Medical/Professional Staff Bylaw Framework

The provisions below can be used as a framework for developing medical/professional staff bylaws. Please note that this framework is not all inclusive, and various provisions included here may not apply to your facility/organization. Additionally, the language provided in this framework provides only a general overview of the various items included within the framework and is not comprehensive. You should not copy and paste the language included in this framework but should work with your facility/organization and legal counsel to develop medical staff bylaws that are appropriate for your facility/organization.

Prior to use of this document, review AANA's member resources:

- CRNA Employment/Practice Setting Considerations, Medical Staff Bylaws Checklist*
- Introduction to Medical/Professional Staff Bylaws*

*Member Login Required

[Depending on the state your facility/organization is in, state statutes and regulations may reference or mandate the use of specific terms, such as "medical staff" or "professional staff." The term "medical/professional staff" is used in this document, but please apply the term that is consistent with state law.]

1. **Definitions**
   [Insert appropriate definitions; modify these definitions to comply with applicable law. State law likely has important definitions and provisions regarding peer review and medical/professional staff matters that should be reviewed and considered for inclusion.]
   - **1.1 Advanced Practice Professionals** - Advanced Practice Registered Nurses, including Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse Practitioners (CNPs), Clinical Nurse Specialists (CNSs), and Certified Nurse Midwives (CNMs); and Physician Assistants.
   - **1.2 Confidentiality (as related to peer review and professional review)** - Peer review, professional review, and quality performance activities are protected from discoverability under ***[insert relevant federal and state law and regulations]***. All activities are to be kept confidential and only authorized individuals have access to the information. Authorized individuals include ***[insert authorized individuals].***
   - **1.3 Quality of Care Concern** - An issue that has interfered with, or has the potential to interfere with, a favorable clinical outcome.
   - **1.4 Peer** - An individual practicing with similar training and experience who can render an unbiased opinion on the quality and conduct of a case. The ***[insert appropriate committee]*** must determine the degree of subject matter expertise required for a practitioner to be considered a "peer". This determination may occur on a case-by-case basis.
   - **1.5 Peer Review** - Evaluation of the quality of care provided by practitioners, including, but not limited to, identification of opportunities to improve care with input from appropriate subject matter experts.

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1.6 **Peer Reviewer** - A member of the medical/professional staff in good standing who has not performed any healthcare management on the patient whose case is under review.

1.7 **Peer Review Information** - Records, data, and knowledge developed and collected in connection with Peer Review, including, but not limited to, applications, reports, minutes, transcripts, recommendations, and summaries relevant to Peer Review.

1.8 **Professional Review** - An activity of the ***[facility/network]*** with respect to an individual practitioner (i) to determine whether an applicant, medical/professional staff member, or practitioner with clinical privileges may have clinical privileges at the ***[facility/network]*** or membership on the medical/professional staff; (ii) to determine the scope or conditions of such privileges or membership; or (iii) to change or modify such privileges or membership.

1.9 **Professional Review Body** - The ***[facility/network]*** and the governing body or any committee of the ***[facility/network]*** or the medical/professional staff ***[insert appropriate entity committees, positions, department chairs, etc.]*** when assisting the governing body in a professional review activity. Any action taken by a Professional Review Body pursuant to these medical/professional staff bylaws or the appointment procedure is in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Health Care Entity) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or medical/professional staff appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

1.10 **Professional Review Information** - Records, data, and knowledge developed and collected in connection with Professional Review, including, but not limited to, applications, reports, minutes, transcripts, recommendations, and summaries relevant to Professional Review.

2. Name

This organization is the medical/professional staff of ***[facility/network]***.

3. Purpose and Authority

The purpose of this medical/professional staff is:

3.1 To organize the activities of medical/professional staff members and practitioners with clinical privileges who practice at ***[facility/network]*** to assist the governing body in executing the functions as delegated by the governing body to the medical/professional staff.

3.2 To establish processes that promote quality healthcare and patient safety for all patients admitted to the hospital or treated at outpatient facilities ***[within the network]***.

3.3 Pursuant to the governing body's authority and approval, the medical/professional staff exercises such power that is reasonably necessary to fulfill its responsibilities under these bylaws and the bylaws of the ***[facility/network]***.

3.4 ***[or insert facility purpose].***

4. Membership

4.1 Nature of Medical/Professional Staff Membership

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Every practitioner who seeks or enjoys medical/professional staff membership must continuously meet the qualifications, standards, and requirements set forth in these bylaws, medical/professional staff rules and regulations, and associated policies of the medical/professional staff, as approved by the governing body.

4.2 Qualification of Membership

An applicant for membership on medical/professional staff must:

4.2.1 Hold current ***[unrestricted]*** licensure by the State of ***[State]*** to practice his/her profession and to exercise privileges applied for or held.

4.2.2 Document his/her background, experience, training, and competence, including current knowledge, judgment, and ability to perform all privileges applied for or granted.

4.2.3 Practice in adherence to the code of ethics of their profession and possess the ability to adequately work with others to assure that any patient under his/her care will be given appropriate healthcare.

4.2.4 Provide evidence of physical and mental health that does not impair, in accordance with applicable law, the fulfillment of his/her medical/professional staff responsibilities and the specific privileges requested by and granted to the applicant. ***[Review with legal counsel to evaluate whether this language, or similar language, complies with federal, state, and local disability discrimination laws.]***

4.2.5 Be a graduate of an approved ***[insert applicable healthcare educational program, e.g., medical, osteopathic, dental, optometry, nurse practitioner, nurse anesthesia, psychology, podiatry].***

4.2.6 Have a record that is free of current Medicare/Medicaid sanctions and not be on the Office of Inspector General's list of excluded individuals/entities.

4.2.7 Have a record that is free of felony convictions within the last three years ***[or another period of time as determined by state statutes and regulations, or as determined by the facility/organization's Governing Board]***, or *occurrences that would raise questions of undesirable conduct that could negatively affect the reputation of the medical/professional staff or hospital. ***[*Clauses such as these cause controversy, and their appropriateness is dependent upon how such a clause is applied.]***

4.2.8 Possess a current valid [unrestricted] U.S. Drug Enforcement Administration (DEA) number, if applicable.

4.3 Nondiscrimination

Medical/professional staff membership or clinical privileges must not be denied based on race, gender, creed, religion, color, national origin, age, veteran's status, sexual orientation, gender identity, gender expression, pregnancy, solely based on education program, or any other status characteristic protected by law. ***[Review federal, state, and local law for applicable language and requirements]***

4.4 Sexual Harassment

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature are incompatible with the cooperative working relationships necessary to provide quality patient care. Such behavior must not be tolerated or condoned. ***[Review federal, state, and local law for applicable language and requirements]***

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4.5 Compliance with Applicable Reimbursement Requirements

Applicants, members of the medical/professional staff, and practitioners with clinical privileges must comply with relevant federal and state reimbursement requirements.

4.6 Prerogatives and Responsibilities of Medical/Professional Staff

Doctor of Medicine (MDs) or osteopathy (DOs) and Advanced Practice Professionals (APPs) may join the medical/professional staff if the practitioners are appropriately licensed, are qualified in accordance with section 4.2, and medical/professional staff membership is in accordance with state law.

Acceptance of medical/professional staff membership or clinical privileges, including temporary appointment or privileges, constitutes the practitioner's agreement to:

4.6.1 Abide by the code of ethics of his/her profession, avoid acts and omissions constituting unprofessional conduct, and comply with federal, state, and local law and regulations.

4.6.2 Provide appropriate, timely, and continuous patient care.

4.6.3 Abide by the medical/professional staff bylaws, medical/professional staff rules and regulations, and other established written facility standards, policies, and rules and regulations.

4.6.4 Accept and appropriately discharge such medical/professional staff committee and facility assignments and obligations for which he or she is responsible by appointment, election, or otherwise, including Professional Review, Peer Review, quality improvement/assurance review, and service on hearing panels.

4.6.5 Prepare and complete in a timely and legible manner medical/healthcare/clinical records for all patients in whose care he/she is involved, including the following:

4.6.5(i) Patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body in accordance with state law and medical/professional staff bylaws.

4.6.5(ii) A medical history and physical examination must be completed and documented for each patient by a physician or other qualified licensed individual in accordance with ***[State]*** law and Medicare Conditions of Participation no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

4.6.5(iii) When the medical history and physical examination are completed within 30 days of admission or registration, the physician or other qualified licensed individual in accordance with ***[State]*** law and Medicare Conditions of Participation must complete and document an updated examination of the patient, including changes in the patient's condition within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

4.6.5(iv) ***[Progress notes requirements].***

4.6.5(v) ***[Discharge summary requirements].***

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4.6.6 Maintaining confidentiality according to the Healthcare Information and Portability Accountability Act of 1996 (HIPAA) and other applicable law.

4.6.7 Practitioners, consistent with their clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the Medical Executive Committee (MEC) and the governing body, after receiving input from the appropriate clinical specialty.

4.6.8 Notify the president of the medical/professional staff and chief executive officer (CE)) promptly of:

4.6.8(i) Changes in licensure.

4.6.8(ii) Changes in professional liability insurance coverage.

4.6.8(iii) Changes in clinical privileges or staff membership at any hospital or healthcare facility/network: voluntary or involuntary denial, limitation, suspension, revocation, non-renewal, renewal subject to probationary conditions, or any pending procedures.

4.6.8(iv) Any professional liability claim.

4.6.8(v) Criminal charge.

4.6.8(vi) Any drug or alcohol charge.

4.6.8(vii) Any revocation, suspension, or voluntary requisition, under threat of sanction of the practitioner's DEA registration.

4.6.8(viii) The commencement of a formal investigation or the filing of charges by any federal, state, or local agency against the practitioner, unless such information is exempt from disclosure by law.

4.6.8(ix) Etc.

4.6.9 Maintain professional liability insurance in such amounts as are required by the governing body. ***[Insert facility/network requirements].*** Medical/professional staff members and practitioners with clinical privileges must notify the ***[insert appropriate personnel, e.g., president]*** immediately of any changes resulting in noncompliance.

5. Categories of Appointment

5.1 Categories of Medical/Professional Staff

The categories of medical/professional staff include the following: active, provisional, affiliate, consulting, telemedicine, honorary and retired.

5.2 Active Staff

5.2.1 Qualifications for Active Status

5.2.1(i) Meet general qualifications for medical/professional staff membership set forth in section 4.2 of these bylaws;

5.2.1(ii) Regularly admit patients, or are otherwise involved in patient care in the facility, or, if emergency physicians, work an average of ***[number]*** hours per month on site in the ***[facility/network]*** Emergency Department during the course of each year after receiving provisional status;

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5.2.1(iii) Perform a sufficient number of procedures, or manage a sufficient number of cases, or have sufficient patient care contact to permit the appropriate medical/professional staff committee(s) to assess the member's current competency and quality for all privileges;

5.2.1(iv) Located in close proximity to the hospital so as to provide timely and appropriate continuity of patient care; and

5.2.1(v) Complete at least ***[time period]*** of satisfactory performance on the provisional staff.

5.2.1(vi) Advanced Practice Professionals, including Certified Registered Nurse Anesthetists (CRNAs) [insert other APP healthcare practitioner categories, e.g., other APRNs], are qualified for active status.

a. Certified Registered Nurse Anesthetists
CRNAs provide patient care within their licensure and professional skills and ability and according to privileges recommended to and approved by the governing body. ***[insert relevant state laws, particularly if relevant to CRNA supervision exemption or requirements]***

b. ***[insert descriptions, requirements, and voting status for other applicable Advanced Practice Professionals]***

5.2.2 Privileges of Active Status

Except when stated otherwise, privileges of an active staff member include:

5.2.2(i) Exercise such clinical privileges as are granted;

5.2.2(ii) Attend, and vote on matters presented at, general and special meetings of the medical/professional staff, department or committees in which he/she is a member;

5.2.2(iii) Hold medical/professional staff office and serve as a voting member of the medical/professional staff and other committees to which he/she is duly appointed or elected by the medical/professional staff or duly authorized representative thereof.

5.2.2(iv) Serve as committee chair of committees to which he/she is duly appointed or elected by the medical/professional staff or duly authorized representative thereof.

5.2.3 Obligations of Active Status

An active medical/professional staff member must:

5.2.3(i) Serve on appropriate medical/professional staff committees;

5.2.3(ii) Reasonably participate in the quality review, risk management, patient safety, and utilization management activities of the facility as required by medical/professional staff;

5.2.3(iii) Satisfy meeting attendance requirements found in these bylaws and medical staff rules and regulations.

5.2.3(iv) Pay all medical/professional staff dues and fees as set forth in these bylaws and medical staff rules and regulations;

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5.2.4 Leave of Absence

A leave of absence request for any absence longer than ***[number]*** days must be submitted in writing to ***the [insert appropriate committee, e.g., credentials committee]***. The request must state the duration of the requested leave and the specific detailed reasons for the request. Such request may be recommended by the ***[insert appropriate individual(s), [e.g., medical/professional staff president, Chief Executive Officer]*** on behalf of the medical/professional staff to the governing body. A leave of absence up to ***[number] [days/months]*** may be granted by the governing body, upon the recommendation of the ***[insert appropriate committee, e.g., credentials committee]***. A longer term may be considered upon special request, in writing. During any period of leave, all medical/professional staff privileges are automatically suspended. An absence over ***[number] [days/months]*** will require that the practitioner submit a new application for reinstatement to the medical/professional staff or of clinical privileges. ***[Additional details on leave of absence process, including termination, may be placed in related rules and regulations or policies or may be included in the bylaws.]***

5.3 Provisional Staff

[Identify relevant requirements for:

5.3.1 *Qualifications of provisional staff*
5.3.2 *Privileges of provisional staff*
5.3.3 *Obligations of provisional staff*
5.3.4 *Proctoring of provisional staff*
5.3.5 *Term of provisional staff status*
5.3.6 *Action at conclusion of provisional staff status]*

5.4 Courtesy Staff

[Identify relevant requirements for:

5.4.1 *Qualifications of courtesy staff*
5.4.2 *Privileges of courtesy staff*
5.4.3 *Obligations of courtesy staff]*

5.5 Affiliate Staff

[Identify relevant requirements for:

5.5.1 *Qualifications of affiliate staff*
5.5.2 *Privileges of affiliate staff*
5.5.3 *Obligations of affiliate staff*
5.5.4 *Leave of absence]*

5.6 Consulting Staff

[Identify relevant requirements for:

5.6.1 *Qualifications of consulting staff*
5.6.2 *Privileges of consulting staff*

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5.6.3 *Obligations of consulting staff, etc.]*

5.7 Telemedicine
[Identify relevant requirements for:

5.7.1 *Qualifications of telemedicine staff*
5.7.2 *Privileges of telemedicine staff*
5.7.3 *Obligations of telemedicine staff, etc.]*

5.8 Honorary and Retired Staff
[Identify relevant requirements for:

5.8.1 *Qualifications of honorary staff*
5.8.2 *Qualifications of retired staff*
5.8.3 *Privileges of honorary and retired status]*

6. Appointment and Credentialing

6.1 Application for appointment

[Consider whether a timeframe should be assigned to complete the application process. Accrediting agencies may require this.]

6.1.1 An application packet, including a cover letter listing required documentation and a copy of the ***[facility/network]*** medical/professional staff bylaws and rules and regulations will be provided to those who are requesting medical/professional staff appointment and those who are requesting clinical privileges. The application may include, but is not limited to the following documentation:

[List requisite documentation, e.g.,

- ***completed application form,***
- ***completed privileges request form,***
- ***curriculum vitae,***
- ***clinical activity summary, if applicable,***
- ***current DEA registration, if applicable,***
- ***Medicare attestation,***
- ***copy of diploma from appropriate professional school,***
- ***copies of all current licenses, registrations, certifications, as applicable,***
- ***evidence of current professional malpractice insurance (including limits and effective dates),***
- ***proof of continuing education, if applicable***
- ***list of at least three peer references,***
- ***copy of official photo identification***
- ***signed authorization, confidentiality statement, and code of professional conduct,***
- ***names of references familiar with the applicant's current professional competence,***
- ***past or pending professional disciplinary actions,***

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- ***licensure limitations, challenges to licensure/registration/certification and voluntary or involuntary relinquishment of such licensure/registration/certification,***
- ***past or pending voluntary or involuntary termination or limitation of clinical privileges at any healthcare institution,***
- ***past or pending malpractice litigation, judgment, or verdict against the applicant and settlement of claims for malpractice, whether or not such claims were subject to litigation,***
- ***list of previous affiliation with hospitals and other institutions and employers,***
- ***etc.]***

[Be sure to review requirements for healthcare tests or inquiries with a lawyer well versed in federal, state, and local disability discrimination law.]

[Additional requirements for practitioners who will have direct contact with patients, may include without limitation:

- ***TB testing/baseline screening documentation***
- ***Hepatitis B statement***
- ***Background check]***

6.1.2 If an applicant does not meet the governing body's membership, credentialing or privileging criteria, his/her application will not be processed. This will not be considered an adverse action, will not be reported to any agency, and does not entitle the applicant to a fair hearing or any rights and due process provided under the medical/professional staff bylaws.

6.1.3 Effect of Application

[Consult with legal counsel on applicable release of liability and immunity language. The language below is an abbreviated sample. Please see all disclaimers.]

By applying for medical/professional staff appointment or reappointment, medical/professional staff category advancement, or clinical privileges, the applicant, medical/professional staff member or practitioner with clinical privileges:

6.1.3(i) Agrees to appear for interviews regarding his/her application.

6.1.3(ii) Authorizes ***[facility/network]*** representatives to solicit, provide, and act upon Professional Review Information and Peer Review information, including otherwise privileged or confidential information.

6.1.3(iii) Releases from liability, promises not to sue, and grants immunity to (1) all ***[facility/network]*** representatives for their acts performed in connection with Professional Review and Peer Review to the fullest extent permitted by

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law; and (2) all third parties who provide information for the purposes of Professional Review and Peer Review, including otherwise privileged or confidential information, to the ***[facility/network]*** and ***[facility/network]*** representatives to the fullest extent permitted by law.

6.1.3(iv) Releases from liability, promises not to sue, and grants immunity to all ***[facility/network]*** representatives who provide third parties information concerning practitioner for the purpose of maintaining quality patient care in this or any other healthcare facility, including information about the practitioner's qualifications, clinical competency, character, ethics, or any other matter that might directly or indirectly affect patient care.

6.1.3(v) Agrees that these provisions are in addition to any agreements, understandings, covenants, waivers, authorizations, or releases provided by law or contained in any application or related forms.

6.1.4 The applicant must sign and complete the application and provide all necessary information for a proper evaluation of his/her competencies, character, ethics, and other qualifications, and for resolving any doubts about such qualifications. By signing the application, the applicant attests to the accuracy and completeness of all information on the application and accompanying documents.

6.1.5 The completed application must be submitted to ***[insert applicable personnel, e.g., medical/professional staff coordinator]*** for review.

6.1.5(i) If the documentation is not acceptable or complete, a letter will be sent to the applicant and no further action will be taken, unless the applicant provides new or additional documentation to complete their application. This will not be considered an adverse action, will not be reported to any agency, and does not entitle the applicant to a fair hearing.

6.1.5(ii) If the information is acceptable and complete, the ***[insert applicable personnel, e.g., medical/professional staff coordinator]***, will proceed with the appointment or credentialing process and verify licensure, education, liability insurance coverage and liability claims, and other documentation submitted to support the application, as well as query the National Practitioner Data Bank. References will be obtained to verify competence. ***[insert additional verification measures]***

6.1.6 The application and verification information will be transmitted to the [***insert applicable committee, e.g., executive committee, credentialing committee]*** for evaluation. This committee may make comment and recommendations including, but not limited to:

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6.1.6(i) Adequacy of the applicant's training, experience, and suitability.

6.1.6(ii) Impact on the facility/network upon granting the requested privileges.

6.1.6(iii) Monitoring recommendations:

6.1.6(iv) **[This may be considered Focused Professional Practice Evaluation (FPPE) in facilities that must follow FPPE accreditation standards. Please see specific FPPE section below.]**

- **a.** Number and types of cases.
- **b.** Type of monitoring. (e.g., direct, indirect)
- **c.** Appropriate personnel to conduct monitoring.

6.1.6(v) Appropriate staff category. (as outlined in bylaws)

6.1.7 Final Recommendation

6.1.7(i) When the ***[insert applicable committee, e.g., MEC, credentialing committee]*** recommendation is favorable, the ***[medical/professional staff president]*** must forward the recommendation and supporting documentation to the governing body and inform the applicant.

6.1.7(ii) When the ***[insert applicable committee, e.g., MEC, credentialing committee]*** recommendation is adverse, the ***[medical/professional staff president]*** must inform the applicant in writing and the applicant must be entitled to the rights provided in the Fair Hearing Plan. An adverse recommendation is defined as a recommendation to deny appointment, requested staff category, or to deny or restrict clinical privileges of an eligible applicant.

6.2 Governing Body Actions

The governing body's actions may include, but are not limited to:

6.2.1 Adopting the recommendation.
6.2.2 Requesting more information.
6.2.3 Modifying the recommendation.
6.2.4 Rejecting the recommendation.
6.2.5 Deferring the recommendation.
6.2.6 Sending the application back to the ***[insert applicable committee, e.g., MEC committee, credentialing committee]*** for further review.

The ***[insert applicable personnel, e.g., medical/professional staff president]*** will provide written notice to the applicant regarding the governing body's decision. The governing body's decision regarding appointment or clinical privilege will be final, upon waiver or exhaustion of the applicant's rights under the Fair Hearing Plan.

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6.3 Focused Professional Practice Evaluation (FPPE) Initially Requested Privileges

[Note: FPPE is not a CMS requirement. It is required by The Joint Commission and Healthcare Facilities Accreditation Program (HFAP). Consult your accreditation requirements.]

All practitioners granted privileges by the governing body will be placed in a Focused Professional Practice Evaluation (FPPE) process to determine competence for privileges granted and on a ***[number]*** month provisional status.

At the conclusion of the FPPE and the provisional status period, the practitioner will be evaluated by persons familiar with their performance. A recommendation will be made to the ***[insert applicable committee, e.g., MEC, credentialing committee]***, who will review and forward the recommendation for permanent privileges until the end of the appointment period to the governing body. The appointment period shall be no longer than ***[number]*** years, including time for provisional status.

If the recommendation to terminate or limit privileges is made, the practitioner has rights as provided in the Fair Hearing Plan.

6.4 Reappointment

6.4.1 Reappointment will be for no more than ***[number e.g., 24 months]***.

6.4.2 At least ***[number]*** months prior to the expiration of the current privileging period, a reappointment application will be sent to the practitioner. The reappointment application must be returned at least ***[number]*** days prior to expiration of privileges. The reappointment application must include all information necessary to update and evaluate the applicant's qualifications.

6.4.3 Reappraisal must include recommendations based on the practitioner's medical/clinical knowledge, technical and clinical skills, interpersonal skills, communication skills, professionalism, professional competence, clinical judgment and performance, evaluation by a peer, conformance to professional ethics, and general conduct ***[and information obtained from an Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), if any] [Note: OPPE and FPPE are required by The Joint Commission and HFAP. Consult your accreditation requirements.]*** The National Practitioner Data Bank will also be queried.

The medical/professional staff will also engage in ***[ongoing professional practice evaluation]*** to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. ***[Ongoing professional practice evaluation]*** must be undertaken as part of the medical/professional staff's process of evaluation, measurement, and improvement of a practitioner's performance. In addition, each practitioner may be subject to ***[focused***

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professional practice evaluation] when issues affecting the provision of safe, high-quality patient care are identified through ***the [ongoing professional practice evaluation]*** process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.4.4 Upon receipt of the reappointment application, the information must be processed as described in section 6.1.3.

6.5 Reapplication After Adverse Action

Any practitioner who has received a final adverse action from the governing body is not eligible to reapply for a period of [number] months. After that timeframe, any reapplication must be processed as an initial application. The applicant must submit additional information sufficient to demonstrate that the basis for the previous adverse action no longer exists.

6.6 Tracking Current Licenses

Since professional licensure or certification renewals may not correspond with appointment and reappointment timeframes, it is the responsibility of the practitioner with clinical privileges to provide updated copies of all necessary licenses or certifications to the ***[insert applicable personnel, e.g., medical/professional staff coordinator]***, who will maintain it in the practitioner's file.

6.7 Leave of Absence

7. Privileging

7.1 Clinical Privileges

7.1.1 Every application or reapplication for clinical privileges must contain a written request for the specific clinical privileges desired ***[and the facilities where those privileges are sought]*** by the applicant.

7.1.2 The applicant has the burden of establishing his/her qualifications and competency for the clinical privileges requested.

7.2 Clinical privilege requests will be reviewed and approved by ***[insert applicable committee(s) or personnel, e.g., credentialing committee, Chief Executive Officer, medical/professional staff president, Department Chair, lead Advanced Practice Professional, Advanced Practice Committee]*** and finally approved by the governing body. These entities will determine whether:

7.2.1 The practitioner has adequate character, education, experience, competence, judgment, references, and other relevant information, including an appraisal by the services in which privileges are sought, to perform the privileges requested.

7.2.2 The requested privileges are consistent with the facility's:

7.2.2(i) Short- and long-term goals and objectives.

7.2.2(ii) Desire or ability to provide equipment, staff, training, and our resources necessary to support the requested privileges.

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7.2.3 Core privileges may be granted in the requested field of expertise but are not a guarantee that the practitioner will be able to practice all privileges requested subject to equipment, personnel, and monitoring resources available.

7.3 Clinical Privileges Restricted

Any practitioner holding clinical privileges at ***[facility/network]*** is entitled to exercise only those clinical privileges specifically granted by the ***[insert appropriate committee]***, except as provided for under temporary and emergency privileges.

Periodic redetermination of clinical privileges and the increase or restriction of clinical privileges must be based upon the observation and evaluation of care provided, review of patient health records, and review of documented evaluation of the practitioner's participation in the delivery of patient care.

7.4 Requests for Change in Privileges

[Note: The Joint Commission and HFAP require FPPE for all new privileges.]

7.4.1 Application

The practitioner must apply in writing to the ***[insert appropriate committee or personnel, e.g., Medical/professional staff president]*** stating in detail the specific additional clinical privileges desired and the relevant recent training and experience which justify the increase in privileges. The application will be transmitted to ***[insert appropriate committee, e.g., credentialing committee]***. The application will be processed in the same manner as an application for initial appointment or as part of a reappointment if the request is made at that time, or an application for initial privileges.

7.4.2 Considerations

The governing body will make its recommendation of whether there is a justification for change in privileges based on:

7.4.2(i) Relevant recent training.
7.4.2(ii) Proctoring of patient care.
7.4.2(iii) Review of patient health records.
7.4.2(iv) Review of documented evaluation of the practitioner's participation in the delivery of patient care.

The recommendation of change in privileges may also include a requirement for supervision or consultation for such a period of time as thought necessary.

7.4.3 Procedure Thereafter

If an adverse recommendation is made, the practitioner must be afforded those rights outlined under the Fair Hearing Plan.

7.5 New Procedures and Techniques

[Note: The Joint Commission and HFAP require FPPE for all new privileges.]

7.5.1 Requests for clinical privileges to perform either a significant procedure not currently being performed at the facility or a new technique for an existing

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procedure will not be processed until the [insert appropriate committee] has determined that:

7.5.1(i) the procedure should be offered at ***[facility/network].***
7.5.1(ii) the criteria to be eligible for those privileges have been established.

7.5.2 The ***[insert appropriate committee]*** will make a preliminary recommendation as to whether the new procedure should be offered. Considerations may include, but are not limited to:

7.5.2(i) Whether there is evidence of improved patient outcomes and/or other clinical benefits to the patient.
7.5.2(ii) Whether the procedure is being performed in similar facilities and their experiences.
7.5.2(iii) Whether ***[facility/network]*** has the resources (e.g., space, equipment, personnel, and other support services) to perform the new procedure safely and effectively.

7.5.3 If recommendation is made that the new procedure be offered, ***[insert appropriate committee]*** will conduct an assessment and consult with internal or external experts to develop recommendations regarding:

7.5.3(i) Minimum education, training, and experience necessary.
7.5.3(ii) Departments that should be permitted to offer the new service/procedure.
7.5.3(iii) Extent of monitoring or supervision required if the privileges are granted.
7.5.3(iv) Criteria or indications for when the new procedure is appropriate.

7.5.4 The ***[insert appropriate committee, e.g., Medical Executive Committee]*** will forward its recommendations to the governing body for final review and approval.

7.6 Temporary Privileges

[Note: Please review your accreditor's requirements.]
Temporary privileges constitute temporary permission to attend patients at the ***[facility/network]***. Temporary privileges are distinguished from other privileges of the ***[facility/network]*** in that they are not based upon complete review of credentials and are granted or revoked by the [President [or Chief Executive Officer] after consultation with the ***[Chief of Staff]*** or his/her designee.

[Consider including the following: Temporary Privileges may be revoked or withdrawn at any time, with or without cause.]

[Alternative Language: Temporary privileges may be granted only for a specific period of time, not to exceed _____ days, and automatically expire at the end of the specified period, without recourse by the practitioner under the medical/professional staff bylaws.]

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7.7 Temporary privileges are granted only under the following circumstances and subject to the following conditions:

7.7.1 Circumstances for Granting Temporary Privileges.
Upon the written concurrence of the Chairperson of the service where the privileges will be exercised and the ***[Chief of Staff, the medical/professional staff president or Chief Executive Officer]*** may grant Temporary Privileges in the following circumstances:

7.7.1(i) After receipt of an application for medical/professional staff appointment or clinical privileges, an appropriately licensed applicant may be granted temporary privileges for an initial period of [***sixty (60)]*** days, with subsequent renewal not to exceed the pendency of the application (the temporary privileges in such case cannot exceed the regular privileges applied for by the applicant). In exercising such privileges, the applicant must act under the supervision of the Chairperson of the service to which he or she is assigned or is appointed;

7.7.1(ii) To practitioners who will provide locum tenens coverage for a period not to exceed ***[sixty (60)]*** days per calendar year.

7.7.2 Limitations. An applicant for locum tenens or case- specific Temporary Privileges must establish that he or she:

7.7.2(i) Holds a valid license to practice his/her profession and a valid controlled substances permit in the state of [State], to the extent applicable;

7.7.2(ii) Has professional liability coverage at least equivalent to the minimum types and amounts required for medical/professional staff appointees or practitioners with clinical privileges and has provided evidence of such coverage to the ***[insert appropriate personnel, e.g., President, Chief Executive Officer]*** of the ***[facility/network]***;

7.7.2(iii) Holds clinical privileges at another healthcare entity encompassing the procedures and responsibilities for which he or she is making request at ***[facility/network],*** or can supply a list of healthcare entity affiliations so that enough data may be obtained for review and evaluation of the applicant's work by the ***[insert appropriate personnel, e.g., Chief of Staff, President, Chief Executive Officer]*** of ***[facility/network];*** and

7.7.2(iv) Has designated an alternate practitioner with appropriate privileges to provide alternate coverage during times when the practitioner exercising temporary privileges is unavailable.

7.8 Emergency or Disaster Privileges
[Note: Please review your accreditor's requirements.]
Special Emergency and Disaster Privileges for Medical/Professional Staff Members and Practitioners with Clinical Privileges at *[facility/network]*

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In case of an emergency or a disaster, if approved ***by [insert applicable personnel, e.g., Medical/professional staff president]***, any medical/professional staff member or practitioner with clinical privileges, to the degree permitted by his/her licensure and regardless of service or staff status, is permitted and assisted to do everything possible to prevent the potential loss of life of a patient, using every facility of the hospital necessary, including calling for consultation necessary or desirable. Once the emergency or disaster situation no longer exists, the emergency and disaster privileges will lapse. Should a practitioner wish to continue to treat the patient, they must request privileges necessary to continue to treat the patient. If they do not wish to request privileges or such clinical privileges are denied, the patient will be reassigned to another appropriate practitioner. For the purpose of this section, "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and that any delay in administering treatment would add to that danger. The provisions of this section are supplemented by policies of the ***[facility/network].***
[The following are two different approaches to emergency/disaster privileges for outside volunteer practitioners.]

[Example #1]
Special Emergency and Disaster Privileges for Non-Member and Practitioners without Clinical Privileges at *[facility/network]*
In the case of emergency or disaster where the Emergency Management Plan, as defined in [] has been officially activated, and [facility/network] may potentially be unable to handle immediate patient care needs, any practitioner who is not a medical/professional staff member of ***[facility/network]*** or any practitioner without clinical privileges at ***[facility/network],*** and who volunteers to provide clinical service to patients during the emergency or disaster must be processed according to the policy and procedure for temporary emergency privileges during activation of the ***[facility/network]*** Emergency Management Plan.

[Example #2]
If the [***facility/network]***'s disaster plan has been activated, and the organization is unable to meet immediate patient needs, the ***[insert applicable personnel, e.g., CEO]*** and other individuals as identified in the ***[facility/network]***'s disaster plan with similar authority may, on a case-by-case basis, grant disaster privileges to selected practitioners. The granting of privileges must be consistent with licensing and other relevant state statutes and regulations. The practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital ID card that clearly identifies professional designation.
- A current license to practice.
- Primary source verification of the license.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team, Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals or other recognized state or federal organizations or groups.

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- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- Identification by a current hospital or medical/professional staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a practitioner during a disaster.
- The medical/professional staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review.
- The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
- Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- Once the immediate situation has passed and such determination has been made consistent with the ***[facility/network]***'s disaster plan, the practitioner's disaster privileges will terminate immediately.
- Any individual identified in the ***[facility/network]***'s disaster plan with the authority to grant disaster privileges also has the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

8. Performance Improvement and Peer Review

8.1 The peer review process is an ongoing component of the facility-wide performance improvement initiative and a responsibility of ***[insert appropriate committee, e.g., Peer Review Committee]***. The ***[insert appropriate committee, e.g., Peer Review Committee]*** examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering healthcare services. The professional or personal conduct of a practitioner may also be reviewed.

8.2 Peer review establishes a process by which medical/professional staff quality of care reviews may be resolved in a non-punitive atmosphere that promotes education, performance improvement, and favorable clinical outcomes.

8.3 **[Insert appropriate committee]** assesses the ongoing professional practice and competence of its medical/professional staff, conducts professional practice evaluations ***[if applicable: including focused professional practice evaluations],*** and uses the results of such assessments and evaluations to improve professional competence, practice, and the quality of patient care.

8.4 Policy

The ***[facility/network]*** supports the medical/professional staff to address quality of care concerns in a non-biased, non-punitive process by which provider-related performance and occurrences are reviewed, documented, and appropriate action is taken. The Peer Review Committee and Medical Executive Committee perform such oversight, with input from the medical/professional staff president, Medical Directors, Chief Nursing Officer, Chief Executive Officer, and Risk Management. ***[insert committees involved in review oversight].***

8.5 Procedure

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Circumstances which may prompt internal or external peer review are listed below. This list can be revised as deemed appropriate by ***[insert appropriate committee(s)]***

Circumstances which may require internal peer review include, but are not limited to:

8.5.1 Competence evaluation for privileging [including OPPE and FPPE].
8.5.2 Performance improvement activities.
8.5.3 Invasive, operative, and non-invasive procedures that place patients at risk.
8.5.4 Blood usage.
8.5.5 Medication use and monitoring.
8.5.6 Clinical practice patterns.
8.5.7 Mortality and morbidity review with a focus on unexpected deaths.
8.5.8 Significant deviation from standard of practice.
8.5.9 Failure to respond to emergency calls within required timeframe.
8.5.10 Patient abandonment.
8.5.11 ***[insert other appropriate reasons, as applicable]***

Circumstances which may require external peer review include, but are not limited to:

8.5.12 Lack of internal expertise in particular specialty.
8.5.13 Introduction of new technology.
8.5.14 Conflict of interests which may compromise objectivity.
8.5.15 As requested by the practitioner whose case is under review. In this circumstance, the practitioner is responsible for costs incurred for the external peer review, outside of the typical external review process.
8.5.16 Expertise is necessary or anticipated for evaluation of a credentialing file or for assistance in developing a benchmark for quality monitoring.
8.5.17 A specific concern about clinical outcomes exists.
8.5.18 The ***[insert appropriate committee(s)]*** cannot make a determination and/or requests external review.

8.6 Process

8.6.1 Quality of care concerns can be raised by ***[insert appropriate individuals]*** and directed to ***[insert appropriate individuals].***
8.6.2 Quality of care concerns arising through performance improvement activities will be directed to ***[insert appropriate individuals].***
8.6.3 If a collegial approach to the concern is not effective, the concerned individual must provide a written statement to ***[insert appropriate individuals].***
8.6.4 The ***[insert appropriate individual(s), e.g., Medical/professional staff president]*** will determine whether the concern is valid.

8.6.4(i) If it is an invalid concern, the process will end.
8.6.4(ii) If it is a valid concern the case will be referred to ***[insert appropriate individual or committee, e.g., Peer Review Committee]***

8.7 Peer Review Committee

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8.7.1 The Peer Review Committee consists of ***[insert appropriate individuals].***

8.7.2 The Peer Review Committee will review peer review or quality of care cases at their regularly scheduled meetings, unless there is a need for a more immediate review.

8.7.3 The assigned peer reviewer will be responsible for reviewing cases or obtaining information from appropriate subject matter experts.
[Consider assigning review timeframe based on severity of the case]

8.7.4 After a case review, the Peer Review Committee can, but is not limited to, recommend the following actions to the Medical Executive Committee:

8.7.4(i) No action necessary.
8.7.4(ii) Discussion of educational purposes with practitioner.
8.7.4(iii) Inquiry letter, requesting response.
8.7.4(iv) Discussion of performance improvement plan with the practitioner.
8.7.4(v) Request additional chart review ***[or FPPE].***
8.7.4(vi) Refer identified issue(s) to appropriate department.
8.7.4(vii) Refer for corrective action investigation to the Medical Executive Committee.

8.8 Medical Executive Committee

8.8.1 The Medical Executive Committee:

8.8.1(i) Has primary oversight for activities related to self-governance of the professional services provided by all practitioners privileged through the medical/professional staff process.
8.8.1(ii) Will review and act upon Peer Review Committee peer review or quality of care case reports and recommendations at regularly scheduled meetings, unless there is a need for a more immediate review.
8.8.1(iii) May seek additional information for appropriate subject matter experts, including but not limited to ***[insert applicable individuals or committee(s)].***

8.8.2 Participation of Practitioner Under Review:

8.8.2(i) The practitioner has the right to present his/her information regarding care management to the Medical Executive Committee.
8.8.2(ii) The practitioner must be notified in writing of cases reviewed, including, the medical record number, case date, and reason for review.

a. This process begins the ***[number]*** day notification countdown to finalize the Medical Executive Committee case review.

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8.8.2(iii) The Medical Executive Committee may request additional information from the practitioner to assist in completing the case review.

8.8.2(iv) The practitioner has ***[number]*** days to respond in writing or a second certified letter will be sent, with a ***[number]*** day response time.

8.8.2(v) If no response is received after the second letter, the practitioner will be placed on summary suspension pending a response from the practitioner.

8.8.2(vi) After the Medical Executive Committee has received all necessary information, the practitioner may, upon request and at the Medical Executive Committee's discretion, attend the Medical Executive Committee meeting to address this case.

8.8.3 All cases will have the conclusion rationale documented. The rationale must be based on the reason the case was reviewed and supported by current clinical practice standards, guidelines, and/or literature.

8.8.4 Upon completion of the review, the Medical Executive Committee will send a final determination letter to the practitioner advising him/her of the review outcome.

8.8.5 The Medical Executive Committee may make a recommendation to the ***[facility/network]*** regarding recommended action to be taken as a result of the case review. This recommendation may include, but is not limited to, changing policies and procedures, counseling the practitioner, issuing a letter of warning, suspending clinical privileges, or recommending to the medical/professional staff president ***[or Chief Executive Officer]*** of the ***[facility/network]*** that a corrective action investigation be conducted.

8.8.6 If the Medical Executive Committee's recommendation is grounds for a fair hearing under section 10 of these bylaws, the practitioner may request a fair hearing within ***[number]*** days following the receipt of the final determination letter from the Medical Executive Committee.

8.9 Access to Peer Review Files

8.9.1 ***[Insert appropriate individuals, e.g., medical/professional staff officers, CEO, facility/network legal counsel]*** and others with a legitimate right of access to part or all the peer review files, must have access to all medical/professional staff records to the extent necessary to perform official functions.

8.9.2 A practitioner has the right to obtain copies of and documents in his/her own credentials and peer review file or which were addressed or copied to the practitioner.

8.9.3 Any practitioner reviewing his/her file or any summary must not pressure, interfere with, demean or otherwise retaliate against those providing information or involved in the peer review process.

8.10 Responsibilities of Medical/Professional Staff Members and Others

All persons holding appointment or clinical privileges at the ***[facility/network]*** and involved in medical/professional staff agree to respect the confidentiality of all peer review information to which they have access in connection with their responsibilities.

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Confidentiality requirement extends not only to the information contained in the peer review files, but also to peer review information in committee records or minutes and the peer review discussions which take place among medical/professional staff committees.

9. Corrective Action

If the activities or professional conduct of any medical/professional staff member or practitioner with clinical privileges are considered below the standards of patient care, disrupt ***[facility/network]*** operations, or violate the bylaws, rules and regulations, or policies of the medical/professional staff, or other applicable bylaws, policies and procedures of the ***[facility/network],*** a corrective action proceeding may be requested to review the activity in question and to recommend a resolution. Misrepresentation of information on an application for clinical privileges or medical/professional staff appointment or reappointment, if discovered after the practitioner has become privileged or a medical/professional staff member, may also be grounds for corrective action. Conduct outside of the ***[facility/network]*** may also be grounds for initiation of a corrective action, if such conduct has a relationship to the quality of care provided to patients in the ***[facility/network].***

9.1 Process

9.1.1 Initiation

A written request specifying the concerns, activities, or conduct that is the basis for requesting corrective action must be submitted to the Medical Executive Committee. Medical/professional staff officers, committee chairs, department chiefs, the CEO, the chief medical officer, or the hospital board chair are authorized to submit a request for a corrective action investigation. If the Medical Executive Committee proceeds with a corrective action investigation, it must document the reasons and rationale.

9.1.2 Corrective Action Investigation

The Medical Executive Committee, via an affirmative vote, may begin a corrective action investigation. If the governing body believes the Medical Executive Committee has erroneously determined that a corrective action investigation is unwarranted, it may direct the Medical Executive Committee to proceed with a corrective action investigation.

The Medical Executive Committee may conduct the corrective action investigation or may delegate the corrective action investigation to a medical/professional staff standing or ad hoc committee.

If a committee other than the Medical Executive Committee is assigned the corrective action investigation, the committee must begin the investigation and submit a written report of its findings, conclusions, and recommendations to the Medical Executive Committee ***[as soon as practicable/within # days of receipt of the request]***. The committee may review all documents it considers relevant; interview individuals; consider appropriate clinical literature and practice guidelines; and retain an external consultant if approved by the Medical Executive Committee and the CEO.

The investigation committee will notify the practitioner under review that the corrective action investigation has begun, inform the practitioner of the nature

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of the charges, and give the practitioner an opportunity to discuss, explain, or refute the charges or provide relevant information to the investigation committee. ***[The investigation committee may require the practitioner under review to undergo a physical/mental examination as related to the practitioner's ability to perform clinical privileges and may review the results of such exams.] [Review with legal counsel to evaluate whether this language, or similar language, complies with federal, state, and local law.]***

Meetings between the practitioner under review and the investigation committee and meetings with other individuals interviewed by the investigation committee do not constitute a "hearing" as defined in section 10 of these bylaws. The procedural rules and process described in section 10 do not apply to these meetings. The practitioner under review does not have the right to be represented by legal counsel or external consultants before the investigation committee. Minutes of these meetings/interviews must be recorded.

If appropriate, after completion of the corrective action investigation, recommendations for corrective action may include, but are not limited to:

9.1.2(i) Termination of membership or clinical privilege(s).
9.1.2(ii) Suspension of membership or clinical privilege(s).
9.1.2(iii) Modification of membership category.
9.1.2(iv) Reduction or limitation of clinical privileges.
9.1.2(v) ***[etc.]***

Despite the status of any corrective action investigation, the Medical Executive Committee retains the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

9.2 Precautionary/Summary Suspension

If immediate action is required, in the interest of patient care, health or safety of an individual, the ***[insert appropriate individual(s) or committee(s), e.g., president of the medical/professional staff, CEO, governing body]*** may suspend medical/professional staff status or all or part of the clinical privileges of a practitioner. Such precautionary/summary suspension will be effective immediately upon imposition. Notice must be given to the ***[insert appropriate committee(s)], appropriate [facility/network]*** departments, respective ***[facility/network]*** Chief Executive Officer, and by certified mail to the practitioner. If a precautionary/summary suspension is imposed, the practitioner has the rights outlined under the Fair Hearing Plan.

9.3 Automatic Relinquishment

The practitioner's privileges and/or membership will be relinquished in the circumstances described in section 9.3.1 through 9.3.6. Fair hearing or any rights and due process provided under the medical/professional staff bylaws do not apply to automatic relinquishment. Notice must be given to the ***[insert appropriate committee(s)]***, appropriate ***[facility/network]*** departments, respective ***[facility/network]*** Chief Executive Officer, and by certified mail to the practitioner. If

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the practitioner disputes the circumstances giving rise to the automatic relinquishment, the relinquishment will remain in effect until the ***[Medical Executive Committee]*** reviews the facts and makes a determination.

Within ***[number]*** days of the relinquishment, the ***[medical/professional staff president]*** may reinstate the practitioner's privileges or membership after determining that the underlying events no longer exist or have been corrected.

The ***[Medical Executive Committee]*** may recommend further corrective action or direct that a corrective action investigation be undertaken whenever the actions set forth in 9.3.1 – 9.3.6 occur.

9.3.1 Licensure

9.3.1(i) Revocation and Suspension
When a practitioner's license or other legal credential authorizing him or her to practice in this state is revoked, suspended, expired, or voluntarily relinquished, the medical/professional staff membership and clinical privileges, will be immediately and automatically relinquished.

9.3.1(ii) Restriction
When a practitioner's license or other legal credential authorizing him or her to practice is limited or restricted, any clinical privileges held by the practitioner that are within the scope of the license limitation or restriction will be automatically limited or restricted in a similar manner throughout the effective period of the license limitation or restriction.

9.3.1(iii) Probation
When a practitioner is placed on probation by the applicable licensing or certifying authority, the medical/professional staff membership and clinical privileges will immediately and automatically be subject to the same terms of the probation throughout the effective period of the probation.

9.3.1(iv) Medicare, Medicaid, or Any Other Federal or State Healthcare Program
When a practitioner has his/her right to bill or participate in Medicare, Medicaid, or any other federal or state health care program revoked or suspended in any manner, the medical/professional staff membership and clinical privileges will be immediately and automatically relinquished as of the effective date of the action. Any practitioner who has his/her name placed on the Office of Inspector General's list of excluded individuals/entities automatically relinquishes his/her medical/professional staff membership and clinical privileges.

9.3.1(v) Failure to Report
A practitioner fails to report to the ***[facility/network]*** any restriction or condition imposed on or probation with respect to his/her license or the legal credential authorizing him or her to

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practice within ***[number]*** days of the imposition of such restriction, condition, or probation.

9.3.2 Controlled substances

9.3.2(i) Drug Enforcement Agency Certificate

Whenever a practitioner's DEA certificate or state-controlled substance registration (if applicable) is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, throughout the effective period of the action.

9.3.2(ii) Probation

Whenever a practitioner's DEA certificate or state-controlled substance registration (if applicable) is placed on probation, the practitioner's right to prescribe such medications will automatically become subject to the same terms of the probation, throughout the effective period of the action.

9.3.3 Medical Record Completion Requirements

If a practitioner, after warning, has incomplete medical records over ***[number]*** days from the discharge date, the practitioner's admitting privileges will be voluntarily relinquished, effective until medical records are completed. This relinquishment will not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries.

9.3.4 Professional Liability Insurance

Failure of a practitioner to maintain the minimum amount of professional liability insurance required by state regulations and ***[the governing body/these bylaws/medical/professional staff or board policies]*** will result in automatic relinquishment of a practitioner's medical/professional staff membership and clinical privileges. This relinquishment will remain in effect until the practitioner has provided ***[the governing body]*** with evidence of the required current professional liability insurance. Continued failure to be in compliance may result in corrective action and/or non-reappointment.

9.3.5 Felony Conviction

Upon conviction of, or a plea of "guilty" or "no contest," or its equivalent to a felony involving violence, physical or sexual abuse, drug offenses, or insurance/healthcare fraud or abuse in any jurisdiction, the practitioner's medical/professional staff membership and privileges will be automatically relinquished. Such relinquishment will become effective immediately on such conviction or plea, regardless of whether an appeal is filed and will remain in effect until the matter is resolved by subsequent action of the governing body or through corrective action, if necessary.

9.3.6 Failure to Provide Requested Information/Failure to Appear

If at any time a practitioner fails to provide required information pursuant to a formal request by ***the [Medical Executive Committee, president, or governing body]***, the practitioner's clinical privileges are automatically relinquished. For purposes of this section, "required information" refers to (1) physical or mental evaluation as specified elsewhere in the bylaws and in accordance with applicable law; (2) information requested during Peer Review,

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Corrective Action Investigation, or Professional Review , or concerning resignation from, or termination, limitation, or relinquishment of, clinical privileges at, another facility; (3) information necessary to evaluate the competency and credentialing/privileging qualifications of the practitioner; (4) information pertaining to professional liability actions involving the practitioner; or (5) failure to appear, without good cause, at any meeting when so directed by the ***[Medical Executive Committee, the administrator, or the governing body]***. The privileges will be restored when the practitioner complies with the requirement for information or appearance. Failure to comply within [30] days will be considered a voluntary resignation from the medical/professional staff.

9.3.7 ***[Some medical/professional staff bylaws address effect of contract termination as automatic relinquishment of medical/professional staff membership and clinical privileges.]***

10. Fair Hearing Plan

[The fair hearing plan may vary depending on state law and accreditation standards. Some bylaws include the substantive elements of the Fair Hearing Plan while others reference policies incorporated into the bylaws. The form below reflects the latter approach.]

The ***[facility/network]*** procedural details of the fair hearing and appeal process are set forth in the Fair Hearing Plan, which is incorporated into these bylaws. The Fair Hearing Plan applies when the ***[insert appropriate committee or body, e.g., Medical Executive Committee]*** makes a recommendation regarding clinical competence or professional conduct that adversely affects a practitioner's appointment to or status as a member of the medical/professional staff or the practitioner's exercise of clinical privileges, unless otherwise specified in these Bylaws. The Fair Hearing Plan includes the following:

10.1 Definitions
10.2 Right to Hearing and Appellate Review

10.2.1 Grounds for Hearing

10.3 Actions Not Giving Rise to Hearing Right
10.4 Request for or Waiver of Hearing
10.5 Notice of Hearing / Statement of Charges/Time and Place of Hearing
10.6 Appointment and Composition of Hearing Committee
10.7 Hearing Procedure

10.7.1 Personal Presence
10.7.2 Representation
10.7.3 Presiding Officer
10.7.4 Requests for Information or Documents
10.7.5 Rights of Parties
10.7.6 Burden of Proof
10.7.7 Admissibility of Evidence
10.7.8 Documentary Evidence
10.7.9 Official Notice
10.7.10 Record of Hearing

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10.7.11 Postponement
10.7.12 Presence of Hearing Committee Members
10.7.13 Hearing Officer
10.7.14 Recesses and Adjournment
10.7.15 Decision and Findings of the Hearing Committee

10.8 Action on Hearing Committee Report
10.9 Notice and Effect of Hearing Result
10.10 Appeal to the Governing Body

10.10.1 Request or Waiver of Appellate Review
10.10.2 Notice of Time and Place of Appellate Review
10.10.3 Appointment and Membership of Appellate Review Committee
10.10.4 Appellate Review Procedure and Final Action
10.10.5 Nature of Proceedings
10.10.6 Written and Oral Statements
10.10.7 Hearing Officer
10.10.8 Consideration of New or Additional Matters
10.10.9 Recesses and Additional Evidence
10.10.10 Final Recommendation by the Appellate Review Committee
10.10.11 Final Decision by the Governing Body
10.10.12 Joint Conference Review [e.g., composed of members of the MEC and the governing body]

10.11 Reports to the National Practitioner Data Bank
The ***[facility/network]*** or its authorized representative must report all adverse actions, as defined in the Health Care Quality Improvement Act of 1986, to the National Practitioner Data Bank only upon the adoption by the governing body of such adverse action as being a final action of the governing body, or as otherwise required by law. The governing body's adoption of such adverse action as a final action must only occur after the hearing process set forth in the medical/professional staff Bylaws has been followed.

11. Medical/Professional Staff Organization

11.1 Officers (e.g., President, Vice President, Communications Officer, Immediate Past President, Secretary)
- *Number of officers on medical/professional staff*
- *Clear description of roles and duties of each office*
- *Specific qualifications required for election to each office*
- *Mechanism for nominating and electing members to each office (and filling vacancies in such offices as necessary)*
- *Grounds and process for recall and removal*
- *Term in office*

11.2 Medical/Professional Staff Meetings

11.2.1 *Regular Meetings*
11.2.2 *Special Meetings*

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11.2.3 *Notice of Meetings*
11.2.4 *Quorum*
11.2.5 *Minutes*

11.3 Committees
[State law may require certain medical/professional staff committees and may set forth required composition and functions]

11.3.1 *Medical Executive Committee*

11.3.1(i) ***[The Joint Commission requires and delineates specific duties and responsibilities as well as a conflict resolution mechanism that addresses conflict between the Medical Executive Committee and the medical/professional staff.]***

11.3.2 *Credentials Committee*

11.3.2(i) ***[Process that occurs when credentials committee member is in direct economic competition with an individual under review by the Credentials Committee***]
11.3.2(ii) ***[To avoid antitrust problems, require the credentials committee member to abstain in participating in all discussions and votes relating to the applicant in direct economic competition with credentials committee member.]***

11.3.3 *Administrative Committees (e.g., medical/professional staff bylaws committee, medical record utilization review committee, infection control committee, joint conference committee)*
11.3.4 Committee Meetings

11.3.4(i) *Regular Meetings*
11.3.4(ii) *Special Meetings*
11.3.4(iii) *Notice of Meetings*
11.3.4(iv) *Quorum*
11.3.4(v) *Minutes*

11.4 Services/Departments

11.4.1 *Describe the purpose and responsibility of services/departments.*

11.4.2 Anesthesia Director
[Consider the following language for CMS-certified hospital]

[Hospital]
Anesthesia services will be provided in an organized manner and function under the direction of an appropriately qualified MD/DO, in accordance with ***[State]*** state law, who is recommended by the ***[insert appropriate committee (e.g., medical executive committee) or medical/professional staff]*** and approved by the governing body.

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[Consider the following language for a critical access hospital with a separate anesthesia department/service. Note: state law may address qualifications for this role.]

[Critical Access Hospital]
Anesthesia services will be provided in an organized manner and function under the direction of an appropriately qualified practitioner (e.g., CRNA), in accordance with ***[State]*** state law, who is recommended by the ***[insert appropriate committee (e.g., medical executive committee) or medical/professional staff]*** and approved by the governing body.

12. Confidentiality
[Consult legal counsel to include appropriate facility/network-specific language in accordance with applicable law.]

12.1 Authorization
12.2 Confidentiality of Information
12.3 Activities and Information Covered
12.4 Credentials File
12.5 [Etc.]

13. Immunity from Liability and Indemnification
[Consult legal counsel to include appropriate facility/network- specific language in accordance with applicable law. The following is merely an example.]

13.1 Action Taken and Information Provided by Representatives
Each authorized representative of this healthcare facility (representative) is immune from liability to a practitioner, whether in judicial or other proceedings, for damages or other relief, for:

13.1.1 Any action taken, or statements or recommendations made within the scope of his/her duties as a representative; or

13.1.2 Providing information concerning any practitioner, including otherwise privileged or confidential information, to another representative or to any third party while performing his assigned duties in accordance with the Bylaws, Rules and Regulations, and defined policies and procedures, provided that such representative acts without malice. Regardless of any provisions of state law, to the contrary, truth is an absolute defense for a representative in all circumstances.

13.2 Information Provided by Third Parties
Each third party is immune from liability to a practitioner, whether in a judicial or other proceeding, for damages or other relief, for providing information without malice concerning any practitioner, including otherwise privileged or confidential information, to a representative.

13.3 Release and Covenant Not to Sue
The practitioner expressly agrees to release and hereby does release from liability and covenants not to sue or make claims against representatives and third parties for furnishing and passing to the ***[facility/network]*** any information disseminated without malice; and any representative for any act, communication,

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report, recommendation, or disclosure, regardless of whether well founded in act or law, provided that it is done or made without malice.

13.4 Activities Covered

The immunity of this section applies to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other healthcare facility or organization's activities, including, but not limited to:

13.4.1 Applications for appointment, reappointment, clinical privileges or modification thereof, and periodic reappraisals of the practitioner's status, clinical privileges, and/or prerogatives;

13.4.2 Corrective action (including summary or automatic relinquishment);

13.4.3 Hearings and appellate reviews;

13.4.4 Practitioner reviews, including without limitation utilization reviews, focused provider evaluations and patient care audits;

13.4.5 Other medical/professional staff committee activities related to monitoring or maintaining quality patient care and other appropriate professional conduct;

13.4.6 Peer review organizations and similar reports; and

13.4.7 Compliance with the Federal Health Care Quality Improvement Act (HCQIA) or any other applicable federal, state, or local law or regulation.

13.5 Privileges and Immunities. The governing body, any committees of the medical/professional staff and/or of the governing body who conduct Professional Review Activities and any individuals within the Health Care Entity authorized to conduct Professional Review Activities, hereby constitute themselves as Professional Review Bodies as defined in the Health Care Quality Improvement Act of 1986 and in the ***[Name of State]*** Act. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said federal and state statutes and regulations. Any action taken by a Professional Review Body pursuant to these medical/professional staff bylaws or the appointment procedure is in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care at the Health Care Entity) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any applicant or medical/professional staff appointee, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

13.6 Indemnification

[Consult legal counsel - provisions addressing indemnification are important to the facility/network bylaws, e.g., indemnification of medical/professional staff members who are sued as a result of peer review activities. It is important that these indemnification provisions are drafted in accordance with applicable law.]

14. Amendment

These bylaws may be amended after submission of the proposed amendment at any regular or special meetings of the medical/professional staff. A proposed amendment must be referred to ***[insert applicable committee]*** which must report on it at the next regular

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meeting of the medical/professional staff or at a special meeting called for such purpose. To be adopted, an amendment requires a two-thirds vote ***[or insert applicable percentage]*** of the active medical/professional staff. ***[Insert any requirements for physical presence at meeting, electronic, or mail-in voting.]*** Amendments so made are effective when approved by the governing body.

15. Governing Law

These medical/professional staff bylaws are governed by and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the ***[State]*** Act, and to the extent not so governed, with the other laws of the State of ***[State]*** without giving effect to its conflict of laws principles.

16. Notice to Members and Practitioners with Clinical Privileges

When bylaws, appendices, rules or policy provisions are adopted, materially amended or repealed, notice of the action and copies of any material changes provisions must be made available to all members and practitioners with clinical privileges.

17. Adoption

These bylaws ***[together with the appended rules and regulations],*** must be adopted at any regular or special meetings of the active medical/professional staff, replace any previous bylaws, ***[rules and regulations],*** and become effective when approved by the governing body of the ***[facility/network].***

ADOPTED BY ***[FACILITY/NETWORK]*** on the ***[day]***th day of ***[month], [year]***

_____

Medical/Professional Staff President

ADOPTED BY ***[FACILITY/NETWORK]*** GOVERNING BODY on the ***[day]***th day of ***[month], [year]***

_____

Governing Body President

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*See Introduction to Medical/Professional Staff Bylaws for resources consulted for this template.

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*These sample medical/professional staff bylaws are presented only as an example. They are intended to serve the purpose of familiarizing CRNAs with the various issues they should consider when reviewing medical staff bylaws. However, this sample should not be used without further consultation with attorney. The law varies in each jurisdiction and local and state regulations can notably affect these types of documents. Part of this sample medical/professional staff bylaw may be invalid, incomplete, or unenforceable based upon the jurisdiction in which it is executed and to be applied. In addition, the specific factual circumstances relating to any particular proposed transaction would like require changes to suit those circumstances.

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