they wish to remain on the medical staff and/or hold clinical privileges.

B. LOA categories

The LOA categories are described below.

1. Administrative LOA

Practitioners placed on ALOA for failure to comply with the medical staff's rules & regulations or policy on influenza vaccinations may remain on ALOA for more than 90 days and will be removed from ALOA per that policy.

Practitioners are placed automatically on ALOA for ***up to 90 days*** when they do not meet an administrative requirement of membership or holding clinical privileges. ***The ALOA period cannot be renewed or extended***. ALOAs automatically end when the practitioner resolves the technical issue or at the end of the 90 day period, *whichever occurs first*. If the practitioner has not resolved the administrative issue by the end of the 90 days, he/she must request to move to another LOA category or he/she will be deemed to have automatically and voluntarily relinquished membership and/or clinical privileges and is not entitled to exercise the hearing and appeal provisions of these bylaws. A request for membership or clinical privileges subsequently received from the practitioner is processed as an initial application.

Unlike other LOA categories and except as specified in the medical staff's rules and regulations or policy on influenza vaccinations, ALOAs are limited to 90 days; ALOAs cannot be renewed or extended.

Practitioners who have not resolved the issue resulting in the ALOA by the end of the 90 days must request to move to another LOA category or will be deemed to have automatically voluntarily relinquished membership and/or clinical privileges. They may reapply but must do so as a new applicant.

APPs are placed on ALOA for up to 90 days when their supervising physician goes on LOA or ALOA, they lose their supervising physician, or their supervising physician resigns medical staff membership or clinical privileges or has his/ her medical staff membership or clinical privileges terminated. If the APP has not secured a new supervising physician who is a current member of the medical staff by the end of the 90 day period, he/she must request to move to another LOA category or will be deemed to have automatically and voluntarily relinquished clinical privileges and is not entitled to the hearing and appeals provisions of these bylaws.

2. Military LOA

A practitioner may request, and be granted, an LOA to fulfill military service obligations. In addition to the written request for leave explained above in section 1-4, A, above, a military reservist must submit a copy of his/her deployment orders. If the practitioner is on active military duty for more than one year, the LOA will be extended *automatically* until the practitioner's active duty is completed.

3. Personal or professional LOA

A practitioner may request an LOA for a variety of personal and professional reasons (*e.g.,* for medical reasons, to pursue additional education, or to serve as a volunteer with Doctors without Borders, etc.). If a practitioner is not able to request LOA because of a physical or psychological condition or health issue, the medical director, in consultation with the CCO, may place the practitioner on LOA and inform the practitioner of this action.

C. Reappointment during LOA

If a practitioner's reappointment or renewal of clinical privileges period occurs during an ALOA or LOA, he/she still must complete the reappointment and/or renewal of clinical privileges application and otherwise comply with all the requirements in these bylaws.

D. Requests for reinstatement

This subsection does not apply to ALOAs; ALOAs automatically end when the practitioner resolves the technical issue or at the end of the 90 day period, whichever occurs first (except for practitioners who are placed on ALOA for failure to comply with the medical staff's rules & regulations or policy on influenza vaccinations; those practitioners may remain on ALOA for more than 90 days and will be removed from ALOA per that policy).

Requests for reinstatement must be submitted in writing to the medical staff office before the end of the LOA and include a summary of the practitioner's relevant clinical activities, if any, during the LOA. The practitioner must provide any other information requested. If the reason for the LOA was related to the practitioner's physical or mental health (including impairment due to addiction) or the ability to care for patients safely and competently, the practitioner must submit an appropriate report from his/her healthcare provider indicating that he/she is physically and/or mentally capable of resuming practice and safely exercising the clinical privileges requested.

The medical director forwards his/her reinstatement recommendation to the credentials committee, which forwards its recommendation to the MEC and the Board of Trustees for

final action. Reinstatement may limit, modify or subject clinical privileges to monitoring or proctoring conditions.

E. Requests for an extension

This subsection does not apply to those on military LOA or ALOA.

Except for military leave and ALOA, requests for an LOA extension must be submitted in writing to the medical staff office and include the reason for, and the dates of, the requested extension. Extension requests may not be for more than one year. The credentials committee forwards it recommendation on the LOA extension to the MEC and the Board of Trustees for final action. Practitioners cannot exercise clinical privileges during the extension and must complete the reappointment and clinical privileges renewal requirements if they wish to remain on the medical staff and/or hold clinical privileges.

F. Failure to request an extension or reinstatement

Practitioners who, without good cause, do not request an extension or reinstatement are deemed to have automatically and voluntary relinquished their membership and/or clinical privileges and do not have the right to the hearing and appeal procedures in these bylaws. A request for membership or clinical privileges subsequently received from the practitioner is processed as an initial application.

Section 1-5. Resigning Membership & Clinical Privileges

In order to resign membership and/or clinical privileges *in good standing*, a practitioner must:

A. submit a written or emailed letter of resignation to the medical staff office;

B. complete all clinical, billing and record-keeping responsibilities;

C. not be under an investigation as described in Article IV or have a significant case under peer review; and

D. not have refused to participate in collegial efforts recommended by the credentials committee.

Practitioners who do not meet these criteria and resign their membership or clinical privileges are deemed to have resigned not in good standing. The credentials committee and the MEC will forward their recommendations on the practitioner's resignation status to the Board of Trustees for final approval.

Section 1-6. Automatic Relinquishment

A practitioner's membership and/or clinical privileges are automatically and voluntarily relinquished if the practitioner:

A. loses his/her license to practice;

B. is excluded or terminated from participating in Medicare, Medicaid or any other federally-funded healthcare program;

C. is on LOA and does not request an extension or reinstatement by the end of the LOA period (*see* section 1-4, D and E, on pages 9 and 10 for requesting an LOA extension and reinstatement);

D. is on ALOA and has not resolved the issue or requested a transfer to another LOA category at the end of the 90 day ALOA period (*see* section 1-4, B, 1, on page 8);

E. fails to complete the reappointment and/or renewal of clinical privileges process per section 3-3 on page 26; or

F. does not undergo a physical or mental examination within a reasonable time as requested by an investigating committee or the credentials committee and make the examination results available to the committee (*see* section 3-2, B, on page 23 and section 4-2, C, 2, on page 38).

The practitioner will be notified in writing that his/her membership and/or clinical privileges have been deemed automatically relinquished, and the practitioner's resignation status (in good standing or not in good standing) will be considered as explained in section 1-5 on page 10. Practitioners whose membership and/or clinical privileges are automatically and voluntarily relinquished under this section are not entitled to exercise the hearing and appeals procedures in these bylaws.

ARTICLE II – ADVANCED PRACTICE PROVIDERS

Article II addresses advanced practice providers (APPs). APPs are not members of the medical staff. APPs have clinical privileges and are privileged through the medical staff privileging process.

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ARTICLE II – ADVANCED PRACTICE PROVIDERS

Advanced practice providers (APPs) perform delegated medical acts under the supervision of a physician and include CRNAs, NPs, and PAs.

APPs may hold and exercise clinical privileges, but they are not members of the medical staff. The basic qualifications APPs must meet are set out below, and APPs must continuously meet these qualifications in order to maintain their clinical privileges. APP applicants may have an application *in process* for a license, professional liability insurance or DEA registration when applying for clinical privileges (*see* sections 2-1, A, F, and H, below), but clinical privileges will not be granted until the license, insurance coverage or DEA registration has been issued.

APPs may hold clinical privileges, but they are not members of the medical staff.

Section 2-1. Basic Qualifications for APPs

A. Licensure

APP applicants for clinical privileges must have a current, active and unrestricted license/ registration to practice as a CRNA, NP, or PA in North Carolina.

B. Certifications

APP applicants for clinical privileges must be certified by the appropriate board, and meet any recertification requirements, as follows:

1. ***Certified registered nurse anesthetists*** must be certified by the National Board of Certification and Recertification for Nurse Anesthetists;
2. ***Nurse practitioners*** must be certified by the American Nurses' Credentialing Center, American Academy of Nurse Practitioners, American Association of Critical Care Nurses, National Certification Corporation or the Pediatric Nursing Certification Board; and
3. ***Physician assistants*** must be certified by the National Commission on Certification of Physician Assistants.

C. Current competence, experience, ethics and character

APP applicants for clinical privileges must provide sufficient documentation of their background, experience, training and current clinical competence; adherence to the ethics of their profession; good reputation and character, including physical health and mental and emotional stability; and their ability to work harmoniously with others such that all

outpatient surgery center patients treated by them will receive quality care and that the outpatient surgery center and medical staff will be able to operate in an orderly manner.

D. Health status and ability to perform privileges

APP applicants for clinical privileges must be able to perform the clinical privileges requested.

E. Geographic service area

APP applicants for clinical privileges must be located (office and residence) within the geographic service area of the outpatient surgery center, as defined by the outpatient surgery center, close enough to provide timely care for their patients.

F. Professional liability insurance

APP applicants for clinical privileges must have current and valid professional liability insurance coverage with limits of at least one million dollars for each claim and three million dollars in the aggregate for the clinical privileges requested from an insurance company that is licensed or approved to do business in North Carolina.

G. Federally-funded healthcare programs

APP applicants for clinical privileges must be eligible to participate in Medicare, Medicaid and other federally-funded healthcare programs and cannot be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally-funded healthcare program.

H. Controlled substance registration

APP applicants for clinical privileges, where applicable to their practice, must have a current, valid and unrestricted DEA registration.

I. Clinical privileges at other healthcare facilities

APP applicants for clinical privileges must not have had clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities.

J. Supervising physician

APP applicants for clinical privileges must have a supervising physician who is a current member of the medical staff in good standing and must submit a copy of their current collaborative practice agreement, as applicable, to the central verification office (CVO).

Section 2-2. Applications for Clinical Privileges

Applications for clinical privileges are addressed in section 3-4 on page 28. The supervising physician for an APP applicant must sign the APP's application for clinical privileges. Applications for initial clinical privileges are processed per the procedures in section 3-2 on page 23.

Section 2-3. Renewal of Clinical Privileges

APPs must apply to renew their clinical privileges at least every two years. The supervising physician for an APP applicant must sign the application for renewal of clinical privileges. Applications for renewal of clinical privileges are processed per section 3-3 on page 26.

Section 2-4. Rights of APPs

APPs have the right to:

A. The credentialing, hearing and appeal procedures described in Articles III, IV and V of these bylaws; and
B. Meet with the medical director. If the issue is not resolved by working with the medical director, the APP then has the right to meet with the credentials committee chairperson.

Section 2-5. Conditions of Practice for APPs

The following conditions of practice are applicable to APPs:

A. APPs may *only* act within the delineated clinical privileges specifically granted to them by the Board of Trustees.
B. APPs must satisfy the basic obligations set out in section 1-3 on page 6.
C. An APP:
    1. Cannot be granted clinical privileges that are broader than the privileges granted to his or supervising physician and cannot practice outside the scope of his or her delineated clinical privileges;
    2. must submit a current copy of their collaborative practice agreement, as applicable, to the CVO;
    3. must report any changes in supervising physician sponsorship to the medical staff office within 24 hours;
    4. automatically has his/her clinical privileges reduced or decreased and voluntarily relinquished to the same extent as any reduction or decrease in his/her supervising physician's clinical privileges and cannot exercise the hearing and appeal procedures in these bylaws.

ARTICLE III – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Article III describes the process for appointment and reappointment to the medical staff and how practitioners are granted clinical privileges.

ARTICLE III – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

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ARTICLE III – APPOINTMENT, REAPPOINTMENT & CLINICAL PRIVILEGES

Being granted membership on the medical staff means the same thing as being appointed or reappointed to the medical staff. Individuals who are granted membership on the medical staff are not automatically granted clinical privileges, and individuals who are granted clinical privileges are not automatically granted membership on the medical staff. Some individuals, such as CRNAs, NPs, and PAs hold and exercise clinical privileges but are *not* members of the medical staff.

Individuals will not be denied membership or clinical privileges on the basis of race, creed, religion, gender, national origin, veteran's status or any other status protected by law. Individuals also are not entitled to receive an application, to be appointed or reappointed to the medical staff or to be granted any particular clinical privileges because he/she is licensed to practice in this, or any other, commonwealth or state; is a member of any particular professional organization; has had, or currently has, medical staff appointment or privileges at any hospital or health care facility; resides in the geographic service area of the outpatient surgery center; or is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO or other entity.

Section 3-1. Applications for Membership & Clinical Privileges

A. Eligibility for an application for membership and clinical privileges

In order to be eligible to receive an application for membership and/or clinical privileges, a prospective applicant must meet the criteria set out below; applications will not be provided, accepted or processed from anyone who does not meet the criteria. Prospective applicants are not entitled to the hearing and appeal provisions in these bylaws because of a refusal to provide, accept or process an application for membership and/or privileges for failure to meet the criteria.

Prospective applicants who have applications *in process* for a license, professional liability insurance or a DEA registration (*see* sections 3-1, A, 1, 4 and 6 below) may receive an application for membership and/or clinical privileges if they otherwise meet the criteria listed below, but membership and/or clinical privileges will not be granted until the license, insurance coverage and/or DEA registration has been issued.

Prospective applicants for membership and/or clinical privileges must:

1. have a current and unrestricted license to practice in North Carolina (or an application for a license in process) in a discipline eligible for membership per section 1-1, A, on page 3 or clinical privileges per section 2-1, A, on page 14;
2. be board eligible or board certified per section 1-1, B, on page 3 if the prospective applicant wishes to apply for membership on the medical staff;
3. be certified per section 2-1, B, on page 14 if the prospective applicant wishes to apply for clinical privileges as an APP;
4. have current and valid professional liability insurance coverage (or an application for coverage in process) with limits of at least one million dollars for each claim and three million dollars in the aggregate from an insurance company that is licensed or approved to do business in North Carolina;
5. be eligible to participate in Medicare, Medicaid and other federally-funded healthcare programs and not be excluded, suspended, debarred or otherwise declared ineligible to participate in a federally-funded healthcare program;
6. have a current, valid and unrestricted DEA registration (or an application for a DEA registration in process), where applicable to their practice;
7. have not had clinical privileges terminated from a Novant Health hospital or from two or more non-Novant Health health systems or healthcare facilities; and
8. have a supervising physician who is currently on staff in good standing or is simultaneously applying for membership and clinical privileges if the prospective applicant wishes to apply for clinical privileges as an APP .

B. Application form and content

Applications for membership and/or clinical privileges must be signed by the applicant and be submitted to the CVO on approved forms. Applications must include a request for the specific clinical privileges sought and require detailed information about the applicant's professional qualifications, which will include, but not be limited to:

1. ***Peer references*** from practitioners who can provide adequate information about the applicant's current professional competence and character.
   a. at least one peer reference must be in the same specialty area as the applicant, and
   b. peer references cannot be from anyone who is:
      - personally related to the applicant, or
      - professionally associated with the applicant (or is about to be professionally associated with the applicant).
2. Information about the applicant's:

a. medical staff ***membership and/or clinical privileges at hospitals or other health care facilities***, including any denial, voluntary or involuntary relinquishment, termination, suspension, limitation or reduction of medical staff membership or clinical privileges and whether the applicant has ever withdrawn an application for membership or privileges or resigned before a final decision was made by the Board of Trustees;

b. ***licenses*** to practice any profession in any state, commonwealth or territory;

c. ***DEA registration***, where applicable to the applicant's practice;

d. ***professional liability insurance*** coverage, professional liability litigation and settlement experience, and whether professional liability insurance coverage has ever been denied, refused or not renewed;

e. membership in ***professional societies***;

f. ***ability to participate in Medicare, Medicaid*** or any other government sponsored program or any private or public medical insurance program;

g. ***physical and mental health*** ability to perform the clinical privileges requested within applicable standards of care;

h. ***criminal background history***; and

i. ***citizenship*** and/or visa status information and information to confirm the applicant's identity.

3. Documentation of:

a. negative PPD skin testing within the past year, or, if the applicant has a history of a positive PPD skin test, documentation of a subsequent chest radiograph with no radiographic evidence of active tuberculosis or a completed course of anti-tuberculous therapy;

b. receipt of a Hepatitis B vaccine, a positive Hepatitis B antibody titer within the past 10 years, or a completed *Hepatitis B Declination* form;

c. an influenza vaccination per the medical staff's rules & regulations or policy; and

4. Any other information the Board of Trustees may require.

C. Applicants already on staff at a Novant Health hospital

If a prospective applicant for membership and/or clinical privileges is already a member or holds clinical privileges at a Novant Health hospital, a streamlined application and verification process may be used. This includes a pre-populated short form application; a new privilege form with evidence satisfying the privilege criteria for the privileges being requested, review of primary source verifications of education and training completed previously to ensure current requirements are satisfied; a completed competency

evaluation form from the medical director, chief of staff, or chief clinical officer (CCO) ; verification of current licensure and board certification; a National Practitioner Data Bank query; and completion of patient safety education materials as approved by the MEC. Otherwise, the application will follow the processing, review and approval processes set out in these bylaws.

D. Burden to provide required information

The burden is on the ***applicant*** to produce all information deemed adequate by the medical staff to properly evaluate the applicant's qualifications for membership and/or clinical privileges, to resolve any doubts about the application and to establish that he/she is competent to exercise the clinical privileges requested. The applicant is responsible for answering all questions on the application; providing accurate, up-to-date information and for ensuring that all supporting information and verifications, including information from training programs, peer references and other health care facilities, are submitted as requested. Any misrepresentation or misstatement in, or omission from, the application (whether intentional or not) is grounds for the automatic rejection of the application, resulting in denial of membership and/or clinical privileges. If membership or clinical privileges was granted before discovering a misrepresentation, misstatement or omission, the practitioner's membership or clinical privileges may be summarily dismissed.

The burden is on the applicant to provide all required information and resolve any doubts about his/her ability to exercise clinical privileges competently.

Once notified additional information is required, applicants have 90 days to provide the required information. If the information is not provided, the application is deemed voluntarily withdrawn. The applicant may reapply, but if the application is deemed voluntarily withdrawn again, the applicant cannot apply again for one year.

The medical staff, outpatient surgery center and any of their committees or representatives may request additional information from the applicant at any time, and the application will not be processed further or considered until the information needed to resolve the doubt or concern is received; neither the medical staff nor the Board of Trustees is obligated to review or consider such an application. Applications are deemed voluntarily withdrawn if the applicant has not provided the requested information or otherwise resolved the doubt or concern ***90 days*** after being notified in writing of the need for further information, and the applicant is not entitled to exercise the hearing and appeal procedures in these bylaws. The applicant may reapply for membership and clinical privileges, but if the application is deemed voluntarily withdrawn again under this subsection, the applicant cannot apply again for a period of one year.

Section 3-2. Initial Appointment and Privileging Process

This section explains the basic steps in the initial appointment and clinical privileging process.

An individual term of appointment and/or granting of clinical privileges cannot be for more than two years but may be for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to appoint or grant clinical privileges for less than two years.

> *A term of appointment or clinical privileges cannot be for more than two years but may be for two years or less.*

A. Medical director recommendation

Applications are submitted to the medical director. The medical director reviews the application and supporting documentation and makes a recommendation on the applicant's request for appointment and/or clinical privileges, including any limitations to privileges or conditions on appointment. A former medical director may perform these duties if the current medical director is unavailable. The medical director has the right to meet with the applicant to discuss any aspect of the application.

B. Credentials committee recommendation

The credentials committee reviews the applicant's application and supporting documentation and the recommendation from the medical director to determine whether the applicant has established and satisfied all the necessary qualifications for appointment and/or clinical privileges.

1. As part of its evaluation, the credentials committee may:
    a. use the expertise of the medical director, any other medical staff member or an outside consultant;
    b. require the applicant to meet with the credentials committee to discuss any aspect of the application; and/or
    c. require the applicant to undergo physical or mental examination by a physician or other provider acceptable to the credentials committee in order to determine the applicant's ability to perform the privileges requested. The applicant must make the examination results available to the credentials committee for its consideration. If an applicant does not have the examination or provide the results to the credentials committee within a reasonable time, the application is deemed voluntarily withdrawn. Applicants who are deemed to have voluntarily withdrawn an application do not have the right to exercise the hearing and appeal procedures in these bylaws.

2. No more than 90 days after the applicant has provided all required information, the credentials committee will make a written recommendation to the MEC either to:
   a. ***appoint the applicant to the medical staff and/or grant clinical privileges***. A recommendation to appoint an applicant to the medical staff must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment
   b. ***defer*** the application for further consideration; or
   c. ***deny*** appointment and/or clinical privileges. The hearing and appeals procedures in these bylaws are *not* triggered by a recommendation from the *credentials committee* to deny appointment and/or clinical privileges.

C. MEC recommendation

At its next meeting after all required information has been received, the MEC or its executive committee reviews the applicant's application and supporting documentation, the recommendations from the credentials committee and the medical director and decides whether to defer the application for further consideration or whether to make a recommendation that the Board of Trustees grant or deny membership and/or clinical privileges.

1. Deferring an application

If the MEC defers the application for further consideration, it must make a written recommendation to the Board of Trustees to grant or deny membership and/or clinical privileges within the next 60 days.

2. Recommendations that are different from the credentials committee

When the MEC's recommendation is different from the credentials committee's recommendation, the MEC will either:

a. send the application back to the credentials committee for further investigation and responses to the MEC's specific questions; or
b. provide clear and convincing reasons, along with supporting information, for its disagreement with the credentials committee's recommendation and forward its recommendation along with the credentials committee's findings and recommendation to the Board of Trustees.

3. MEC recommendations that entitle an applicant to request a hearing

MEC recommendations that are ***adverse*** to the applicant entitle the applicant to request a hearing per Article V (*see* section 5-1, A, on page 43 for recommendations that are ***adverse***). The MEC forwards the adverse recommendation to the outpatient surgery center administrator rather than the Board of Trustees, and the outpatient surgery

center administrator sends written notice of the adverse recommendation to the applicant per section 5-1, B, on page 43. The MEC's recommendation will be held and will not be sent to the Board of Trustees for final action until the hearing and appeals process in Article V is complete *or* the practitioner has waived his/her right to a hearing and appeal.

4. MEC that do not entitle an applicant to request a hearing
   MEC recommendations that are ***not adverse*** are forwarded to the Board of Trustees for final action, and the applicant is not entitled to request a hearing. A recommendation to appoint an applicant to the medical staff must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment.

D. Board of trustees final action

The Board of Trustees will take action on the application at its next regular meeting following receipt of the MEC's recommendation. The Board of Trustees may either:

1. adopt the MEC's recommendation;
2. refer the matter back to the MEC with instructions for further review and a time frame for responding to the Board of Trustees; or
3. take unilateral action.

Decisions to appoint an applicant to the medical staff must include the specific clinical privileges to be granted, including any limitations on privileges or conditions on appointment. Applicants will be notified in writing of the Board of Trustees' final decision within 30 days.

When the MEC's recommendation to the Board of Trustees is ***not adverse***, but the Board of Trustees considers modifying it such that it ***is adverse*** per section 5-1, A, on page 43, the practitioner is entitled to a hearing, and the outpatient surgery center administrator will send the practitioner written notice of the adverse recommendation as explained in section 5-1, B, on page 43 and the Board of Trustees will not take final action until the hearing and appeals process in Article V is complete *or* the practitioner has waived his/her right to a hearing and appeal.

Section 3-3. Reappointment and Renewal of Clinical Privileges

This section explains the basic steps in the reappointment and renewal of clinical privileges process.

Members of the medical staff are reappointed and practitioners with clinical privileges must renew clinical privileges *at least every two years*. Applications for reappointment and/or renewal of privileges must be processed and approved before the current appointment and/or privileges term expires. ***Membership and clinical privileges cannot be granted for more than two years***, but they may be granted for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to grant membership or clinical privileges for less than two years.

> *Reappointment and renewal of clinical privileges must occur at least every two years.*
>
> *Applications for reappointment and/or renewal of privileges must be processed and approved before the current appointment and/or privileges term expires.*

A. Applications for reappointment and renewal of clinical privileges

The CVO will provide practitioners who meet the eligibility requirements in section 3-1, A on page 19 with electronic access to an application for reappointment and/or renewal of clinical privileges before the practitioner's current appointment or privileges term expires. Applications must include a request for the specific clinical privileges sought and require detailed information concerning the practitioner's professional qualifications, which will include, but not be limited to, those items listed in section 3-1, B, on page 20.

Applications for reappointment and/or renewal of clinical privileges are processed in the same manner as applications for initial appointment and clinical privileges (*see* section 3-2, on page 23). Recommendations for reappointment are based on the member's:

1. ethical behavior, current clinical competence, and clinical judgment in the treatment of patients, including any professional performance evaluations;
2. participation in staff duties, as required by the bylaws;
3. compliance with the medical staff's bylaws, rules & regulations and policies; and the outpatient surgery center's policies;
4. professional behavior;
5. physical, mental, and emotional health;
6. capacity to satisfactorily treat patients as indicated by the results of the outpatient surgery center's quality assessment activities or other reasonable indicators of continuing qualifications;

7. satisfactory completion of continuing education requirements that directly relate to the practitioner's area of practice per the appropriate licensure board;
8. current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;
9. current licensures and registrations, including pending challenges to any license or registration or any voluntary or involuntary relinquishment of any license or registration;
10. voluntary or involuntary termination of appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at a hospital or health care facility;
11. criminal background history; and
12. other reasonable indicators of continuing qualifications and relevant findings from the outpatient surgery center's quality assessment activities.

B. Burden to provide required information

Practitioners are responsible for submitting an application and all required information per section 3-1, D, on page 22 to the CVO by the due date. Practitioners who do not submit all required materials by the due date may obtain an extension of time by paying a processing fee; if the processing fee is not paid, membership and/or clinical privileges will be deemed voluntarily relinquished. Applications from practitioners who pay the processing fee but fail to submit the required information by the end of the extension period will ***not*** be processed, and membership and/or clinical privileges will be deemed voluntarily relinquished.

Practitioners whose membership or privileges have been deemed voluntarily relinquished may reapply but must do so as new applicants. Those who reapply as new applicants within the year following the voluntary relinquishment of their membership or privileges must pay an additional processing fee.

Practitioners whose membership and/or clinical privileges are deemed voluntarily relinquished under this subsection are not entitled to the hearing and appeals procedures in these bylaws. These practitioners may reapply but must do so as new applicants. Practitioners who reapply as new applicants within the year following the voluntary relinquishment of their membership and/or clinical privileges must pay an additional processing fee.

Section 3-4. Clinical Privileges

Being appointed or reappointed to the medical staff does not grant automatically clinical privileges. Clinical privileges are delineated on an individual basis and will include any limitations or restrictions, where necessary. Practitioners are only able to exercise those clinical privileges that have been specifically granted to them by the Board of Trustees, except in an emergency per section 3-4, F, 2, on page 31. Clinical privileges cannot be granted for more than two years, but they may be granted for two years or less. Practitioners are not entitled to the hearing and appeals procedures in these bylaws as a result of a decision to grant clinical privileges for less than two years.

Practitioners may only exercise those clinical privileges that have been specifically granted to them by the Board of Trustees.

Applicants for clinical privileges and practitioners who hold clinical privileges agree to fulfill the basic obligations contained in section 1-3 on page 6.

A. Eligibility for an application for clinical privileges

Prospective applicants for initial clinical privileges and practitioners renewing clinical privileges must meet the eligibility requirements in section 3-1, A, on page 19.

B. Applications for clinical privileges content and processing

The requirements on application forms, content and the burden to provide required information in section 3-1, B and D, on pages 20 and 22 apply to applicants for initial clinical privileges and practitioners renewing clinical privileges.

Applications for initial clinical privileges are processed in the same manner as applications for initial appointment per section 3-2 on page 23, and applications for renewal of clinical privileges are processed in the same manner as applications for reappointment per section 3-3, on page 26.

C. Clinical privileges recommendations

Clinical privileges recommended to the Board of Trustees are based on the following:

1. the applicant's education, training, experience, demonstrated current competence, judgment, references, utilization patterns, and health status;
2. the availability of qualified physicians or other appropriate practitioners to provide back-up medical coverage for the applicant;
3. adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
4. the outpatient surgery center's available resources and personnel;

5. any successful or pending challenges to licensure or registration, or the voluntary or involuntary relinquishment of licensure or registration;
6. any information concerning the voluntary or involuntary termination, lapse or relinquishment of medical staff membership or the voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility; and
7. other relevant information, including the written report and findings by the medical director.

D. Requests for additional clinical privileges

Practitioners may request additional clinical privileges at any time, but the request must be in writing on approved forms, detail the specific additional clinical privileges desired, and be supported by documentation of training and experience that justify the additional privileges. Requests for additional privileges made during a current appointment or privileges term are processed in the same manner as an application for initial clinical privileges (*see* section 3-2 on page 23).

Recommendations for additional clinical privileges are based on the practitioner's relevant recent training; OPPE; observation of patient care provided; reviews of the records of patients treated in the outpatient surgery center or hospitals, if available; results of the outpatient surgery center's quality assessment activities; and other reasonable indicators of the practitioner's continuing qualifications for the privileges requested, including any professional performance evaluations. Recommendations for additional clinical privileges may include requirements for supervision, consultation or other conditions for such periods of time as are thought necessary.

E. Clinical privileges for new procedures and techniques

Requests for clinical privileges to perform a significant procedure not currently being performed at the outpatient surgery center or a significant new technique for performing an existing procedure will ***not*** be processed until the medical staff, in conjunction with the outpatient surgery center's administration and relevant departments such as nursing determines that the procedure will be offered, and the medical staff has established eligibility criteria for requesting those clinical privileges.

The credentials committee will work in conjunction with the medical director and the practitioner requesting permission to perform the new procedure or technique to make a preliminary recommendation to the MEC about whether the new procedure or technique should be offered to the community. Factors to be considered will include, but are not limited to whether:

1. there is empirical evidence of improved patient outcomes or other clinical benefits to patients;
2. the new procedure or technique is being performed at other similar outpatient surgery centers and their experiences; and
3. the outpatient surgery center has the resources, including space, equipment, personnel and other support services, to safely and effectively perform the new procedure or technique.

If the recommendation is to offer the new procedure or technique, the credentials committee will partner with the medical director to develop recommendations regarding the minimum education, training, and experience necessary to perform the new procedure or technique, as well as the extent of monitoring and supervision that should occur if the privileges are granted. The credentials committee may also develop criteria and/or indications for when the new procedure or technique is appropriate.

The credentials committee forwards its recommendations to the MEC, which will review the matter and forward its recommendation to the Board of Trustees for final action.

F. Temporary clinical privileges

The outpatient surgery center administrator may grant temporary privileges in the situations set out below. Temporary privileges must be specifically delineated; special requirements for supervision and reporting may be imposed by the medical director. Temporary privileges *automatically terminate* at the end of the specific period for which they were granted.

Temporary privileges automatically terminate at the end of the specific period for which they were granted.

Granting temporary privileges is a courtesy and not a right. For good cause shown, the outpatient surgery center administrator, after consultation with the medical director, the credentials committee chairperson and/or the chief of staff may terminate an individual's temporary privileges. Individuals do *not* have the right to the hearing and appeal provisions in these bylaws because of their inability to obtain temporary privileges or because temporary privileges are terminated.

1. To an applicant when the application raises no concerns

When an applicant has applied for clinical privileges, the outpatient surgery center administrator may grant temporary clinical privileges for ***no more than 120 days*** on the recommendation of the chief of staff if:

a. all required information has been received and raises no concerns;

b. information about the applicant's current licensure; training or experience; current competence and ability to perform the privileges requested; character and ethical standing; DEA registration (where applicable to the applicant's practice); and professional liability insurance have been received and reviewed;

c. the applicant meets all qualifications and conditions of appointment set out in these bylaws;

d. a query from the National Practitioner Data Bank has been obtained and evaluated;

e. information verifies that there are no current or previously successful challenges to licensure or registration; medical staff membership at another organization has not been involuntarily terminated; and clinical privileges have not been involuntarily limited, reduced, denied or lost; and

f. the medical director and the credentials committee have recommended that clinical privileges be granted.

2. To an individual in an emergency

For the purposes of this subsection, an emergency is a condition that could result in serious or permanent harm to a patient and any delay in administering treatment would add to that harm or danger.

In an emergency, any provider, regardless of membership status or clinical privileges, is permitted to do everything possible within the scope of his/her license to save the life of a patient or prevent serious harm. When the emergency situation no longer exists, the patient's care will be assigned to a medical staff member with appropriate privileges. If the provider who provided the emergency care to the patient wants to continue to care for the patient, he/she must apply for membership and/or privileges per these bylaws. Emergency temporary privileges do not grant or imply membership on the medical staff, do not entitle the provider to the hearing and appeal procedures set forth in these bylaws, and do not afford them any of the rights outlined in these bylaws.

Section 3-5. Authorization to Obtain and Release Information

When applicants apply for appointment, reappointment or clinical privileges, they authorize the medical staff, outpatient surgery center and their representatives to obtain and release information during the processing and consideration of the application, whether or not appointment, reappointment or clinical privileges are granted. This authorization also applies throughout any term of appointment, reappointment or clinical privileges.

A. Authorization to obtain and release information

Applicants and practitioners specifically authorize the outpatient surgery center and its authorized representatives to:

1. consult with any third party who may have information bearing on the applicant's or practitioner's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on his/her qualifications for appointment, reappointment or clinical privileges;
2. inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures from third parties that may be relevant to such questions, and applicants and practitioners specifically authorize third parties to release this information to the outpatient surgery center and its authorized representatives upon request; and
3. release such information to hospitals, health care facilities, managed care organizations and their agents who solicit such information for the purpose of evaluating the applicant's or practitioner's professional qualifications pursuant to a request for appointment, reappointment or clinical privileges.

B. Immunity

To the fullest extent permitted by law, applicants and practitioners release from any and all liability, agree not to sue and extend immunity to the outpatient surgery center and its authorized representatives, and any third parties with respect to any acts, communications, documents, recommendations or disclosures involving the applicant or practitioner as set forth below:

1. applications for appointment or clinical privileges, including temporary privileges;
2. evaluations concerning reappointment or changes in clinical privileges;
3. proceedings for suspension or reduction of clinical privileges, termination of medical staff membership or clinical privileges, or any other disciplinary action;
4. precautionary suspension;
5. hearing and appellate reviews;
6. medical care evaluations and other activities relating to the quality of patient care or professional conduct;
7. matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or

8. any other matter that might directly or indirectly relate to clinical competence, patient care, or to the orderly operation of this or any other outpatient surgery center, hospital or health care facility.

C. Definitions

As used in this section, the terms:

1. "outpatient surgery center and its authorized representatives" means Novant Health, Inc., the outpatient surgery center and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's or practitioner's credentials or for acting upon an application or conduct at the outpatient surgery center: the members of the Board of Trustees and their appointed representatives; the CCO and Novant Health chief medical officer; the medical staff office and CVO; members of the credentials committee and members of the MEC; outpatient surgery center employees, medical director, consultants and agents; outpatient surgery center attorneys and their partners, associates or designees; members of the medical staff and APPs; and
2. "third parties" means all individuals, including but not limited to: members of the medical staff and APPs; members of other medical staffs; other physicians and APPs; nurses and other members of the healthcare team; and other organizations, associations, partnerships, corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the outpatient surgery center or its authorized representatives.

ARTICLE IV – REVIEWS & INVESTIGATIONS

Article IV describes how medical staff leadership works collegially with practitioners to review and improve clinical performance or behavior. It also addresses the investigatory process used when medical staff leadership do not believe collegial action is appropriate or when the practitioner does not wish to proceed collegially.

ARTICLE IV – REVIEWS & INVESTIGATIONS
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ARTICLE IV – REVIEWS & INVESTIGATIONS

Section 4-1. Reviews

Concerns related to clinical competence or professional behavior may be reviewed and addressed collegially with the practitioner without conducting an investigation or recommending adverse actions (*see* section 4-2, below for information on investigations and section 5-1, A, on page 43 for adverse recommendations). The goal of these efforts is to promote a collegial and educational approach to resolve the concerns through voluntary action by the practitioner. Examples of collegial efforts include, but are not limited to:

1. letters of education, warning or reprimand;
2. requirements for additional education or training;
3. retrospective reviews and prospective monitoring;
4. proctoring or consultation with another provider when the consultant's approval is *not* needed to proceed with clinical care; and
5. requirements for outside assessment, examination or screening.

While collegial efforts are encouraged, they are not mandatory and an investigation may be requested per section 4-2, A, below if a practitioner does not wish to participate in the collegial process or in the discretion of the appropriate medical staff leader or committee. Collegial efforts are part of the outpatient surgery center's professional review activities, but they are ***not adverse*** actions or recommendations and do not entitle the practitioner to the hearing and appeal procedures in these bylaws.

Section 4-2. Investigations

A. Grounds for requesting an investigation

The chief of staff, the medical director, the chairperson of the credentials committee or the MEC, a majority of the members of the credentials committee or the MEC, the outpatient surgery center administrator or the Board of Trustees chairperson may request an investigation when, on information and belief, there is cause to question a practitioner's:

1. clinical competence;
2. care and treatment of patients or management of a case;
3. known or suspected violation of applicable ethical standards;
4. known of suspected violation of medical staff, outpatient surgery center or Board of Trustees bylaws, rules & regulations or policies (including, but not limited to, the quality assessment, risk management and utilization review programs); and/or

5. behavior or conduct that is considered lower than the standards of the outpatient surgery center or disruptive to the orderly operations of the medical staff or the outpatient surgery center, including the inability of the practitioner to work harmoniously with others.

The request for the investigation must be in writing, submitted to the credentials committee and specifically reference to the activity or conduct for the request. The credentials committee also may initiate an investigation on its own motion.

B. Initial review by credentials committee

The credentials committee will meet as soon as possible after receiving a request for an investigation to discuss it. In its discretion, the credentials committee may, among other actions:

1. determine the matter is unfounded and take no further action;
2. address the matter through collegial efforts;
3. proceed under an applicable medical staff policy;
4. refer the matter to an appropriate committee; and/or
5. conduct a formal investigation.

In making its determination, the credentials committee may discuss the matter with the practitioner but is *not* required to do so. If the credentials committee decides to conduct a formal investigation, the meeting minutes will specifically recite that an investigation is being conducted, the credentials committee will appoint an investigating committee per section 4-2, C, 2, on page 38, and the investigation procedures set out below will be followed.

The decision to conduct an investigation should be reflected in the credentials committee's meeting minutes. Practitioners under investigation are notified in writing of the investigation.

Investigations are conducted by the full credentials committee, a subcommittee of the credentials committee, or an ad hoc committee of no more than three members who may be, but are not required to be, members of the medical staff.

C. Investigation procedures

1. Notice of the investigation

When the credentials committee decides to investigate a matter, the credentials committee chairperson, CCO or the medical director will send the practitioner written notice that the credentials committee has opened an investigation and advise the

practitioner that he/she will have an opportunity to meet with the investigating committee before it makes a final recommendation (*see* section 4-2, C, 2, b, below).

2. Investigating committee

The credentials committee may decide to:

- conduct the investigation by the full credentials committee;
- appoint a subcommittee of the credentials committee to conduct the investigation; or
- appoint an ad hoc committee to conduct the investigation. If an ad hoc committee is used, it *cannot* have more than three members. Ad hoc committee members may, but do not have to be, members of the medical staff, and they *cannot* be partners, associates or relatives of the practitioner being investigated.

a. Authority of the investigating committee

The investigating committee may use the full resources of the medical staff and outpatient surgery center to conduct the investigation. This includes, but is not limited to, reviewing relevant documents, interviewing individuals, using outside consultants, and/or requiring the practitioner to undergo a physical and/or mental examination by a health care professional satisfactory to the investigating committee. The practitioner must make the examination results available to the investigating committee for its consideration. If a practitioner does not undergo the examination within a reasonable time, his/her membership and/or clinical privileges will be deemed to have been voluntarily relinquished, and the practitioner does not have the right to exercise the fair hearing and appeal provisions in these bylaws.

b. Practitioner's opportunity to respond

The practitioner being investigated *must* be given an opportunity to meet with the investigating committee *before* it makes a recommendation to the credentials committee. At this meeting (but not as a matter of right before it), the practitioner will be informed of the general nature of the evidence supporting the matter being investigated and be invited to discuss, explain or refute it. This meeting is *not* a hearing, and none of the procedural rules for hearings apply to this meeting (*see* section 5-1 on page 43 for hearings). The practitioner does *not* have the right to represented by legal counsel at this meeting.

Practitioners under investigation must be given an opportunity to meet with the investigating committee before it makes a recommendation on the matter to the credentials committee. This meeting is not a hearing and none of the rules for hearings in Article V apply.

A summary of the meeting will be included in the investigating committee's report to the credentials committee.

c. Recommendations and report

The investigating committee will prepare a report for the credentials committee that includes a summary of its meeting with the practitioner as well as its findings, conclusions and recommendations.

> *The investigating committee's report should contain a summary of its meeting with the practitioner.*

3. Credentials committee review of recommendations

The credentials committee will review the investigating committee's recommendations and may accept, modify or reject them. The credentials committee will forward its findings and recommendations to the MEC, and the credentials committee chairperson will be available to the MEC to answer questions.

4. MEC

The MEC will review the credentials committee's recommendation and determine what recommendations to make to the Board of Trustees.

a. Recommendations that entitle a practitioner to a hearing

If the MEC's recommendation is ***adverse***, it entitles the practitioner to a hearing (*see* section 5-1, A, on page 43 for MEC recommendations that are considered adverse). The outpatient surgery center administrator will send the practitioner written notice of the adverse recommendation as explained in section 5-1, B, on page 43, and the MEC's recommendation will be held and will not be sent to the Board of Trustees for final action until the hearing and appeals process in Article V is complete ***or*** the practitioner has waived his/her right to a hearing and appeal.

When the MEC's recommendation to the Board of Trustees is ***not adverse***, but the Board of Trustees considers modifying it such that it ***is adverse*** per section 5-1, A, on page 43, the practitioner is entitled to a hearing, and the outpatient surgery center administrator will send the practitioner written notice of the adverse recommendation as explained in section 5-1, B, on page 43 and the Board of Trustees will not take final action until the hearing and appeals process in Article V is complete ***or*** the practitioner has waived his/her right to a hearing and appeal.

b. Recommendations that do not entitle a practitioner to a hearing

If the MEC 's recommendation is ***not adverse*** per section 5-1, A, on page 43, it does not entitle the practitioner to a hearing, and the MEC's recommendation takes effect immediately without Board of Trustees action and without the right to the

hearing and appeals procedures in these bylaws. The MEC will prepare and transmit a report of the action taken and reasons supporting it to the Board of Trustees.

Section 4-3. Precautionary Suspensions

A. Grounds for precautionary suspension of privileges

All, or a portion, of a practitioner's clinical privileges may be precautionarily suspended at any time if failing to do so might result in imminent danger to the health and/or safety of any individual or to the orderly operations of the outpatient surgery center. The chief of staff, medical director, the credentials committee chairperson and the outpatient surgery center administrator each have the authority precautionarily to suspend clinical privileges. Precautionary suspensions are effective immediately and remain in effect until lifted or modified by the outpatient surgery center administrator or the Board of Trustees. Precautionary suspensions must be reported immediately in writing to the medical director, the credentials committee chairperson and the outpatient surgery center administrator.

Clinical privileges may be precautionarily suspended if failing to do so might result in imminent danger to the health and/or safety of any individual or to the orderly operations of the outpatient surgery center.

Precautionary suspensions are interim precautionary steps in a professional review activity, but they are not complete professional review actions in and of themselves and do not imply any final finding of responsibility for the situation that caused the suspension.

B. Investigation following precautionary suspension

After clinical privileges have been precautionarily suspended, an investigation must be conducted per the investigation procedures in section 4-2, C on page 37 within a reasonable time period that ***cannot exceed 14 days***. If the investigation cannot be completed within 14 days, the reasons for the delay must be explained to the Board of Trustees (or its committee) so that it may consider whether or not to lift the precautionary suspension.

When clinical privileges have been precautionarily suspended, an investigation must be conducted within 14 days. If the investigation cannot be completed within 14 days, the Board of Trustees must consider whether or not to lift the precautionary suspension.

ARTICLE V – HEARINGS & APPEALS

Article V explains the hearing and appeal procedures available to applicants and practitioners who are the subject of an adverse recommendation made by the MEC or by the Board of Trustees when the MEC's recommendation to the Board of Trustees was favorable.

ARTICLE V – HEARINGS & APPEALS
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ARTICLE V – HEARINGS & APPEALS

Section 5-1. Hearings

A. Adverse recommendations

Applicants and practitioners who are the subject of an ***adverse recommendation*** are entitled to request a hearing. A recommendation is *only* considered adverse when the MEC recommends, for reasons related to professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of patients, that the Board of Trustees:

1. deny an applicant's request for initial appointment to the medical staff and/or initial clinical privileges;
2. deny a practitioner's request for reappointment to the medical staff, renewal of clinical privileges and/or additional clinical privileges;
3. restrict and/or suspend all, or some, of a practitioner's clinical privileges for more than 30 days, or terminate clinical privileges or membership; and/or
4. require a practitioner to obtain a consultation from a consultant whose approval is required in order for the practitioner to proceed with clinical care for more than 30 days.

The recommendations listed above also are considered ***adverse*** when made by the Board of Trustees, for reasons related to professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of patient, when the MEC's recommendation to the Board of Trustees was ***not adverse***. ***No other recommendations or actions entitle applicants or practitioners to request a hearing***.

B. Notice of an adverse recommendation

When the MEC or Board of Trustees has made an ***adverse*** recommendation as explained in section 5-1, A, above the outpatient surgery center administrator will inform the applicant or practitioner of the adverse recommendation in writing by certified mail, return receipt requested. The notice must include:

1. the adverse recommendation made and the general reasons for it;
2. a statement that the applicant or practitioner has the right to request a hearing within 30 days of receipt of the notice;
3. a statement that the failure to request a hearing is a waiver of the hearing and appeal rights in this Article V and that the adverse recommendation will become final; and
4. a copy of this Article V on hearings and appeals.

C. Requesting a hearing

The applicant or practitioner has 30 days from the date the notice of adverse recommendation is received to request a hearing. ***The request for a hearing must be in writing and delivered to the outpatient surgery center administrator either in person or by certified mail, return receipt requested.*** If a hearing is not requested as described within the 30 days, the applicant or practitioner is deemed to have ***waived*** the right to a hearing and to have accepted the adverse recommendation. The recommendation will become effective when the Board of Trustees takes final action on it.

An applicant or practitioner has 30 days to request a hearing in writing. If a hearing is not requested, the applicant or practitioner is deemed to have waived the right to request a hearing and to have accepted the adverse recommendation.

D. Scheduling a hearing

When a hearing has been requested as required by section 5-1, C, above the outpatient surgery center administrator will schedule the hearing to begin as soon as practical, but no sooner than 30 days after the notice of the hearing. The hearing may be scheduled earlier, however, if both of the parties specifically agree to an earlier date in writing. The outpatient surgery center administrator will send a written notice to the applicant or practitioner by certified mail, return receipt requested that includes:

1. the time and date of the hearing and where it will be held;
2. a proposed list of witnesses who will testify or present evidence in support of the MEC or the Board of Trustees and a brief summary of the nature of the anticipated testimony (the applicant or practitioner must provide his or her witness list within 10 days of receiving the notice of the hearing as explained in section 5-1, F, 1, on page 47);
3. the names of the hearing panel members or the hearing officer, if known (*see* section 5-1, E, on page 45); and
4. a statement of the specific reasons for the adverse recommendation and a list of patient records and information that support the recommendation. This statement and list may be amended at any time, even during the hearing, as long as the additional material is relevant and the applicant or practitioner and his/her counsel have sufficient time to study the additional material and rebut it.

E. Appointing either a hearing panel or a hearing officer

When a hearing has been properly requested, the outpatient surgery center administrator, in consultation with the chief of staff, CCO, medical director, and the chairperson of the Board of Trustees if the hearing is the result of a Board of Trustees adverse recommendation, will appoint either a hearing panel *or* a hearing officer (*see* section 5-1, E, 1, directly below for the hearing panel and section 5-1, E, 2, on page 46 for the hearing officer). If a hearing panel is appointed, the outpatient surgery center administrator also will select either a hearing panel chairperson or a presiding officer.

When a hearing has been properly requested, the outpatient surgery center administrator will appoint either a hearing panel or a hearing officer.

If a hearing panel is appointed, the outpatient surgery center administrator will select either a hearing panel chairperson or a presiding officer.

1. Hearing panel

A hearing panel must have at least three members. A majority of the hearing panel members must be:

- members of the medical staff who have not actively participated in the matter at issue at any previous level;
- physicians and/or lay people who are not connected with the outpatient surgery center; or
- any combination of such persons.

Knowledge of the underlying matter does not prohibit anyone from serving as a hearing panel member. The panel may not include anyone who is in direct, economic competition with the applicant or practitioner or anyone who is professionally associated with, or related to, the applicant or practitioner.

When a hearing panel is appointed, the outpatient surgery center administrator also will select either a hearing panel chairperson or a presiding officer.

a. Hearing panel chairperson

The outpatient surgery center administrator may appoint one member of the hearing panel to serve as its chairperson. The chairperson is entitled to one vote and may be advised by legal counsel to the outpatient surgery center. The hearing panel chairperson will:

i. ensure all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence, with reasonable limits on the number of witnesses and duration of direct and cross examination that are

applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

ii. maintain decorum throughout the hearing;

iii. determine the order of procedure throughout the hearing;

iv. make rulings on all questions that relate to procedural matters and the admissibility of evidence;

v. act so that all information reasonably relevant to the appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations; and

vi. conduct argument by counsel on procedural points outside the presence of the hearing panel, unless the panel members wish to be present.

b. Presiding officer

Instead of a hearing panel chairperson, the outpatient surgery center administrator may appoint an attorney at law or other qualified person to serve as a presiding officer. The presiding officer performs all the duties assigned to the hearing panel chairperson in section 5-1, E, 1, a, on page 45. The presiding officer may be legal counsel to the outpatient surgery center but must not act as a prosecuting officer or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and be a legal advisor to it but is not entitled to vote on the recommendations. Legal counsel may thereafter continue to advise the Board of Trustees on the matter.

2. Hearing officer

If a hearing officer is appointed instead of a hearing panel, all references to a hearing panel, the hearing panel chairperson or the presiding officer refer instead to the hearing officer, unless the context clearly requires otherwise.

As an alternative to a hearing panel, the outpatient surgery center administrator, in consultation with the chief of staff, CCO, medical director and the chairperson of the Board of Trustees if the hearing is the result of a Board of Trustees adverse recommendation, may appoint a hearing officer to perform the functions that would otherwise be performed by the hearing panel. A hearing officer is preferably an attorney at law or some other individual capable of conducting the hearing. The hearing officer may not be anyone who is in direct, economic competition with the applicant or practitioner or anyone who is professionally associated with, or related to, the applicant or practitioner. The hearing officer cannot act as a prosecuting officer or as an advocate to either side at the hearing.

F. Pre-hearing discovery

There is no right to pre-hearing discovery. All objections to documents and/or witnesses, to the extent then reasonably known, must be submitted in writing to the hearing panel chairperson *before the hearing*. The hearing panel chairperson will not entertain later objections, unless the party offering the objection demonstrates good cause. Applicants and practitioners are not entitled to, will not be given access to, and will not be allowed to introduce, any evidence of any peer review records, minutes or other documents or information that relate to other applicants or practitioners or actions taken or not taken with respect to other applicants or practitioners.

1. Witness lists

Within 10 days of receiving the notice of the hearing, the applicant or practitioner must provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf and a brief summary of the nature of the anticipated testimony. The proposed list of witnesses who will testify or present evidence in support of the MEC or the Board of Trustees is provided to the applicant or practitioner in the notice of hearing as explained in section 5-1, D, on page 44. Team members appearing on the MEC or Board of Trustees' witness list *cannot* be contacted by the applicant or practitioner, his/her attorney or anyone else acting on the applicant or practitioner's behalf, unless specifically agreed to by outpatient surgery center counsel.

In the discretion of the hearing panel chairperson, the witness list of either party may be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The hearing panel chairperson also has the authority to limit the number of witnesses (s*ee* section 5-1, E, 1, a, on page 45).

2. Documents

The applicant or practitioner is entitled to copies of, or reasonable access to, the following documents, upon specific request, *if* a stipulation is signed by both parties that the documents will be maintained as confidential and not be disclosed or used for any purpose outside of the hearing:

- all patient medical records referred to in the statement of reasons, at his/ her expense;
- reports of experts relied on by the credentials committee or the MEC; and
- any other documents relied on by the credentials committee or the MEC.

Disclosure of any document per this subsection shall *not* constitute a waiver of the protections provided by state or federal peer review, credentialing or quality review or medical review statutes. Intentional disclosure of documents by the applicant,

practitioner or his/her representative contrary to these procedures or applicable law constitutes independent grounds for disciplinary action, up to and including termination of medical staff membership and/or clinical privileges. Any and all documents produced hereunder shall be returned to the outpatient surgery center or destroyed upon the completion of the hearing.

3. Exhibit lists

Before the hearing, on the date set by the hearing panel chairperson or the date agreed to by counsel for both sides, each party must provide the other party with a list of proposed exhibits.

G. Hearing procedure

1. Failure of the applicant or practitioner to appear and proceed

The applicant or practitioner's personal appearance at the hearing is required. If the applicant or practitioner fails to appear personally and proceed at the hearing without good cause, he/she is deemed to have waived the right to a hearing and to have accepted the adverse recommendation. The recommendation will become effective when the Board of Trustees takes final action on the matter.

2. Record of the hearing

A reporter will be present to make a record of the proceedings. The outpatient surgery center is responsible for the costs of the reporter, and copies will be provided to the applicant or practitioner at his/her expense (see section 5-1, G, 3, below). The hearing panel may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the panel who is entitled to notarize documents in this State.

3. Rights of both sides

Subject to reasonable limits as determined by the hearing panel chairperson, both sides have the right to:

a. be represented by an attorney or other person of choice;
b. have a record made of the proceedings, copies of which may be obtained by the applicant or practitioner upon payment of any reasonable charges associated with its preparation;
c. call, examine, and cross-examine witnesses;
d. present evidence determined to relevant by the hearing panel chairperson, regardless of its admissibility in a court of law; and
e. submit a written statement or memorandum of points and authorities at the close of the hearing.

An applicant or practitioner who does not testify on his/her own behalf may be called and examined as if under cross-examination.

4. Admissibility of evidence

The hearing does *not* have to be conducted strictly according to the rules of law on examining witnesses or presenting evidence. Any relevant evidence will be admitted if it is the sort of evidence upon which responsible people are accustomed to rely in the conduct of serious affairs, regardless of whether the evidence would be admissible in a court of law. The concern of the hearing panel is with the truth of the matter, providing adequate safeguards for the rights and fairness of both parties. The hearing panel is entitled to consider all other information that may be considered, pursuant to these bylaws, in connection with applications for appointment or reappointment and for clinical privileges.

The hearing panel also may question witnesses, call additional witnesses, and/or request documentary evidence if it deems it appropriate.

5. Burden of proof

The MEC or the Board of Trustees, depending upon whose recommendation prompted the hearing, bears the initial burden of presenting evidence in support of its recommendation and to present evidence that the recommendation is supported by a preponderance of the evidence.

6. Postponements

Requests for postponements or extensions of time beyond any time limit in this Article may be granted by the hearing panel chairperson on a showing of good cause.

7. Recesses and adjournment

The hearing panel chairperson may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing will be finally adjourned.

H. Hearing panel deliberations and written report

The hearing panel will conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed per section 5-1, E, 1, b, on page 46). Within 20 days of the hearing's final adjournment, the hearing panel will send the hearing record, a written report of its findings and recommendations and all supporting documentation to the outpatient surgery center administrator. The hearing panel's decision must be based on the evidence produced at the hearing, including:

1. oral testimony of witnesses;

2. written statements or memoranda of points and authorities;
3. any information about the applicant or practitioner so long as the information was admitted into evidence at the hearing and the applicant or practitioner had an opportunity to comment on, and refute, it;
4. any all applications, references and accompanying documents;
5. other documented evidence, including medical records; and
6. any other evidence that has been admitted.

The outpatient surgery center administrator will send the hearing panel's report and supporting documentation to the applicant or practitioner by certified mail, return receipt requested. The applicant or practitioner may request a copy of the hearing record at his or her expense. The outpatient surgery center administrator will also send the report and supporting documentation to the MEC.

Either party may request an appeal within 10 days of receiving the hearing panel's report as described more fully in section 5-2, B, on page 50.

Section 5-2. Appeals

A. Grounds for an appeal

Either party may request an appeal for the grounds listed below:

1. there was substantial failure to comply with these bylaws such as to deny due process or a fair hearing;
2. the hearing panel's recommendations were made arbitrarily, capriciously or with prejudice; or
3. the hearing panel's recommendations were not supported by substantial evidence.

B. Requesting an appeal

An appeal must be requested for the grounds listed above in section 5-2, A, within 10 days of receiving the hearing panel's report (*see* section 5-1, H, on page 49 for the hearing panel's report). The request for an appeal must be in writing and delivered to the outpatient surgery center administrator either in person or by certified mail. The request must include a brief statement of the reasons for appeal.

Either party may request an appeal in writing within 10 days of receiving the hearing panel's report. If an appeal is not requested, both parties are deemed to have waived the right to request a hearing and to have accepted the recommendations in the hearing panel's report

If an appeal is not requested within 10 days as described, both parties are deemed to have

waived the right to request an appeal and to have accepted the recommendation in the hearing panel's report, and the recommendation will take effect immediately and become final upon adoption by the Board of Trustees.

C. Scheduling an appeal

When an appeal has been properly requested, the chairperson of the Board of Trustees will, within 10 days of receiving the request, schedule and arrange for the appellate review. The applicant or practitioner will be given written notice of the time, date and place of the appellate review by certified mail, return receipt requested. The appeal cannot be held *less* than 10 days, or *more* than 30 days, from the date of receipt of the request for appellate review.

If, however, the request for an appeal is from a practitioner who is under a current suspension, the appeal will be held as soon as arrangements may be reasonably made, but it must be held within 14 days of the receipt of the request for an appeal. The time for the appeal may be extended by the Board of Trustees chairperson for good cause.

D. Appointing an appeals panel

The Board of Trustees chairperson will appoint an appeals panel that is composed of at least three members, who are either Board of Trustees members or others, including but not limited to reputable persons outside the outpatient surgery center, to consider the record upon which the hearing panel's recommendation was made and to recommend final action to the Board of Trustees. At least one member of the appeals panel must be a physician.

The appeal panel must have at least three members; at least one member must be a physician (MD/DO).

E. Appeal procedure

1. Each party has the right to present a written statement to the appeals panel in support of its position on appeal.
2. The appeals panel may, in its discretion, allow each party or its representative to appear personally and make oral argument.
3. The appeals panel may accept additional oral or written evidence, subject to the same rights of cross-examination, provided at the hearing panel proceedings. Additional evidence may be accepted *only* if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the appeals panel.

The appeals panel may allow oral argument but is not required to allow it.

F. Appeals panel written report

The appeals panel will send a written report of its recommendation on the matter to the Board of Trustees chairperson.

G. Final decision of the board of trustees

The Board of Trustees may refer the matter for further review and recommendation, or it may affirm, modify or reverse the appeal panel's recommendation. If referred for further review and recommendation, the recommendation must be made promptly to the Board of Trustees per its instructions. This further review process *cannot* exceed 30 days, unless the parties agree to a longer time period in writing.

Within 30 days of the Board of Trustees receipt of the appeal panel's written report or the recommendation resulting from the further review process explained directly above, the Board of Trustees must make a final decision on the matter and send a copy of its written final decision to the applicant or practitioner by certified mail, return receipt requested. A copy is also sent to the chairpersons of the credentials committee and the MEC.

The Board of Trustees decision is final, effective immediately and is not subject to further review.

H. Right to one appeal only

No applicant or practitioner is entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal.

ARTICLE VI – MISCELLANEOUS

Article VI explains how the medical staff's bylaws, rules & regulations and policies are adopted and approved and when histories and physical examinations must be performed and documented.

ARTICLE VI – MISCELLANEOUS
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ARTICLE VI – MISCELLANEOUS

Section 6-1. Governing Documents

The medical staff follows and enforces its bylaws, rules & regulations, and policies. Rules & regulations and policies cannot be inconsistent with these bylaws. The process for adopting and approving the medical staff's governing documents is described below.

A. Medical staff bylaws and rules & regulations

The MEC may propose amendments to the bylaws and rules & regulations to the Board of Trustees. Amendments are not effective until they are approved by the Board of Trustees and must then be communicated promptly to the medical staff.

The MEC, on its own, may adopt and approve technical corrections to the bylaws or the rules & regulations (*e.g.,* the MEC may correct errors in punctuation, spelling, or grammar and may correct inaccurate cross-references, labeling, or numbering). Technical corrections are effective immediately.

B. Medical staff policies

Medical staff policies may be developed as necessary to implement the general principles in these bylaws. Medical staff policies are effective once approved by the MEC and must then be communicated promptly to the medical staff.

Section 6-2. Histories and Physical Examinations

A history and physical examination (H&P) must be completed and documented by a physician, oral surgeon, or podiatrist, consistent with his/ her delineated clinical privileges, for each patient not more than 30 days before the date of the scheduled surgery. A podiatrist may complete and document a focused H&P of the foot and ankle and their related soft tissue structures to the level of the myotendinous junction, but a physician (MD/DO) must perform the rest of the H&P.

If an H&P was performed outside the outpatient surgery center, upon admission and before surgery or a procedure requiring anesthesia services, an updated examination of the patient must be completed and documented for any changes in the patient's condition since the completion of the most recently documented H&P.

For patients undergoing a procedure requiring deep sedation or general anesthesia, the H&P must contain: chief complaint, history of present illness, relevant past medical history, social

and family histories, a relevant physical examination, conclusions and impressions from the H&P exam, the diagnosis or diagnostic impression, and the treatment plan. The physical examination, at a minimum, must describe the status of the cardiac, pulmonary and neurologic systems; airway; and any other findings relevant to the procedure and the treatment and care of the patient.

For patients undergoing outpatient procedures with moderate sedation, the H&P must contain: chief complaint, history of present illness, relevant past medical history, a relevant physician examination, conclusions or impressions from the H&P exam, and the diagnosis or diagnostic impression. The physical examination, at a minimum, must describe the status of the cardiac, pulmonary and neurologic systems; airway; and any other findings relevant to the procedure and the treatment or care of the patient.

DEFINITIONS

Advanced practice providers – certified registered nurse anesthetists, nurse practitioners and physicians' assistants. These individuals exercise clinical privileges under the supervision of a physician (MD/DO). APPs hold clinical privileges, but they are not members of the medical staff.

Applicant – an individual who is applying for membership on the medical staff and/or clinical privileges.

Board of trustees – the Board of Trustees for Novant Health Forsyth Medical Center.

Chief clinical officer (CCO) – the CCO employed by Novant Health or one of its subsidiaries or affiliates.

Collaborative practice agreement – the written statement between an APP and his/her supervising physician(s) that is required by North Carolina law and describes those medical acts, tasks and functions delegated to the APP by the primary supervising physician that are appropriate to the APP's education, qualification, training, skills, and competence.

Days – calendar days, unless it is specifically noted to be *business* days.

Dentist – an individual with a DDS degree who is fully licensed to practice dentistry in North Carolina.

Federal health care program – any plan or program that provides health benefits that are funded directly, in whole or in part, by the federal government or a state health care program (with the exception of the Federal Employees Health Benefits Program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

Investigation – a formal investigation opened by the credentials committee per Article IV, as reflected in the credentials committee's meeting minutes, regarding a practitioner's clinical competence; care and treatment of patients or management of a case; known or suspected violation of applicable ethical standards; known of suspected violation of medical staff, outpatient surgery center or Board of Trustees bylaws, rules & regulations or policies (including, but not limited to, the outpatient surgery center's quality assessment, risk management and utilization review programs); and/or behavior or conduct that is considered lower than the standards of the outpatient

surgery center or disruptive to the orderly operations of the medical staff or the outpatient surgery center, including the inability of the practitioner to work harmoniously with others.

Ineligible person – any individual who: (1) is currently excluded, suspended, debarred, or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

Investigating committee – the committee appointed by the credentials committee to conduct an investigation per Article IV. The investigating committee may be the full credentials committee, a subcommittee of the credentials committee, or an ad hoc committee. If an ad hoc committee is used, it cannot have more than three (3) members, who may or may not be members of the medical staff, and cannot include partners, associates or relatives of the practitioner being investigated.

Medical staff – the formal organization of physicians, oral surgeons, dentists and podiatrists who have been appointed to the medical staff by the Board of Trustees.

Oral surgeon – an individual with a DDS or DMD degree who is fully licensed to practice oral surgery in North Carolina and is board certified or board eligible by the American Board of Oral and Maxillofacial Surgery (ABOMS).

Outpatient surgery center – refers to Novant Health Kernersville Outpatient Surgery.

Physician – an individual with an MD or DO degree who is fully licensed to practice medicine in North Carolina and is board eligible or board certified by an American Board of Medical Specialties member board or the American Osteopathic Association, as applicable.

Podiatrist – an individual with a DPM degree who is fully licensed to practice podiatry in North Carolina and is board eligible or board certified by the American Board of Podiatric Medicine or the American Board of Foot and Ankle surgery.

Practitioner – a collective term used to refer to all the members of the medical staff and to all individuals who hold clinical privileges at the outpatient surgery center.

Prospective applicant – an individual who has requested an application for membership on the medical staff and/or clinical privileges.

Review – the process used to determine whether an investigation, or other action, is needed to address concerns related to a practitioner's clinical competency or professional behavior.

Rules & regulations – the rules & regulations of the medical staff that have

been adopted and approved as explained in these bylaws.

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