Madonna Rehabilitation Hospital

Lincoln Campus:
5401 South Street
Lincoln, NE 68506

Omaha Campus:
17500 Burke Street
Omaha, NE 68118

MEDICAL STAFF BYLAWS

Part I: Governance

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Section 1. Definitions

The following definitions apply to the terms used as a part of the Medical Staff Bylaws ("Bylaws"):

"Allied Health Professionals" or **"AHP"** means individuals other than Medical Staff members who are authorized by law and by the Governing Body to provide patient care services at MRH.

"AMA" means the American Medical Association.

"CEO or designee" means the individual appointed by the Governing Body to act on its behalf in the overall management of MRH.

"Chief Medical Officer" or **"CMO"** means the individual appointed by the Board to act as the Chief Medical Officer and Chairperson of the Medical Executive Committee.

"Clinical Privileges" or **"Privileges"** means the authorization granted by the Board to render specific patient care services.

"CRC" means a Conflict Resolution Committee.

"Governing Body" or "Board" means the Board of Directors of Madonna Rehabilitation Hospital, which has the overall responsibility for the Hospital.

"Hospital" means, either individually or collectively, any hospital owned or operated by MRH.

"JCC" means Joint Conference Committee.

"MEC" means the Medical Executive Committee.

"Medical Staff" means practitioners appropriately licensed in the State of Nebraska to practice medicine and surgery, osteopathic medicine and surgery, dental medicine and surgery, podiatric medicine, or optometry, who provide care to patients admitted to hospital licensed units at MRH, and who are granted staff privileges by the Board.

"MRH" means Madonna Rehabilitation Hospital, a Nebraska nonprofit corporation, including Madonna Rehabilitation Hospital Lincoln, Madonna Rehabilitation Specialty Hospital Lincoln, Madonna Rehabilitation Hospital Omaha, and Madonna Rehabilitation Specialty Hospital Omaha.

"Notice" unless otherwise defined therein, shall mean written communication sent by certified or registered mail to the address shown on the applicant's most recent initial application or reappointment application, return receipt requested or by personal delivery receipted for and shall contain a reference to the appropriate section of the Bylaws for any deadline involved.

"Practitioner" means privileged provider at MRH.

Section 2. Medical Staff Purpose and Authority

2.1 Purpose

The purpose of this unified Medical Staff is to organize the activities of physicians and other clinical Practitioners who practice at MRH in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board. Specifically, the Medical Staff is to be responsible to the Board for the quality of patient care and treatment provided in MRH.

2.2 Authority

Subject to the authority and approval of the Board, the Medical Staff shall exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of MRH.

Section 3. Medical Staff Membership

3.1 Nature of Medical Staff Membership

Membership on the unified Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oromaxillofacial surgeons, podiatrists, and optometrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and the Hospital.

3.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials/Privileges Procedures).

3.3 Nondiscrimination

The Hospital shall not discriminate in granting Medical Staff appointment and/or Privileges on the basis of national origin, race, gender identity, religion, color, age, sexual orientation, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

3.4 Conditions and Duration of Appointment for Practitioners

The Board shall make initial appointments and reappointments to the Medical Staff. Appointments shall be based on review of credentialing and recommendations from the MEC. Subsequently, the Board shall act on appointment and reappointment only after the MEC has had an opportunity to submit a recommendation. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

3.5 Medical Staff Membership and Privileges for Practitioners

Requests for Medical Staff membership and/or Privileges shall be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or Privileges shall be granted and administered as delineated in Part III of these Bylaws (Credentials/Privileges Procedures).

3.6 Practitioner Responsibilities

3.6.1 Each Medical Staff member or other Practitioner with Privileges shall provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.

3.6.2 Each Practitioner shall participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions as assigned.

3.6.3 Each Practitioner shall submit to a health evaluation as requested by the MEC when it appears necessary to protect the well-being of patients and/or staff. This shall be considered part of an evaluation of the Practitioner's ability to exercise Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff or Hospital policies addressing Practitioner health or impairment.

3.6.4 Each Practitioner shall abide by these Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital.

3.6.5 Each Practitioner shall provide evidence of professional liability coverage of a type and in an amount established by the Board.

3.6.6 Each Practitioner agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the Practitioner and his/ her credentials.

3.6.7 Each Practitioner shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Practitioner provides care in the Hospital.

3.6.8 Each Practitioner shall use confidential information only as necessary for treatment, payment or health care operations in accordance with MRH policy, HIPAA laws, and any other applicable regulations. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives prior to disclosure.

3.6.9 Each Practitioner shall participate in competency evaluations when determined necessary by the MEC and/or Board in order to properly delineate that Practitioner's Privileges.

3.6.10 Each Practitioner shall maintain professional standards of conduct and behavior and abide by the AMA Code of Ethics.

3.6.11 Each Practitioner shall provide, with or without request, new or updated licensure, malpractice claims, felony convictions, exclusion from any state or federally funded program, loss of privileges at another hospital, or loss of DEA certificate to the Chief Medical Officer or designee as it occurs.

3.6.12 Each Practitioner shall support the mission of the Hospital to provide care appropriate to the Hospital population and to the region it serves and to disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital.

3.7 Medical Staff Member Rights

3.7.1 Each Medical Staff member has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC. In the event such Practitioner is unable to resolve a matter of concern after working with appropriate Medical Staff, that Practitioner may, upon written notice to the Chief Medical Officer or designee two (2) weeks in advance of a regular meeting, meet with the MEC to request to discuss the issue.

3.7.2 Each Medical Staff member may call a special meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by twenty-five percent (25%) of the Medical Staff members, the MEC shall schedule a special Medical Staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

3.7.3 Each Medical Staff member may challenge any rule or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty-five percent (25%) of the members of the Medical Staff. Upon presentation of such a petition, the amendment procedure outlined in Section 7.3 shall be followed. This section shall not be invoked to challenge a rule or policy during corrective action, which is addressed in Part I of these Bylaws

(Governance), Section 3.7.4 below.

3.7.4 The above sections 3.7.1 to 3.7.3 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or Privileges, or any other matter relating to individual membership or Privileges. Part II of these Bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan) provides recourse in these matters.

3.7.5 Any Medical Staff member has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan in Part II of these Bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan).

3.7.6 All Medical Staff members shall have access to the current Medical Staff Bylaws, as well as MEC meeting minutes by accessing the provider portal.

3.8 Immunity

3.8.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law and these Bylaws for the credentialing, peer review, and performance improvement work they perform on behalf of the Hospital and Medical Staff.

Section 4. Medical Staff Structure and Categories

4.1 Structure of the Medical Staff

4.1.1 The Medical Staff of MRH shall be structured as a non-departmentalized Medical Staff.

4.2 The Active Category

4.2.1 Qualifications

Members of this category qualify in accordance with the Bylaws and provide employed or contracted attending physician services at MRH. Active Staff demonstrate a commitment to participation on the MEC and to participate in performance and quality improvement functions. Active Staff contribute to program development or service expansion. In the event that a Medical Staff member does not meet the qualifications for the Active category, the member will be reassigned to an appropriate category with appropriate Privileges if s/he meets the eligibility requirements for such category.

4.2.2 Prerogatives

Members of this category may:

a. Admit and attend to patients; and

b. Exercise Clinical Privileges that have been granted.

4.2.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, and in the discharge of other staff functions as may be required;

c. Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures; and

d. Provide advisory services for program and service development.

4.3 The Consulting Category

4.3.1 Qualifications

Consulting Medical Staff shall consist of Practitioners who:

a. Qualify for Medical Staff membership in accordance with these Bylaws; and

b. Act only as consultants.

4.3.2 Prerogatives and Responsibilities

Members of this category may:

a. Provide consultations and ongoing care as needed;

b. Participate in peer review and performance improvement processes;

c. Serve on the MEC.

d. Should a Consulting Medical Staff member, through a contractual arrangement with MRH, provide admitting or attending services, such activity will require, without further action or approval, the transfer of Consulting category to Active Staff category.

4.4 The Honorary Category

The Honorary category is restricted to those individuals recommended by the MEC and approved by the Board. Once appointed, the status is ongoing and does not require reappointment or biennial review processing. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the Hospital. They may attend Medical Staff meetings and continuing medical education activities. They shall not hold Clinical Privileges, hold office, or be eligible to vote.

Section 5. Committees

5.1 Designation and Substitution

The MEC shall be the Medical Staff committee designated to carry out the purpose in Nebraska Rev. Statute 71-2046. Other standing and special committees can be established by the MEC and shall report to the MEC. Those functions requiring participation of, rather than direct oversight by the Medical Staff, may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The MEC may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

5.2 Medical Executive Committee

5.2.1 Composition: The MEC shall be a standing committee consisting of the officers and up to eleven (11) additional voting members from the Medical Staff. New members may be proposed by a member of the MEC and voted upon by the MEC with final approval by the Board. Each Hospital of a unified Medical Staff will have voting representation on the MEC.

a. **Officers of MEC:** The officers of the MEC will be the Chairperson and the Vice Chairperson. The Chairperson of the MEC will be the Chief Medical Officer. The Vice Chairperson will be nominated by the Chairperson, approved by the MEC, with final approval by the Board. A vacancy in the office of Chairperson of MEC will be filled by the Vice Chairperson of MEC, who will serve temporarily until the Chairperson of MEC is replaced. Vice Chairperson of MEC will serve a two (2)-year term, with renewal based on approval of MEC.

b. **Other members:** The CEO or designee, the Vice President of Patient Care, the Director of Quality and Risk Management, and other designated leaders from MRH shall be ex officio non-voting members of the MEC.

5.2.2 Duties: The duties of the MEC, as delegated by the Board, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with these Bylaws and provide oversight for all Medical Staff functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Privileges, and corrective action;

d. Report to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff members, including collegial and educational efforts and investigations when warranted, and receive additional reports from the CMO or designee regarding physician quality competency and behavior;

f. Make recommendations to the Board on medical administrative and Hospital management matters;

g. Advise and consult with the CEO or designee with regard to all matters of mutual concern;

h. Give guidance and review quality and patient safety indicators;

i. Participate in performance improvement efforts;

j. The MEC delegates the development of policies and procedures to minimize medication errors to the Medication Safety Committees;

k. Review, develop, and approve Hospital medical policies, procedures, and protocols that guide and support the provision of patient care services;

l. Determine procedures and treatments that require informed consent;

m. Allied Health Professional Activities:

(i) determine categories of AHPs providing services at MRH

(ii) determine credentialing process for AHPs

(iii) make written recommendations concerning AHP initial applications, reappointments, and annual reviews to the Board

n. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

o. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

p. Review and act on reports from Medical Staff committees and other assigned activity groups;

q. Formulate and recommend to the Board, Medical Staff rules, policies, protocols, and procedures;

r. Request evaluations of Practitioners privileged through the Medical Staff process when there is question about an applicant or Medical Staff member's ability to perform Privileges requested or currently granted;

s. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or Privileges may be terminated, and the mechanisms for fair hearing procedures;

t. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;

u. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;

v. Hold Medical Staff leaders and committees accountable for fulfilling their duties and responsibilities; and

w. Conduct votes of the Medical Staff.

5.2.3 Meetings: The MEC shall meet at least quarterly each year, and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

a. MEC members will be provided notice of all regular meetings including date, time, and place.

b. The MEC Chairperson will set the agenda for MEC meetings.

c. Members of the MEC are expected to attend at least fifty percent (50%) of all meetings.

d. MEC meetings shall be run in a manner determined by the Chairperson of the meeting. Recommendations and actions will be determined by majority vote of members present. At least five (5) of the MEC voting members must be present in order to vote.

e. Minutes of all MEC meetings will be prepared and will include a record of members in attendance, issues discussed, recommendations made and votes taken, decisions made, and next steps.

5.3 Qualifications of MEC Officers

5.3.1 Only those members of the Medical Staff who satisfy the following criteria initially and continuously will be eligible to serve as an officer of the MEC, unless waived by the Board after considering recommendations of MEC. These members must:

a. Be appointed and in good standing to the Medical Staff;

b. Be board-certified by a medical or surgical specialty;

c. Have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges;

d. Have experience in a leadership position;

e. Indicate a willingness and ability to serve;

f. Be willing to participate in continuing education relating to Medical Staff leadership and/or credentialing or peer review functions prior to or during the term of office, as determined by the MEC; and

g. Have demonstrated an ability to work well with others.

5.3.2 MEC officers may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the Hospital. Non-compliance with this requirement shall result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the Hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

5.4 Duties of MEC Officers and MEC Members

5.4.1 The MEC Chairperson will:

a. Act in coordination and cooperation with MRH administration and Board in matters of mutual concern involving the care of patients in MRH;

b. Represent and communicate the views, policies, and needs of the Medical Staff and report on the activities of the Medical Staff to the CEO or designee and the Board;

c. Report to the Medical Staff on activities of the MEC and the Board through meetings and other appropriate means;

d. Call, preside at, and be responsible for the agenda of all meetings of the MEC;

e. Chair the MEC as a voting member;

f. Be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within MRH, and for the effectiveness of patient care evaluations and the quality improvement functions delegated to the Medical Staff;

g. Promote adherence to, and be responsible for, the enforcement of the Medical Staff Bylaws, rules, regulations, and policies, and for implementation of actions, including collegial intervention taken consistent with these documents; and

h. Serve as a support staff member, attending meetings of the Board.

5.4.2 The MEC Vice Chairperson will:

a. Assume all duties of the Chairperson and act with full authority as the Chairperson in his or her absence;

b. Serve on the MEC as a voting member; and

c. Assume all such additional duties as are assigned to him or her by the MEC Chairperson, the MEC, or the Board.

5.4.3 MEC Members:

MEC members are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty.

5.5 Removal

5.5.1 Removal of an MEC officer or a member of the MEC may be initiated for:

a. Failure to comply with applicable policies, Bylaws, or rules and regulations;

b. Failure to continue to satisfy any of the qualification criteria of these Bylaws;

c. Failure to perform the duties of the position held;

d. Conduct detrimental to the interests of the Medical Staff or MRH; or

e. An infirmity that renders the individual incapable of fulfilling the duties of that office.

5.5.2 Removal of the Vice Chairperson or a member of the MEC may be completed if at least sixty percent (60%) of the MEC vote such action.

5.5.3 At least ten (10) days prior to the initiation of any removal action, the individual will be given written notice of the date of the meeting at which action is to be considered. The individual will be afforded an opportunity to speak to the MEC, as applicable, prior to removal.

Section 6. Conflict Resolution

6.1 Conflict Resolution – Board and MEC

6.1.1. In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may, at the request of the Board or MEC, be submitted to a JCC. The JCC shall be composed of the two (2) officers of the MEC and an equal number of members of the Board. The JCC shall review and make a recommendation to the full Board. The JCC shall submit its report to the Board within thirty (30) days of its meeting. In addition, individual JCC participants may submit individual written reports to the Board. Following receipt of the report or reports, the Board may make a final decision on the matter.

6.1.2 In addition to conflicts involving actions before the Board, the Chairperson of the Board or the Chairperson of the MEC may call for a JCC meeting as described above at any time and for any reason in order to seek direct input from the Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.

6.2 Conflict Resolution – MEC and Medical Staff

6.2.1 In the event of a conflict between the members of the Medical Staff and the MEC regarding the adoption or enforcement of any Bylaw, rule, regulation, or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by twenty-five percent (25%) of the members of the Medical Staff, the matter shall be submitted to the conflict resolution process described in this Section 6. In such case, a CRC shall be formed consisting of an equal number of Medical Staff members designated by the Medical Staff and representatives of the MEC appointed by the Chairperson of the MEC. The CEO or designee shall be an ex officio non-voting member of any CRC formed under this Section 6.

6.2.2 Following conclusion of the CRC process, the MEC or Medical Staff members shall implement any consensus reached, or, if consensus is not reached, the MEC or Medical Staff members may proceed with the action that prompted the disagreement, provided, that if it is an action requiring Board or Medical Staff approval, such approval shall be required.

6.2.3 Any matter presented to the Board for approval by the MEC or Medical Staff members as to which the Board is advised there is a significant unresolved disagreement between the MEC and Medical Staff members, may, at the election of the Board, be submitted to an expanded JCC process as described in Section 6.1 with four (4) additional JCC members representing the Medical Staff also participating.

6.2.4 In the event of a dispute between or among the leaders or segments of the Medical Staff, the matter in dispute may, at the election of the MEC, be submitted to a CRC composed of an equal number of members representing opposing viewpoints who are appointed by the Chairperson of the MEC or the MEC and who will meet under the supervision of the MEC. Alternatively, the MEC may facilitate and preside over a meeting to discuss differences. At the conclusion of the process, the MEC may take action to resolve the differences, provided that any action that requires approval of the Board or Medical Staff will obtain such approval.

6.3 General Standards

6.3.1 The members of the JCC or CRC shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with a desire to maintain smooth operations and high quality care for patients.

6.3.2 If deemed appropriate by the Chairperson of the MEC and the CEO or designee, a non-biased outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

Section 7. Review, Revision, Adoption, and Amendment

7.1 Adoption and Amendment of Bylaws, Generally

The MEC adopts and amends Medical Staff Bylaws, following the processes described in this Section 7, and such Bylaws and amendments become effective only when approved by the Board. Neither the MEC nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations.

7.1.1 The MEC shall follow a process for biennial review of the Bylaws.

7.1.2 In addition to the biennial review process, amendments to the Bylaws and policies may be proposed and acted upon as described below.

7.2 Medical Staff Unification/Disunification

7.2.1 Unification with other Medical Staffs

Not more than every two (2) years, the Medical Staff may vote to be included in a unified Medical Staff of MRH in which the Hospital participates only after:

a. Prior written notice to all Medical Staff members describing the proposed unification, setting forth its risks, benefits, and effects to the Medical Staff and its members;

b. The MEC concurs following review and study; and

c. A majority of all Medical Staff members with voting rights who hold Clinical Privileges to practice on-site at the Hospital and cast votes in favor of unification. The MEC shall determine whether the Medical Staff votes:

(i) at a special meeting called for that purpose, or

(ii) via confidential mail or electronic balloting.

If all these requirements are not met, the Medical Staff shall remain separate from any system-unified Hospital and continue as the Medical Staff of the Hospital. If the Medical Staff votes to accept unification, these Medical Staff Bylaws will remain in effect as to the members, until the Medical Staff Bylaws are amended or new Medical Staff Bylaws are adopted pursuant to the terms of these Bylaws.

7.2.2 Disunification from other Medical Staffs

Not more than every two (2) years, the Medical Staff may vote to disunify by a majority of votes cast by all Medical Staff members with voting rights who hold Clinical Privileges to practice on-site at the Hospital.

7.3 Bylaw Amendment with MEC Approval

7.3.1 Bylaw amendments shall be submitted to the MEC for consideration and shall be discussed by the MEC prior to vote. The MEC shall vote on proposed amendments at a regular meeting or a special meeting called for such purpose.

7.3.2 Bylaw amendments are approved upon receiving consensus or the affirmative vote of a majority of the MEC members present. Members of the MEC shall receive at least three (3) days advance notice of the proposed changes. Amendments, when so approved by the MEC, will be forwarded to the Board and effective only when approved by the Board.

7.3.3 If the Board *rejects* an amendment that has been approved by the MEC, it shall notify the MEC. If the MEC requests, the Board shall invoke the conflict resolution process through the JCC, as described in Section 6 of this Part I of these Bylaws.

7.3.4 If the Board *modifies* an amendment that has been approved by the MEC, the amendment, as modified, shall be returned to the MEC, which may accept or reject the modifications. If the MEC rejects the modifications, it shall notify the Board and the Board shall invoke the conflict resolution process described in Section 6 of this Part I of these Bylaws.

7.4 Resolution of Differences

The responsibilities described in this Section 7 shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various Sections of these Bylaws.

7.5 Adoption and Amendment of Rules, Regulations, and Policies

7.5.1 The MEC may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.

7.5.2 Rules, regulations, and policies may be adopted by the MEC and are effective when approved by the Board. The CEO or designee reviews proposed rules, regulations, and policies, and amendments thereto, for consistency with MRH corporate bylaws and policies and regulatory requirements.

7.5.3 In the event the Chief Medical Officer or designee determines there is a documented need for an urgent amendment to rules and regulations, or the adoption of a new rule or regulation to comply with a law or regulation, the CMO or designee may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the rules and regulations without prior notification to the MEC. In such event, the MEC shall be immediately notified of the amendment and shall vote on the provisional amendment within fifteen (15) calendar days of notification. Any conflicts between the MEC and the Board related to the provisional amendment shall be submitted to the conflict resolution process described in Section 6 of these Bylaws. The results of the conflict resolution process shall be communicated to the MEC and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

7.6 Technical Corrections and Amendments

The MEC may adopt such amendments to these Bylaws, that are, in the MEC's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but shall be approved by the Chairperson of the Board or designee.

APPROVED by the Medical Executive Committee:

_____

Donald Schmidt, M.D. Date
Chairperson of the Medical Executive Committee

APPROVED by the Governing Authority:

_____

Lauren Pugliese Date
Chairperson of the Board of Directors

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MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

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"Chief Medical Officer" or **"CMO"** means the individual appointed by the Board to act as the Chief Medical Officer and Chairperson of the Medical Executive Committee.

"Clinical Privileges" or **"Privileges"** means the authorization granted by the Board to render specific patient care services.
"DEA" means U.S. Drug Enforcement Administration.

"FPPE" means focused professional practice evaluation.

"GSA" means the U.S. General Services Administration.

"Governing Body" or "Board" means the Board of Directors of Madonna Rehabilitation Hospital, which has the overall responsibility for the Hospital.

"Hospital" means, either individually or collectively, any hospital owned or operated by MRH.

"MEC" means the Medical Executive Committee.

"Medical Staff" means practitioners appropriately licensed in the State of Nebraska to practice medicine and surgery, osteopathic medicine and surgery, dental medicine and surgery, podiatric medicine, or optometry, who provide care to patients admitted to hospital licensed units at MRH, and who are granted staff privileges by the Board.

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"NPDB" means the National Practitioner Data Bank.

“OIG” means Office of Inspector General.

“Practitioner” means privileged provider at MRH.

“SAM” means System for Award Management, a U.S. government website.

Section 2. Collegial, Educational, and/or Informal Proceedings

2.1 Collegial Intervention

These Bylaws encourage Medical Staff leaders and Hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to a Practitioner's clinical practice and/or professional conduct. The goal of these progressive steps is to help the Practitioners voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and Hospital management shall be treated as part of the Hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. When any observations arise suggesting opportunities for a Practitioner to improve, the matter may be referred to the CMO or designee. Collegial intervention efforts may include but are not limited to the following:

2.1.1 Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2.1.2 Following up on any questions or concerns raised about the clinical practice and/or conduct of Practitioners and recommending steps to improve performance; and

2.1.3 Sharing summary comparative quality, utilization, and other relevant information to assist Practitioners to conform their practices to appropriate norms.

2.2 Criteria for Initiating Investigation or Corrective Action

Investigation or corrective action may be initiated when the person or body initiating it has reason to believe that:

2.2.1 A Practitioner has failed to meet the Practitioner responsibilities as outlined in Part I of these Bylaws (Governance), Section 3.6; or elsewhere in these Bylaws, or

2.2.2 A Practitioner is not meeting the qualifications and criteria of Medical Staff membership or Privileges held by the Practitioner.

Section 3. Investigations

3.1 Initiation

A request for an investigation or corrective action may be submitted by a member of the Medical Staff, CEO or designee, the CMO or designee, or by the MEC on its own initiative. The request shall be supported by references to the specific activities or conduct that is of concern. If the MEC initiates an investigation, it shall appropriately document its reasons. The Board shall be notified of all decisions regarding whether or not the MEC has determined an investigation is necessary. In lieu of investigation, the MEC may direct a period of FPPE or other fact-finding steps.

3.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation be undertaken through the adoption of a formal resolution communicated to the Practitioner. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

If the investigation is delegated to a person or group other than the MEC, such person or committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO or designee. The investigating body may also require the Practitioner under review to undergo a physical and/or psychological examination and may access the results of such exams. The investigating body shall notify the Practitioner in question that the investigation is being conducted and offer an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the Practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

3.2.1 An external peer review consultant should be considered when:

- **a.** Litigation seems likely;
- **b.** The Hospital is faced with ambiguous or conflicting recommendations from investigating team or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;
- **c.** There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the Practitioner under review.

3.3 MEC Action

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

3.3.1 Determining not to take corrective action; and if the MEC determines there is not credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner's file;

3.3.2 Deferring action for a reasonable time when circumstances warrant;

3.3.3 Issuing letters of admonition, censure, guidance, warning, or reprimand although nothing herein shall be deemed to preclude appropriate supervisors from issuing informal written or oral warnings prior to or in the absence of an investigation. In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in the Practitioner's file;

3.3.4 Placing the Practitioner under FPPE or concurrent monitoring for a period of time;

3.3.5 Recommending special limitation upon continued Medical Staff membership or exercise of Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

3.3.6 Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of Privileges;

3.3.7 Recommending reductions of Medical Staff membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;

3.3.8 Recommending suspension, revocation, or probation of Medical Staff membership;

3.3.9 Taking other actions deemed appropriate under the circumstances.

3.4 Subsequent Action

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

Section 4. Corrective Action

4.1 Automatic Relinquishment or Limitation/Voluntary Resignation

In the following instances, the Practitioner's Privileges and/or Medical Staff membership shall be considered relinquished or limited as described, and the action shall be final without a right to hearing.

Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation shall stand until the MEC determines it is not applicable. The MEC shall make such a determination as soon as practicable. The Chief Medical Officer or designee, at the recommendation of the MEC, may reinstate the Practitioner's Privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) calendar days, the Practitioner shall be required to apply for reinstatement before Medical Staff membership and/or Privileges are fully restored. In addition, further corrective action may be recommended in accordance with these Bylaws whenever the MEC deems it is warranted. Automatic relinquishment is appropriate whenever any of the following actions occur:

4.1.1 Licensure

a. **Revocation and Suspension:** Whenever a Practitioner's license or other legal credential authorizing practice in Nebraska is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and Privileges shall be automatically relinquished by the Practitioner as of the date such action becomes effective**.**

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

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

d. **Medicare, Medicaid, Tricare, or other Federal Programs:** Whenever a Practitioner is barred from participating in Medicare, Medicaid, Tricare, or other federally funded health care programs, Medical Staff membership and Privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the OIG List of Excluded Individuals/Entities or the GSA Excluded Parties List System/SAM Exclusions database shall be considered to have automatically relinquished his or her Privileges.

4.1.2 Controlled substances

a. **DEA certificate**: Whenever a Practitioner's DEA certificate is revoked, limited, or suspended, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

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

4.1.3 **Medical record completion requirements**: Failure of a Practitioner to maintain medical records may result in automatic suspension or termination of the Practitioner's Medical Staff membership and Privileges.

4.1.4 **Professional liability insurance**: Failure of a Practitioner to maintain professional liability insurance of a type and in the amount required by the Board shall result in immediate automatic suspension of a Practitioner's Privileges. If within sixty (60) calendar days of the relinquishment, the Practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the Practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The Practitioner shall notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage.

4.1.5 **Failure to satisfy the special appearance requirement**: A Practitioner who fails, without good cause, to appear at a meeting after two (2) notices where his/her special appearance is required, shall be considered to have automatically relinquished all Privileges with the exception of emergencies. These Privileges shall be restored when the Practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days shall be considered a voluntary resignation from the Medical Staff.

4.1.6 **Failure to participate in an evaluation**: A Practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership or Privileges, as required under these Bylaws (whether an evaluation of physical or psychological health or of clinical management skills), shall be considered to have automatically relinquished all Privileges until the Practitioner participates in the evaluation. Failure to comply within thirty (30) calendar days shall be considered a voluntary resignation from the Medical Staff.

4.1.7 **Failure to execute release and/or provide documents:** A Practitioner who fails to execute a general or specific release and/or provide documents when requested by the CMO or designee to evaluate the competency and credentialing/privileging qualifications of the Practitioner shall be considered to have automatically relinquished all Privileges. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the Practitioner may be reinstated. If the release is not executed or the documents are not provided within thirty (30) calendar days, the Practitioner shall be deemed to

have resigned voluntarily from the Medical Staff and shall reapply for Medical Staff membership and Privileges.

4.1.8 MEC deliberation: As soon as practicable after action is taken or warranted, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in Section 4.1 above.

4.2 Precautionary Restriction or Suspension

4.2.1 Criteria for initiation: A precautionary restriction or suspension may be imposed when in the judgment of the CMO or designee, CEO or designee, immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person, or when Medical Staff leaders and/or the CEO or designee determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety, the effective operation of MRH, the compliance or financial status of the Hospital, or when the reputation of the Medical Staff or Hospital is at stake. Under such circumstances either the CEO or designee, or CMO or designee, or the MEC may restrict or suspend the Medical Staff membership or Privileges of such Practitioner as a precaution. A suspension of all or any portion of a Practitioner's Clinical Privileges at another hospital may be grounds for a precautionary suspension of all or any of the Practitioner's Clinical Privileges at this Hospital.

a. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Practitioner, the MEC, the CEO or designee, and the Board. If imposed by an individual, this decision shall be ratified by the MEC as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan), to remain effective.

b. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, is not disciplinary in nature, and it shall not imply any final finding regarding the circumstances that caused the suspension.

c. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Medical Staff member by the CMO or designee, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute Practitioner.

4.2.2 MEC action: As soon as practicable, and within fourteen (14) calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in above. Upon request, and at the discretion of the MEC, the Practitioner shall be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Practitioner, constitute a "hearing" as defined in this

hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event, it shall furnish the Practitioner with notice of its decision.

4.2.3 **Procedural rights**: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation, the Practitioner shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than fourteen (14) calendar days.

4.3 Administrative Time Out

The MEC may, with approval of the CEO or designee and the Board Chairperson, institute one (1) or more administrative time outs for a Practitioner for a cumulative period not to exceed seven (7) consecutive calendar days. During an administrative time out the Practitioner may not exercise any Clinical Privileges except in an emergency situation. An administrative time out may be instituted only for non-clinical matters and when all of the following conditions are met:

4.3.1 When the action that has given rise to the time out relates to one (1) of the following policies of the Medical Staff: completion of medical records, Workplace Violence Prevention Policy, or the AMA Code of Ethics;

4.3.2 When the action(s) have been reviewed by the MEC and only when the MEC has determined that one (1) or more of the above have been violated;

4.3.3 When the affected Practitioner has been offered an opportunity to meet with the MEC prior to the imposition of the administrative time out. Failure on the part of the Practitioner to accept the MEC's offer of a meeting shall constitute a violation of the Medical Staff Bylaws regarding special meetings and shall not prevent the MEC from issuing the administrative time out.

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

Section 5. Initiation and Notice of Hearing

5.1 Grounds for Hearing

Any Practitioner eligible for Medical Staff reappointment/reprivileging shall be entitled to request a hearing whenever the MEC recommends and the Board takes action, either upon the recommendation or acting in its own discretion, one (1) of the following adverse actions based on the Practitioner's clinical competence or professional conduct, which conduct may adversely affect patient welfare:

5.1.1 Denial of Medical Staff reappointment;

5.1.2 Revocation of Medical Staff appointment;

5.1.3 Denial or restriction of requested Privileges;

5.1.4 Involuntary reduction or revocation of Privileges;

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

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

5.2 Hearings Shall Not Be Triggered by the Following Actions

The following actions shall not trigger a right to a hearing. The MEC may, nevertheless, grant a hearing if it determines any such action under the circumstances of the case will require a report to the NPDB:

5.2.1 Issuance of a letter of admonition, censure, guidance, warning, or reprimand that does not affect reappointment, Privileges, or action beyond fourteen (14) calendar days;

5.2.2 Imposition of a requirement for proctoring (i.e., observation of the Practitioner's performance by a peer in order to provide information to a Medical Staff peer review committee) or concurrent monitoring with no restriction on Privileges;

5.2.3 Failure to process a request for a Privilege when the applicant/Medical Staff member does not meet the eligibility criteria to hold that Privilege;

5.2.4 Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

5.2.5 Conducting or extending FPPE of the Practitioner;

5.2.6 Requirement to appear for a special meeting under the provisions of these Bylaws;

5.2.7 Automatic relinquishment or voluntary resignation of appointment or Privileges;

5.2.8 Imposition of a precautionary suspension or administrative time out that does not exceed fourteen (14) calendar days;

5.2.9 Denial of a request for leave of absence, or for an extension of a leave;

5.2.10 Determination that an application is incomplete or untimely;

5.2.11 Determination that an application shall not be processed due to misstatement or omission;

5.2.12 Decision not to expedite an application;

5.2.13 Termination or limitation of temporary Privileges unless for demonstrated incompetence or unprofessional conduct;

5.2.14 Determination that an applicant for membership does not meet the requisite qualifications/criteria for Medical Staff membership;

5.2.15 Ineligibility to request Medical Staff membership or Privileges or continue Privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive Provider agreement;

5.2.16 Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

5.2.17 Termination of any contract with or employment by Hospital;

5.2.18 Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill accreditation or regulatory standards on FPPE;

5.2.19 Any recommendation voluntarily accepted by the Practitioner;

5.2.20 Expiration of membership and Privileges as a result of failure to submit an application for reappointment within the allowable time period;

5.2.21 Change in assigned Medical Staff category;

5.2.22 Refusal of the MEC to consider a request for appointment, reappointment, or Privileges within three (3) years of a final adverse decision regarding such request;

5.2.23 Any requirement to complete an educational assessment;

5.2.24 Retrospective chart review;

5.2.25 Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;

5.2.26 Grant of conditional appointment or appointment for a limited duration;

5.2.27 Appointment or reappointment for duration of less than twenty-four (24) months;

5.2.28 Denial, suspension, reduction, or revocation of Privileges of an Allied Health Practitioner with whom the Practitioner has a supervisory or collaborative relationship.

5.3 Notice of Recommendation

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

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

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

5.3.3 Notification that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the NPDB;

5.3.4 The individual shall receive a copy of Part II of these Bylaws (Investigations,

Corrective Actions, Hearing and Appeal Plan) outlining procedural rights with regard to the hearing.

5.4 Request for Hearing

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

5.5 Notice of Hearing and Statement of Reasons

The CEO or designee shall schedule the hearing and shall give written Notice to the person who requested the hearing. The Notice shall include:

5.5.1 The time, place, and date of the hearing;

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

5.5.3 The names of the hearing panel members and presiding officer or hearing officer, if known; and

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

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

5.6 Witness List

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

Section 6. Hearing Panel and Presiding Officer or Hearing Officer

6.1 Hearing Panel

6.1.1 When a hearing is requested as a result of a MEC action involving direct clinical care, the Chief Medical Officer or designee, after considering the recommendations of the MEC, shall appoint a hearing panel.

6.1.2 When a hearing is requested as a result of a Board action or as the result of a matter that does not involve direct clinical care, the CEO or designee, acting for the Board, and after considering the recommendations of the Chief Medical Officer or designee or those of the Chairperson of the Board, shall appoint a hearing panel or a hearing officer.

6.1.3 The hearing panel shall be composed of not fewer than three (3) individuals. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the Hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

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

6.1.5 The CEO or designee shall notify the Practitioner requesting the hearing of the names of the panel members and the date by which the Practitioner shall object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO or designee, who shall determine whether a replacement panel member should be identified. Although the Practitioner who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members shall rest with the CEO or designee.

6.2 Hearing Panel Chairperson or Presiding Officer

6.2.1 In lieu of a hearing panel chair, the CEO or designee, acting for the Board, and after considering the recommendations of the Chief Medical Officer or designee, or those of the Chairperson of the Board if the hearing is occasioned by a Board determination, may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. Such presiding officer shall not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

6.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be

appointed by the CEO or designee from among the hearing panel members to serve as the presiding officer and shall be entitled to one (1) vote.

6.2.3 The presiding officer, or hearing panel chair, shall do the following:

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

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing shall last no more than eight (8) hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

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

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

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

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

i. Conduct pre-hearing proceedings to organize and rule on witnesses, evidence and testimony.

6.3 Hearing Officer

If the hearing is occasioned by a Board determination, or as the result of a matter not involving direct clinical care, then a hearing officer may be appointed as an alternative to the hearing panel described in Section 6.1. Under these circumstances, the CEO or designee, acting for the Board and after considering the recommendations of the Chief Medical Officer or designee or those of the Chairperson of the Board, may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney.

The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 7. Pre-Hearing and Hearing Procedure

7.1 Provision of Relevant Information

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

- **a.** Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons that will be introduced or testified to in the MEC's or the Board's case, at his or her expense;
- **b.** Reports of experts relied upon by the MEC that will be introduced or testified to in the MEC's or the Board's case;
- **c.** Copies of redacted relevant committee minutes that will be introduced or testified to in the MEC's or the Board's case;
- **d.** Copies of any other documents relied upon by the MEC or the Board that will be introduced or testified to in the MEC's or the Board's case;
- **e.** No information regarding other Practitioners shall be requested, provided, or considered;
- **f.** Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant Clinical Privileges shall be excluded.

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

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

7.1.4 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the Hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the Hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or his/her counsel or directed by the presiding officer.

7.2 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or

witnesses, and determine the time to be allotted to each witness's testimony and cross-examination.

7.3 Failure to Appear

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

7.4 Record of Hearing

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

7.5 Rights of the Practitioner and the Hospital

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

- **a.** To call and examine witnesses to the extent available;
- **b.** To introduce exhibits;
- **c.** To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- **d.** To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may call, examine, cross-examine witnesses, and present the case. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
- **e.** To submit a written statement at the close of the hearing.

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

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

7.6 Admissibility of Evidence

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

7.7 Burden of Proof

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

7.8 Post-Hearing Memoranda

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

7.9 Official Notice

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

7.10 Postponements and Extensions

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

7.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CMO or designee or CEO or designee. One (1) or more representatives of the MEC or the Board, whose action or recommendation triggered the hearing, may be present.

7.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.13 Basis of Recommendation

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

7.14 Adjournment and Conclusion

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

7.15 Deliberations and Recommendation of the Hearing Panel

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

7.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the CEO or designee, who shall forward it, along with all supporting documentation, to the Board for further action. The CEO or designee shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

Section 8. Appeal to the Hospital Board

8.1 Time for Appeal

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

8.2 Grounds for Appeal

A party requesting an appeal shall be required to state the grounds for an appeal and to describe the basis for believing the grounds to be supported. The grounds for appeal shall be limited to the following:

8.2.1 There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or

8.2.2 The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

8.2.3 The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

8.3 Time, Place, and Notice

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

8.4 Nature of Appellate Review

8.4.1 The Chairperson of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the Practitioner under review.

8.4.2 The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence may be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

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

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

8.5 Final Decision of the Hospital Board

Within forty (40) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the Chairperson of the MEC, in person or by certified mail, return receipt requested.

8.6 Right to One Hearing and Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter that may be the subject of an appeal. If a Practitioner requests a hearing in connection with a precautionary suspension or limitation which is followed by an adverse action or recommendation listed in Part II of these Bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan), the hearings shall be combined.

8.7 Time Period for Reapplication

In the event that the Board ultimately determines to deny Medical Staff appointment, reappointment, or Clinical Privileges to an applicant, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges of a current member, that individual may not apply within three (3) years for Medical Staff appointment or for those Privileges at this Hospital, unless the Board advises otherwise.

APPROVED by the Medical Executive Committee:

_____

Donald Schmidt, M.D. Date
Chairperson of Medical Executive Committee

APPROVED by the Governing Authority:

_____

Lauren Pugliese Date
Chairperson of the Board of Directors

Madonna Rehabilitation Hospital

Lincoln Campus:
5401 South Street
Lincoln, NE 68506

Omaha Campus:
17500 Burke Street
Omaha, NE 68118

MEDICAL STAFF BYLAWS

Part III: Credentials/Privileges Procedures

Table of Contents

Section 1. Definitions

The following definitions apply to the terms used as a part of the Medical Staff Bylaws ("Bylaws"):

"ABMS" means the American Board of Medical Specialties.

"ACGME" means the Accreditation Council for Graduate Medical Education.

"ADA" means the American Dental Association.

"Allied Health Professionals" or **"AHP"** means individuals other than Medical Staff members who are authorized by law and by the Governing Body to provide patient care services at MRH.

"AOA" means the American Osteopathic Association.

"APMA" means the American Podiatric Medical Association.

"APRN" means Advanced Practice Registered Nurse.

"CEO or designee" means the individual appointed by the Governing Body to act on its behalf in the overall management of MRH.

"Chief Medical Officer" or **"CMO"** means the individual appointed by the Board to act as the Chief Medical Officer and Chairperson of the Medical Executive Committee.

"Clinical Privileges" or **"Privileges"** means the authorization granted by the Board to render specific patient care services.

"CVO" means credentials verification organization.

"DEA" means U.S. Drug Enforcement Administration.

"DHHS" means Department of Health and Human Services.

"DMAT" means Disaster Medical Assistance Team.

"DPM" means Doctor of Podiatric Medicine.

"ESAR-VHP" means Emergency System for Advance Registration of Volunteer Health Professionals.

"FDA" means U.S. Food and Drug Administration.

"FPPE" means focused professional practice evaluation.

"Governing Body" or "Board" means the Board of Directors of Madonna Rehabilitation Hospital, which has the overall responsibility for the Hospital.

"Hospital" means, either individually or collectively, any hospital owned or operated by MRH.

"H&P" means History & Physical.

"MEC" means the Medical Executive Committee.

"Medical Staff" means practitioners appropriately licensed in the State of Nebraska to practice medicine and surgery, osteopathic medicine and surgery, dental medicine and surgery, podiatric medicine, or optometry, who provide care to patients admitted to hospital licensed units at MRH, and who are granted staff privileges by the Board.

"MRC" means Medical Reserve Corps.

"MRH" means Madonna Rehabilitation Hospital, a Nebraska nonprofit corporation, including Madonna Rehabilitation Hospital Lincoln, Madonna Rehabilitation Specialty Hospital Lincoln, Madonna Rehabilitation Hospital Omaha, and Madonna Rehabilitation Specialty Hospital Omaha.

"Notice" unless otherwise defined therein, shall mean written communication sent by certified or registered mail to the address shown on the applicant's most recent initial application or reappointment application, return receipt requested or by personal delivery receipted for and shall contain a reference to the appropriate section of the Bylaws for any deadline involved.

"NPDB" means the National Practitioner Data Bank.

"OIG" means Office of Inspector General.

"OPPE" means ongoing professional practice evaluation.

"OSHA" means Occupational Safety and Health Administration.

"PA" means Physician Assistant.

"Practitioner" means privileged provider at MRH.

"SAM" means System for Award Management, a U.S. government website.

Section 2. Qualifications for Membership and/or Privileges

2.1 No Practitioner shall be entitled to membership on the Medical Staff or to Privileges merely by virtue of licensure, membership in any professional organization, or Privileges at any other health care organization.

2.2 Exceptions

2.2.1 Only the Board may create additional exceptions to the below Section 2.3 or 2.4 after recommendation from the MEC.

2.3 Qualifications

The following qualifications shall be met by all applicants for Medical Staff appointment, reappointment, or Privileges:

2.3.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, optometry, or an applicable recognized course of training in a clinical profession eligible to hold Privileges;

2.3.2 Be currently licensed or otherwise authorized to practice his/her profession in Nebraska in accordance with state licensing requirements;

2.3.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities or the SAM excluded provider database;

2.3.4 A physician applicant, M.D. or DO, shall have successfully completed an allopathic or osteopathic residency program, approved by the ACGME or the AOA and have evidence of passing board certification at initial appointment or become board certified within five (5) years of completing formal training or as defined by the appropriate specialty board of the ABMS or the AOA. Exceptions for physicians trained outside of the United States will be considered by the CMO or designee based on standards similar to the ACGME or the AOA. Physicians initially credentialed prior to December 2015 will be grandfathered (excepted) from this provision.

2.3.5 Dentists shall have graduated from an ADA-approved school of dentistry accredited by the Commission of Dental Accreditation, and have completed a hospital-based residency in general dentistry, a dental specialty residency, or have equivalent experience as a dentist member of a hospital medical staff;

2.3.6 Oral maxillofacial surgeons shall have graduated from an ADA-approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an ADA-approved residency program, and be board certified or become board certified within five (5) years of completing formal training, as defined by the American Board of Oral and Maxillofacial Surgery; oral maxillofacial surgeons initially credentialed prior to December 2015 will be grandfathered (excepted) from this provision.

2.3.7 A podiatric physician (DPM) shall have successfully completed an approved residency in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the APMA, and be board certified or become board certified within five (5) years of completing formal training from an accredited national podiatric certification program; Podiatrists initially credentialed prior to December 2015 will be grandfathered (excepted) from this provision.

a. Additionally, per Nebraska statute, no podiatrist initially licensed in this state shall be granted Privileges to perform surgery on the ankle unless such person has

successfully completed an advanced postdoctoral surgical residency program of at least two (2) years duration.

2.3.8 An optometrist shall have earned an optometric degree from a college accredited by the Accreditation Council on Optometric Education and have met the training requirements for licensure established by the appropriate Nebraska licensing authority;

2.3.9 A psychologist shall have earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have met the training requirements for licensure established by the appropriate Nebraska licensing authority. The Privileges of employed psychologists will be reflected in the job descriptions and will be evaluated every six (6) months by the campus Director of Neuropsychology;

2.3.10 An APRN shall be licensed as a registered nurse in the State of Nebraska, have successfully completed an approved APRN program, have earned a masters, post-masters, or doctorate degree from an accredited educational institution, have passed an approved credentialing examination, and meet all the regulatory requirements in 172 NAC 100, including demonstration of two thousand (2000) hours of supervised practice or submission of a Transition to Practice Agreement with an approved supervising provider.

a. In order for an APRN to practice at MRH, his/her sponsoring physician shall be a member of the Medical Staff of the Hospital. Privileges granted may not exceed those granted to sponsoring physician.

b. Privileges for the APRN shall be terminated if the collaborative relationship with a sponsoring physician member of the Medical Staff is terminated or the Privileges of the sponsoring physician terminate.

2.3.11 A PA shall be licensed in Nebraska as a physician assistant, demonstrates graduation from an approved program for the education of physician assistants, have evidence of passing the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants, and whom the DHHS, with the recommendation of the Board, has approved to perform medical services under the supervision and written agreement of a physician.

a. In order for a PA to practice at MRH, his/her supervising physician shall be a member of the Medical Staff of the Hospital. Privileges granted may not exceed those granted to sponsoring physician.

b. Privileges for the PA shall be terminated if the PA supervising physician member of the Medical Staff is terminated or the Privileges of the supervising physician terminate.

2.3.12 Other Practitioners eligible for Privileges shall have successfully completed educational and training requirements for current certification to practice in Nebraska and as required for delineation of Privileges applicable to the profession;

2.3.13 Possess a current, valid, unrestricted DEA certificate, if applicable;

2.3.14 Have appropriate written and verbal communication skills;

2.3.15 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities;

b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

2.4 The following qualifications shall also be met by all applicants requesting Privileges:

2.4.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all Privileges requested;

2.4.2 Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and the specific Privileges requested by and granted to the applicant;

2.4.3 Any Practitioner requesting Privileges to admit an inpatient shall demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.4.4 Provide evidence of professional liability insurance appropriate to all Privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

Section 3. Initial Appointment/Privileging Procedure

3.1 Initial Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for Privileges shall be forwarded to the credentialing office. Upon receipt of the request, the credentialing office shall provide the applicant an application package, which shall include a complete set or overview of the Medical Staff Bylaws and educational materials or reference to an electronic source for this information. This package shall enumerate the eligibility requirements for Medical Staff membership and/or Privileges and a list of expectations of performance for individuals granted Medical Staff membership or Privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, but is not limited to:

a. A complete, signed, dated initial application including payment of application fee;

b. A completed Privilege delineation form if requesting Clinical Privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or Clinical Privileges and to establish current competency;

d. A current picture ID;

e. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the Privileges being requested.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application shall not be processed and the applicant shall not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or Privileges, the credentialing process shall be terminated, the applicant will be notified and no further action taken.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the credentialing office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the Hospital, that the applicant meets the requirements for Medical Staff membership and/or the Privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information shall be sent to the applicant. If the requested information is not returned to the credentialing office within forty-five (45) calendar days of the receipt of the request letter, the application shall be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application, the CMO or designee shall determine if the qualifications of Section 2.3 and 2.4 are met. In the event the qualifications of Section 2.3 and 2.4 are not met, the potential applicant shall be notified that s/he is ineligible to apply for membership or Privileges on the Medical Staff, the application shall not be processed and the applicant shall not be eligible for a fair hearing. If the qualifications of Section 2.3 and 2.4 are met, the application shall be accepted for further processing.

3.1.4 A completed application including verification of current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a CVO is necessary for credentialing (when it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source). In addition, relevant additional information shall be collected as appropriate, which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past five (5) years;

b. Documentation of the applicant's past clinical work experience;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or Privileges; in addition, the credentialing office shall primary source verify Nebraska or federal licensure at the time of renewal or revision of Privileges, whenever a new Privilege is requested, and at the time of license expiration;

d. Information from sources that may include the AMA or AOA Physician Profile, Federation of State Medical Boards, OIG List of Excluded Individuals/Entities, SAM excluded provider database, and Nebraska DHHS Medicaid excluded provider list;

e. Information from professional training programs including residency and fellowship programs;

f. Information from the NPDB; in addition the NPDB shall be queried at the time of renewal of Privileges and whenever a new Privilege(s) is requested;

g. Other information about adverse credentialing and privileging decisions;

h. One (1) or more peer recommendations, as selected by the MEC, chosen from Practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current patient care, medical/clinical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, system-based practice and physical, mental, and emotional ability to perform requested Privileges;

i. Information from a criminal background check;

j. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold Privileges.

3.1.5 When the items identified in Section 3.1 above have been obtained, the file shall be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Release

The applicant shall complete and sign the application including attestation, authorization, and release statements. By signing or accepting membership or Privileges, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or Privileges, the individual's appointment and Privileges may lapse effective

immediately upon notification of the individual without the right to a fair hearing or appeal, at the discretion of MEC and to be reported to the Board;

3.2.2 Consents to appear for any requested interviews in regard to his/her application;

3.2.3 Authorizes the Hospital and its representatives to solicit, obtain, review, and act upon information bearing upon, or reasonably believed to bear upon, the Practitioner's competence or professional conduct, and releases the Hospital and its authorized representatives for so doing to the fullest extent permitted by law;

3.2.4 Authorizes any other individual and organization to provide information to this Hospital and its authorized representatives bearing upon, or reasonably believed to bear upon, the Practitioner's competence or professional conduct, and agrees to execute authorizations and releases to facilitate obtaining such information and releases such other parties for so doing to the fullest extent permitted by law;

3.2.5 Consents to inspection of records and documents that may be material to an evaluation of his or her competence or professional conduct; authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying; agrees to execute authorizations and releases to facilitate obtaining or reviewing such records and documents from such parties; and releases such parties for so doing to the fullest extent permitted by law;

3.2.6 Agrees to provide accurate, current, and complete information in connection with the appointment, reappointment, privileging, quality improvement, and corrective action processes at the Hospital, or in response to specific inquiries from the Hospital and its authorized representatives, or as a continuing obligation under these Bylaws;

3.2.7 Agrees to immediately inform the credentialing office of any material changes or developments affecting or changing the information provided in or with his or her application;

3.2.8 Agrees to cooperate with the Hospital and its authorized representatives in the conduct of peer review activities involving him or her, which includes appearing at interviews, answering questions and working within the peer review structure described in these Bylaws;

3.2.9 Authorizes the Hospital and its authorized representatives to disclose or report to other hospitals, medical associations, licensing boards, practice groups, government bodies, and similar organizations information regarding his or her competence or professional conduct, in connection with such other party's peer review and related activities, and releases this Hospital and its authorized representatives for so doing to the fullest extent permitted by law;

3.2.10 Releases from liability to the fullest extent permitted by law and agrees not to sue this Hospital and its authorized representatives for their acts performed in connection with conducting peer review activity;

3.2.11 Acknowledges that the foregoing provisions are express conditions to an application for Medical Staff membership and Privileges, the continuation of such membership and Privileges and the exercise of Clinical Privileges at the Hospital.

As used in this Section, the term "Hospital and its authorized representatives" means credentialing office, MEC, the members of the MRH Board of Directors and their appointed representatives, the CEO or designee.

3.3 Application Evaluation

3.3.1 Initial and renewal applications for appointment to the Medical Staff and/or requests for Clinical Privileges may be referred to a Medical Staff "Credential s Committee" for review prior to review by the MEC. The Credentials Committee will apply the rules and processes defined in these Bylaws and make recommendations regarding the application to the MEC. The Credentials Committee would function as a subcommittee of the MEC and perform duties under the direction of the MEC.

3.3.2 **Category 1**: A completed application that does not raise concerns as identified in the criteria for Category 2.

3.3.3 **Category 2**: If one (1) or more of the following criteria are identified in the course of reviewing a completed and verified application, the application shall be treated as Category 2. Applications in Category 2 shall be individually reviewed and acted on by the MEC, and the Board. The MEC and/or the Board may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the Medical Staff and for the granting of requested Privileges. Category 2 applications will not qualify for expedited credentialing. Criteria for Category 2 applications include, but are not necessarily limited to the following:

- **a.** The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of hospital privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- **b.** Applicant is under investigation by a state medical board or has prior disciplinary actions or legal sanctions;
- **c.** Applicant has had an unusual pattern of malpractice cases filed;
- **d.** Applicant changed medical schools or residency programs or has gaps in training or practice;
- **e.** Applicant has changed practice locations more than three (3) times in the past ten (10) years;
- **f.** Applicant has one (1) or more reference responses that raise concerns or questions;
- **g.** Discrepancy is found between information received from the applicant and references or verified information;
- **h.** Applicant has an adverse NPDB report other than related to medical malpractice as specified in Section 3.3.2.c;
- **i.** The request for Privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- **j.** Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- **k.** Applicant has potentially relevant physical, mental, and/or emotional health problems;
- **l.** Other reasons as determined by the CMO or designee or other representative of the Hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for Medical Staff membership

or Privileges.

3.3.4 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of Privileges may be required to participate in an interview at the discretion of the Chief Medical Officer or designee, MEC, or Board. The interview may take place in person or by telephone at the discretion of the Hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided concerning qualifications. The interview may also be used to communicate Medical Staff performance expectations.

b. Failure of the applicant to appear for a scheduled interview shall be deemed a withdrawal of the application.

3.3.5 Medical Executive Committee Action

The CMO or designee or representative of the Credentials Committee presents applications designated as Category 2 to the MEC with the following recommendations:

a. A recommendation to approve the applicant's request for Medical Staff membership and/or Privileges; to approve membership but modify the requested Privileges; or deny membership and/or Privileges;

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of Privileges;

c. Comments supporting the recommendations in 3.3.5 a. and b. above.

d. MEC will forward their final recommendation to the Board.

3.3.6 Board Action

a. If the application is designated by the MEC as Category 1, it is presented to the Board. If the Board agrees with the recommendations of the MEC, the application is approved and the requested Medical Staff membership and/or Privileges are granted for a period not to exceed twenty-four (24) months. If the Board disagrees with the recommendation, then the procedure for processing Category 2 applications shall be followed.

b. If the application is designated as a Category 2 by MEC, the Board reviews the recommendation, may review the application, and votes for one (1) of the following actions:

(i) The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made. If the Board concurs with the applicant's request for membership and/or Privileges it shall grant the appropriate Medical Staff membership and/or Privileges for a period not to exceed twenty-four (24) months.

(ii) In the event the decision of the Board differs substantially from the recommendations of the MEC, further action by the Board shall be held in abeyance for a period not to exceed thirty (30) calendar days while the matter is referred back to the MEC for further consideration and recommendation.

The MEC shall review the proposed action of the Board, conduct any further investigation, and make such additional comments or recommendations, as the MEC deems appropriate.

(iii) After receiving further recommendations from the MEC, the Board shall take final action. In the event no comments or recommendations are received from the MEC within thirty (30) calendar days of the date that the Board referred the matter back to the MEC, the proposed decision of the Board shall become final, unless the Board, in its sole discretion, extends the time for the MEC to act.

If the Board's action is adverse to the applicant, a notice stating the reason shall be sent to the applicant

The Board shall take final action in the matter as provided in Part II of these Bylaws (Investigations, Corrective Actions, Hearing, and Appeal Plan).

3.3.7 Notice of Final Decision: Notice of the Board's final decision shall be given, through the CEO or designee or Chief Medical Officer or designee, to the MEC, if adverse. The applicant shall receive written Notice of appointment and Notice of any adverse final decisions within fourteen (14) calendar days of the Board's decision. A decision and Notice of appointment includes the Medical Staff category to which the applicant is appointed, the Clinical Privileges s/he may exercise, and any special conditions attached to the appointment.

3.3.8 Time Periods for Processing: All individual and groups acting on an application for Medical Staff appointment and/or Privileges shall do so in a timely and good faith manner, and, except for good cause, each application shall be processed within one hundred eighty (180) calendar days. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigations, Corrective Actions, Hearing, and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment/Reprivileging Procedure

4.1 Criteria for Reappointment/Reprivileging

It is the policy of the Hospital to approve for reappointment and/or renewal of Privileges only those Practitioners who meet the criteria for initial appointment/privileging as identified in Part III of these Bylaws (Credentials/Privileges Procedures), Section 2, and who have satisfactorily complied with the Medical Staff responsibilities as outlined in Part I of these Bylaws (Governance) during the intervening period since prior appointment. The MEC shall also determine that the Practitioner provides effective care that is consistent with the Hospital standards regarding ongoing quality and the Hospital performance improvement program. The Practitioner shall provide the information enumerated in Section 4.2 below. All reappointments and renewals of Privileges are for a period not to exceed twenty-four (24) months. The granting of new Privileges to existing Medical Staff members or AHPs shall follow the steps described in Section 3 above concerning the initial granting of new Clinical Privileges and Section 7 concerning FPPE. A suitable peer shall review current competency of the Chief Medical Officer, and recommend appropriate action to the MEC.

4.2 Information Collection and Verification

4.2.1 **From appointee**: On or before five (5) months prior to the date of expiration of a Medical Staff appointment or grant of Privileges, a representative from a contracted CVO (if contracted services are utilized) or the credentialing office supplies the Practitioner with an application for reappointment for membership and/or Privileges. At least sixty (60) calendar days prior to this date the Practitioner shall return the following to the credentialing office:

- **a.** A completed reapplication form, which includes complete information to update the Practitioner's file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;
- **b.** A completed Privilege delineation form if requesting Clinical Privileges;
- **c.** Information concerning continuing training and education internal and external to the Hospital during the preceding period;
- **d.** By signing the reapplication form, the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 **From internal and/or external sources**: The credentialing office collects and verifies information regarding each Medical Staff appointee's professional and collegial activities to include those items listed in the Practitioner Reappointment Application.

4.2.3 **The following information may be collected and verified:**

- **a.** A summary of clinical activity at this Hospital for each Practitioner due for reappointment;
- **b.** Performance and conduct in the Practitioner's primary and secondary hospital since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
- **c.** Timely and accurate completion of medical records;
- **d.** Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the Hospital and Medical Staff;

e. Any significant gaps in employment or practice since the previous appointment or reappointment;

f. Verification of current Nebraska licensure;

g. NPDB query;

h. Medicare, OIG, SAM, and DHHS Nebraska Medicaid excluded provider queries;

i. When sufficient peer review data is not available to evaluate competency, one (1) or more peer recommendations, as selected by the CMO or designee, chosen from practitioner(s) who have observed the applicant's current competence to perform requested Privileges;

j. Malpractice history for the past two (2) years, which is primary source verified with the Practitioner's malpractice carrier(s) or NPDB.

4.2.4 Failure, without good cause, to provide any requested information, at least sixty (60) calendar days prior to the expiration of appointment shall result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded.

4.2.5 Once the information is received, the credentialing office verifies this additional information and notifies the Practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 The reappointment application shall be reviewed and acted upon as described in Section 3.3 above.

Section 5. Privileges

5.1 Exercise of Privileges

A Practitioner providing clinical services at the Hospital may exercise only those Privileges granted to him/her by the Board or emergency and disaster Privileges, as described herein, at the Hospital in which Privileges were requested. Privileges may be granted by the Board upon recommendation of the MEC to Practitioners who are not members of the Medical Staff. Such individuals may be APRNs including nurse practitioners, PAs, physicians serving short-term locum tenens positions, telemedicine practitioners or others deemed appropriate by the MEC and Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff shall contain a request for the specific Privileges the applicant desires. Specific requests shall also be submitted for temporary Privileges and for modifications of Privileges in the interim between reappointments and/or granting of Privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for Privileges shall be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence.

5.3.2 Privileges for which no criteria have been established

In the event a request for a Privilege is submitted for a new technology, a procedure new to the Hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty Privilege for which no criteria have been established, the request shall be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC shall:

a. Review the community, patient, and Hospital need for the Privilege and reach agreement with administration and the Board that the Privilege is approved to be exercised at the Hospital;

b. Review with members of the MEC the efficacy and clinical viability of the requested Privilege and confirm that this Privilege is approved for use in the setting – specific area of the Hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

c. Work with administration to ensure that, if granted, such Privileges would not conflict with any exclusive or other contracts. The MEC shall formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request shall be processed as described herein.

(i) For the development of criteria, the credentialing office or Director of Quality and Risk Management or designee shall compile information relevant to the Privileges requested, which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers and publications from industry experts, as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate;

(ii) Criteria to be established for the Privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Proctoring

requirements, if any, shall be addressed, including who may serve as proctor and how many proctored cases shall be required. The CMO or designee presents new Privilege requests to MEC with supporting documents for their recommendation;

(iii) If the Privileges requested overlap two (2) or more specialty disciplines, an ad hoc committee may be appointed by the MEC to recommend criteria for the Privilege(s) in question. This committee shall consist of at least one (1), but not more than two (2), members from each involved discipline. The chair of the ad hoc committee shall be a member of the MEC who has no vested interest in the issue.

5.3.3 Requests for Privileges shall be consistently evaluated on the basis of prior and continuing education, training, experience, compliance with all responsibilities of Medical Staff membership and Privileges, utilization practice patterns, current ability to perform the Privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining Privileges are patient care needs, the Hospital's capability to support the type of Privileges being requested, and the availability of qualified coverage in the Practitioner's absence. Madonna does not have an operating room. Approved invasive procedures are performed at bedside. The basis for Privileges determination to be made in connection with periodic reappointment or a requested change in Privileges shall include documented clinical performance and results of the Practitioner's performance improvement program activities. Privileges determinations shall also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the Practitioner exercises hospital privileges.

5.3.4 The procedure by which requests for Privileges are processed are as outlined in Section 3 above.

5.4 Admission of Patients

5.4.1 MRH shall accept patients for care and treatment in accordance with the Medical Staff Bylaws and the MRH corporate bylaws. No distinction shall be made on the basis of color, race, sex, religion, national origin, or payer source in the admission or treatment of patients, the accommodations provided; the use of equipment and other facilities or the assignment of personnel providing services.

5.4.2 A doctor of medicine or osteopathy member of the Medical Staff shall be responsible for the admission, medical care, and treatment of each patient, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient.

5.5 Privileges without Membership

5.5.1 Requests for Privileges from individuals eligible for Privileges but not membership may be processed in the same manner as requests for Clinical Privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of Practitioners approved by the Board for providing services at the Hospital are eligible to apply for Privileges.

5.5.2 Physicians in this category may exercise delineated Privileges granted by the Board but shall not be eligible for membership on the Medical Staff. Examples include, but may not

be limited to locum tenens physicians, telemedicine physicians, and military physicians.

5.5.3 AHPs in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients either under the supervision of a physician or in collaboration with a physician. Such Privileges with supervision or collaboration shall be as specifically outlined in the delineation of Privileges form for each Practitioner.

5.5.4 The Privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the Hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the Medical Staff is terminated for any reason, or if the Privileges of the supervising or collaborating physician terminate.

5.6 Telemedicine

5.6.1 Definitions

a. "Telemedicine" is the provision of clinical services to patients by practitioners exchanged from one site to another via electronic communication to improve patients' health status. Telemedicine utilizes real time audio and visual interactive communication between the patient and the practitioner at a distant site. The distant-site telemedicine physician or practitioner provides clinical services to the hospital patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services. "Simultaneously" means that the clinical services (for example, assessment of the patient with a clinical plan for treatment, including any medical orders needed) are provided to the patient in "real time" by the telemedicine physician or practitioner, similar to the actions of an on-site physician or practitioner. "Non-simultaneously" means that, while the telemedicine physician or practitioner still provides clinical services to the patient upon a formal request from the patient's attending physician, such services may involve after-the-fact interpretation of diagnostic tests in order to provide an assessment of the patient's condition and do not necessarily require the telemedicine practitioner to directly assess the patient in "real time." This would be similar to the services provided by an on-site radiologist who interprets a patient's x-ray or CT scan and then communicates his or her assessment to the patient's attending physician who then bases his or her diagnosis and treatment plan on these findings.

b. Credentialing by Proxy (CBP) is a streamlined process which permits the originating site hospital or telemedicine entity to rely on the credentialing and privileging decisions made by the distant site

c. Originating site is MRH

d. Distant site is the hospital or telemedicine entity where the practitioner is actually located, credentialed and privileged. The distant site is a Medicare-participating hospital or a telemedicine entity that provides:

(i) telemedicine services; and

(ii) contracted services in a manner that enables the Hospital to meet all applicable CMS Hospital Conditions of Participation related to the credentialing and privileging of physicians and contracted services.

5.6.2 Scope of Privileges

The MEC shall make recommendations to the Board, who will approve the clinical services that may be appropriately delivered through the medium of telemedicine, and the scope of such services at the Hospitals. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

5.6.3 Requirements

1. Any practitioner who consults with a patient, assesses, prescribes, renders a diagnosis, or otherwise provides clinical treatment from a distance via electronic communications, must be credentialed and privileged through the MEC, approved by the Board pursuant to the credentialing and privileging procedures described in the Medical Staff Bylaws, as applicable.
2. Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the MEC and BOD.
    a. A request for telemedicine privileges may be processed through the full credentialing processes, as set forth in Sections 3 and 4 of these Bylaws.
    b. Credentialing by Proxy. In such cases, MRH must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. MRH will remain responsible for complying with applicable state regulations regarding the credentialing and privileging of Practitioners and assuring competency and the lack of adverse events.
        i. The distant site hospital or telemedicine entity must provide:
            1. A list of practitioners providing telemedicine services and provider profile for each
            2. Current privileges granted at the distant site. Privileges at originating site may not exceed privileges granted at distant site.
            3. Any other attestations or information required by the agreement or requested by MRH.
        ii. MRH will verify from primary sources:
            1. Current licensure status
            2. Results from a National Practitioner Data Bank query
3. This information shall be provided to the MEC for review and recommendation to the BOD.
4. Telemedicine privileges, if granted, shall be for a period of not more than two years or in accordance with the agreement.
5. Individuals granted telemedicine privileges shall be subject to MRH peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the distant site.
6. Recognizing that physicians providing care through telecommunications may be privileged at more than one health care facility and entity, the MEC shall assure credentialing and Privileges related to the telemedicine provision of medical care and the scope of such care is clearly identified for the specific Hospital.

5.7 Special Conditions for Residents or Fellows in Training

5.7.1 Residents or fellows in training in the Hospital shall not hold membership on the Medical Staff and shall not normally be granted specific Privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the residency training program in collaboration with the Chief Medical Officer or designee. The protocols shall delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician shall countersign. The protocol shall also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions shall be communicated to appropriate Medical Staff and Hospital leaders. CMO or designee may serve as the Director of Graduate Medical Education at MRH.

5.7.2 The residency program director of the educational institution shall communicate annually through the Chief Medical Officer or designee to the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care, and shall work with the MEC to assure that all supervising physicians possess Privileges commensurate with their supervising activities.

5.7.3 Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings. All aspects of patient care rendered by residents must receive close faculty supervision. All aspects of patient care are ultimately the responsibility of the attending physician. Attending or supervising physicians have the right to prohibit resident participation in the care of their patients. Supervising physicians also have the right to determine the roles and responsibilities that are granted to a given resident under their supervision, subject to any guidelines established by the Medical Staff. Residency is a process of increasing responsibility; residents will be granted those responsibilities based on demonstrated competence and within the parameters of the written protocols, as outlined in Part III of these Bylaws (Credentials/Privileges Procedures), Section 6.1. Those roles and responsibilities cannot exceed those Privileges that have been granted to the supervising physician by the Hospital. When a resident is involved in the care of a patient, it is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, examination, and interpretation of diagnostic testing and intended implementation of a treatment plan. It is the supervising physician's responsibility to personally examine all patients on a daily basis, review all entries in the medical record by the resident, make necessary corrections in the treatment plan, and document their involvement in the care of the patient.

5.8 Temporary Privileges

The CEO or designee, acting on behalf of the Board, and based on the recommendation of the Chief Medical Officer or designee, may grant temporary Privileges provided the credentialing office is able to verify the information below. Temporary Privileges may be granted only in two (2) circumstances: (i) to fulfill an important patient care, treatment, or service need; or (ii) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board. Temporary Privileges may be granted as follows:

5.8.1 Non-Applicants to Fill a Need. The CEO or designee, following consultation with the Chief Medical Officer or designee, may grant temporary Privileges for a period not to exceed one hundred twenty (120) days to a Practitioner who is not applying for Medical Staff appointment, when determined necessary to fill a patient care, treatment, or service need. Examples include Practitioners who will provide *locum tenens* coverage for a member of the Medical Staff and Practitioners who will provide needed coverage or services to the Hospital under contract or other arrangement on a temporary basis.

a. Minimum Qualifications and Verifications. Before granting temporary Privileges to non-applicants, the Hospital shall:

(i) Verify current Nebraska licensure and current DEA certification, if applicable;

(ii) Verify current professional liability insurance in amounts required for membership and Privileges;

(iii) Verify that the individual is not excluded from any federally-funded health care program;

(iv) Verify that the individual meets the education and training requirements for membership and Privileges;

(v) Query the NPDB and make follow-up inquiry as indicated; and

(vi) Obtain one (1) or more peer references for the individual to verify current competency and ability to perform the Privileges requested.

b. Duration. The duration of temporary Privileges for non-applicants shall be stated at the time they are granted and communicated to the Practitioner. The maximum duration of initial temporary Privileges for non-applications and any extensions is one hundred twenty (120) days. All temporary Privileges granted to cover a specific patient, Practitioner or absence, or Hospital coverage or service need shall end when the particular patient is discharged or the Practitioner or absence or Hospital coverage or service ends.

5.8.2 Clean Application Awaiting Approval: Temporary Privileges may be granted for up to one hundred twenty (120) calendar days when the new applicant for Medical Staff membership and/or Privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary Privileges in these circumstances are outlined in the above Section 3 of these Bylaws and include the criteria for Category 1 credentialing consideration as noted in the above Section 3 of these Bylaws.

5.8.3 Except in unusual circumstances, temporary Privileges shall not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, rules, regulations, and policies of the Medical Staff and Hospital in all matters relating to his/her temporary Privileges.

5.8.4 Termination of Temporary Privileges: The CEO or designee, acting on behalf of the Board, and after consultation with the CMO or designee, may terminate any or all of the Practitioner's Privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's Privileges. Additionally, when a person entitled to impose precautionary suspension believes that grounds for precautionary suspension exist, he/she may terminate temporary Privileges. In the event of any such termination, the Practitioner's patients then shall be assigned to another Practitioner by the CEO or designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.

5.8.5 Rights of the Practitioner with Temporary Privileges: A Practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigations, Corrective Actions, Hearing, and Appeal Plan) because his/her request for temporary Privileges is refused or because all or any part of his/her temporary Privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.9 Emergency Privileges

In the case of a medical emergency, any Practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, and based on specialty and/or training. A Practitioner exercising emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up. Such emergency Privileges/authority shall end as soon as a regularly privileged Practitioner is ready and able to assume the patient care or when the emergency ends.

5.10 Disaster Privileges

5.10.1 If the Hospital's Disaster Plans have been activated and the organization is unable to meet immediate patient needs, the CEO or designee and other individuals, as identified in the Hospital's Disaster Plans with similar authority, may, on a case by case basis, consistent with medical licensing and other relevant state statutes, grant disaster Privileges to selected Practitioners. These Practitioners shall 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. A current picture hospital ID card that clearly identifies professional designation;

b. A current Nebraska license to practice unless otherwise directed by state or federal authorities;

c. Primary source verification of the license;

d. Identification indicating that the individual is a member of a DMAT, or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

f. Identification by a current Hospital or Medical Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed practitioner during a disaster.

5.10.2 The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster Privileges by direct observation, mentoring, or clinical record review. The Hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within seventy-two (72) hours whether disaster recovery Privileges should be continued.

5.10.3 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the Hospital.

5.10.4 Once the immediate situation has passed and such determination has been made consistent with the Hospital's Disaster Plans, the practitioner's disaster Privileges shall terminate immediately.

5.10.5 Any individual identified in the Hospital's Disaster Plans with the authority to grant disaster Privileges shall also have the authority to terminate disaster Privileges. Such authority may be exercised in the sole discretion of the Hospital and shall not give rise to a right to a fair hearing or an appeal.

Section 6. Clinical Services

6.1 History and Physical Examination (H&P)

6.1.1 The attending physician or designee, shall provide all pertinent patient information within twenty-four (24) hours following the admission of the patient. This information shall include:

- **a.** Past history;
- **b.** A description of the present illness;
- **c.** Admission physical examination with current medical findings;
- **d.** A review of systems;
- **e.** Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care and prognosis.

6.1.2 Immediately upon admission, complete and accurate medical records shall be made and kept on each patient.

6.1.3 Each Practitioner shall comply with all generic substitutions and therapeutic interchanges approved and authorized by the Pharmacy & Therapeutics Committee of MRH.

6.2 Medical Supervision

6.2.1 As a licensed Hospital, MRH provides attending physician coverage. Staff physicians will evaluate all patients for determining rehabilitation potential and assume medical responsibility, including admission and discharge responsibilities, ordering the rehabilitation component of care, and participation in the interdisciplinary team meetings. The attending physician shall designate an alternate physician from whom emergency medical care may be obtained by the patient in the event the attending physician is not available.

6.2.2 Community physicians credentialed at MRH, referring patients to MRH, may continue to follow their patients along with the MRH Practitioner. The MRH Practitioner will communicate with the community physician during the patients' Hospital stay, and at discharge as necessary. The patient is returned to the care of the community physician upon completion of the MRH program.

6.2.3 Each Practitioner attending a patient at MRH must evaluate the patient's immediate and long-term needs. Included in the evaluation shall be a planned regimen of medical care which covers indicated medication, treatment, diet, special procedures recommended for the health/safety of the patient, activities and plans for continuing care and discharge. The attending Practitioner shall review orders and the plan of patient care for patients, as required by current regulations, and as deemed necessary by the Practitioner. Documentation in the patient record of the medical supervision shall be evidenced by signed written orders and progress notes.

6.2.4 MRH attending physicians or sponsored Practitioners will provide daily medical management based on the pathophysiologic needs of the patient.

6.2.5 Practitioners employed or contracted to provide attending medical services, shall be authorized to order restraints or seclusion for inpatients in MRH. Education on the Hospital's restraint policies will be provided to these Practitioners at initial appointment/privileging, when restraint policies are revised with essential information, and every two (2) years.

6.2.6 All medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the Practitioner responsible for providing or evaluating the service provided. Verbal orders will be accepted only when necessary and shall be accepted only by licensed personnel authorized by the State of Nebraska to receive such orders. Verbal orders are to be written into the appropriate clinical record by the licensed personnel receiving them and an appropriate notation should be made indicating that the orders were received verbally. The ordering Practitioner, or another Practitioner who is responsible for the care of the patient, must date, time, and authenticate the verbal order as noted in the clinical record within the time frame as prescribed by rule and regulation.

6.2.7 Rubber stamp signatures of Practitioners will not be accepted.

6.2.8 Medical students in training at MRH shall be supervised by a currently credentialed physician on the MRH Medical Staff. The credentialed physician shall assume full responsibility for the medical student.

6.2.9 In all cases of unusual deaths, or cases of medical/legal, or educational interest, an autopsy may be requested by the Practitioner.

6.2.10 Lab tests are ordered as deemed medically necessary by the qualified licensed Practitioners.

6.3 Discharge of Patients

6.3.1 A patient shall be discharged only upon a documented order from the attending physician or designee. At the time of the discharge, the Practitioner shall complete the medical record of the patient, which shall include a summarization of the care the patient received medications at discharge, and condition on discharge. The medical record must be completed within thirty (30 days) of discharge.

6.4 Medical Records and Other Protected Health Information

6.4.1 All records are the property of MRH and may not be taken from MRH or the Hospital without prior permission. In case of readmission of a patient, all previous patient records held by contract with MRH shall be available for the use of the readmitting physician.

- **a.** Patient medical records shall be completed in accordance with federal and state regulations, and MRH policy;
- **b.** H&P dictated within twenty-four (24) hours of admission;
- **c.** Discharge Summary dictated within ten (10) days of discharge;
- **d.** Verbal orders signed, dated, and timed within seven (7) days;
- **e.** Orders written by the physician or other Practitioner are to be dated and timed;
- **f.** Medical records must be completed within thirty (30) days of discharge.

6.4.2 Failure to complete medical records in time and manner described in these Bylaws may result in a change in Privileges or may require a plan for correction by the Practitioner in agreement with CMO or designee and/or MEC. Failure to achieve agreed upon outcome may result in discontinuation of Privileges.

6.4.3 Members of MRH Medical Staff are an "Organized Health Care Arrangement" for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under, as amended from time to time ("HIPAA"). By accepting Medical Staff membership, Medical Staff members agree to abide by MRH's Notice of Privacy Practices concerning protected health information regarding patients treated at MRH that has been created or received by a member of the Medical Staff or his or her agents as part of the Organized Health Care Arrangement with MRH. MRH Notice of Privacy Practices shall be considered a joint notice as permitted by HIPAA. MRH Notice of Privacy Practices is incorporated into these Bylaws by reference and may be amended from time to time.

Section 7. Professional Practice Evaluation

The MEC performs these functions on behalf of the Medical Staff as described in Part III of these Bylaws (Credentials/Privileges Procedures).

7.1 FPPE

7.1.1 All Practitioners at the time of initial application for Privileges may be subject to a period of FPPE when issues affecting the provision of safe, high quality patient care are identified.

7.2 OPPE

7.2.1 The MEC, on behalf of the Medical Staff, shall also engage in OPPE to identify professional practice trends that affect quality of care and patient safety related to Privileges granted. Review of external OPPEs may also be utilized.

Section 8. Preceptorship

8.1 A Practitioner who has not provided inpatient care within the past three (3) years who requests Clinical Privileges at the Hospital shall arrange for a preceptorship either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the Hospital.

8.2 A description of the preceptorship program, including details of monitoring and consultation shall be written and submitted for approval to the MEC. At a minimum, the preceptorship program description shall include the following:

8.2.1 The scope and intensity of required preceptorship activities including but not limited to a description of whether the precepting will be prospective, concurrent, or retrospective;

8.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the Privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the Privileges requested, and professional ethics and conduct.

Section 9. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

9.1 Reapplication after Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a Practitioner who has received a final adverse decision refusing, revoking, or terminating membership or Privileges, or who has resigned or withdrawn an application for appointment or reappointment or Privileges while under investigation or to avoid an investigation, is not eligible to reapply to the Medical Staff or for Privileges for a period of three (3) years from the date of the Notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the Practitioner shall submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication shall be considered incomplete and voluntarily withdrawn and shall not be processed any further.

9.2 Request for Modification of Appointment Status or Privileges

A Medical Staff appointee, either in connection with reappointment or at any other time, may request modification of Privileges by submitting a written request to the Chief Medical Officer or designee. A modification request shall contain all pertinent information supportive of the request. All requests for additional Clinical Privileges shall be accompanied by information demonstrating additional education, training, and current clinical competence in the specific Privileges requested. The credentialing office will also verify the following: Hospital's ability to support requested Privilege, current medical license, and NPDB query. A Practitioner who determines that s/he no longer exercises, or wishes to restrict or limit the exercise of, particular Privileges that s/he has been granted shall send written Notice to the Chief Medical Officer or designee. A copy of this Notice shall be included in the Practitioner's credentials file. All requests for modification of Privileges shall be approved by the CMO or designee, MEC, and Board.

9.3 Resignation of Staff Appointment

A Practitioner who wishes to resign his/her Medical Staff appointment shall provide written Notice to the Chief Medical Officer or designee. The resignation shall specify the reason for the resignation and the effective date. A Practitioner who resigns his/her Medical Staff appointment and/or Privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. A resignation is effective when accepted by the Board or its designee. The Board is not obligated to accept the resignation of a Practitioner who is not current on medical records or other obligations.

9.4 Exhaustion of Administrative Remedies

Every Practitioner agrees that s/he shall exhaust all the administrative remedies afforded in the various sections of these Medical Staff Bylaws before initiating legal action against the Hospital or its agents.

9.5 Reporting Requirements

The CEO or designee shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any applicable Nebraska state law and regulations. Actions that shall be reported include any adverse professional review action against a physician related to clinical competence or professional conduct that affects or may affect adversely patient welfare, and any voluntary surrender of Medical Staff membership or Privileges or acceptance of limitations thereon while under or to avoid an investigation. Reportable events including actions that lead to a denial of reappointment; reduction in Privileges for greater than thirty (30) calendar days; resignation, surrender of Privileges, or acceptance of Privilege reduction either during an investigation or to avoid an investigation.

Section 10. Leave of Absence

10.1 Leave Request

A leave of absence shall be requested for any absence from the Medical Staff and/or patient care responsibilities longer than ninety (90) days if such absence is related to the Practitioner's physical or mental health or to the ability to care for patients safely and competently. A Practitioner who wishes to obtain a voluntary leave of absence shall provide written notice to the Chief Medical Officer or designee stating the reasons for the leave and approximate period of time of the leave, which may not exceed one (1) year, except for military service or express permission by the Board. Requests for leave shall be forwarded with a recommendation from the MEC and affirmed by the Board.

While on leave of absence, the Practitioner may not exercise Clinical Privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. In the event that a Practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

10.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the Practitioner may request reinstatement by sending a written notice to the Chief Medical Officer or designee. The Practitioner shall submit a written summary of relevant activities during the leave if the MEC or Board so requests. A Practitioner returning from a leave of absence for health reasons shall provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of Privileges are followed. If the Practitioner's current grant of Medical Staff membership and /or Privileges is due to expire during the leave of absence, the Practitioner shall apply for reappointment, or his/her appointment and/or Privileges shall lapse at the end of the appointment period.

10.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, Privileges, and prerogatives. A Medical Staff member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these Bylaws (Investigations, Corrective Actions, Hearing and Appeal Plan). A request for Medical Staff membership subsequently received from a Practitioner so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

10.4 Effect of Leave

A leave of absence shall not have the effect of extending a Practitioner's period of appointment or Privileges. Even while on leave, a Practitioner must apply for reappointment or renewal of Privileges according to his/her reappointment cycle.

Section 11. Practitioners Providing Contracted Services

11.1 Exclusivity Policy

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

11.2 Qualifications

A Practitioner who is or shall be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital shall meet the same qualifications, shall be processed in the same manner, and shall fulfill all the obligations of his/her appointment category as any other applicant or Medical Staff appointee.

11.3 The terms of the Medical Staff Bylaws shall govern disciplinary action taken by or recommended by the MEC.

11.4 Effect of Contract or Employment Expiration or Termination

The effect of expiration or other termination of a contract upon a Practitioner's Medical Staff appointment and Privileges shall be governed solely by the terms of the Practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone shall not affect the Practitioner's Medical Staff appointment status or Privileges.

Section 12. Medical Administrative Officers

12.1 A medical administrative officer is a Practitioner engaged by the Hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other Practitioners under the officer's direction.

12.2 Each medical administrative officer shall achieve and maintain Medical Staff appointment and Privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other Medical Staff members.

12.3 Effect of removal from office or adverse change in appointment status or Privileges:

12.3.1 Where a contract exists between the officer and the Hospital, its terms govern the effect of removal from the medical administrative office on the officer's Medical Staff appointment and Privileges and the effect an adverse change in the officer's Medical Staff appointment or Privileges has on his or her remaining in office.

12.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or Privileges. The effect of an adverse change in appointment status or Privileges on continuance in office shall be as determined by the Board.

12.3.3 A medical administrative officer has the same procedural rights as all other Medical Staff members in the event of an adverse change in appointment status or Privileges unless the change is, by contract a consequence of removal from office.

APPROVED by the Medical Executive Committee:

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Julie Lyon, M.D. Date
Chairperson of Medical Executive Committee

APPROVED by the Governing Authority:

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Lauren Pugliese Date
Chairperson of the Board of Directors