

LABETTE HEALTH

**MEDICAL STAFF
BYLAWS**

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PREAMBLE

The independent health care practitioners practicing at Labette Health hereby organize themselves into a Medical Staff in conformity with the Bylaws of Labette Health. The Medical Staff has been organized and these Bylaws adopted in response to the delegation to the Medical Staff by the Board of Trustees of Labette Health of the responsibility for credentialing new applicants to the Medical Staff and monitoring the quality of care rendered by current appointees to the Medical Staff. The responsibilities delegated to the Medical Staff shall at all times be subject to the ultimate authority of the Board of Trustees of Labette Health.

ARTICLE I NAME

- 1.1. The name by which this organization shall be known is Labette Health.

ARTICLE II PURPOSE AND FUNCTION

- 2.1. **Purpose.** The purpose of this Medical Staff shall be:
 - 2.1.1 To serve as the primary means of accountability to the Board of Trustees for the quality and appropriateness of the professional performance and ethical conduct of its Members and to strive toward assuring that the patient care in the hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.
 - 2.1.2 To promote medical care consistent with the standards of the Centers of Medicare & Medicaid Services and other regulatory bodies.
 - 2.1.3 To monitor the quality of medical care provided at the Hospital and make recommendations thereon to the Board of Trustees.
 - 2.1.4 To recommend to the Board of Trustees of Labette Health the appointment or reappointment of applicants to the Medical Staff, to recommend to the Board the Clinical Privileges any applicant shall enjoy, and to recommend to the Board appropriate action that may be necessary in connection with any Member of the Medical Staff or anyone enjoying Clinical Privileges at the Hospital.
 - 2.1.5 To provide appropriate educational programs as an aid to the Medical Staff on a continuous basis.
- 2.2. **Responsibility.** All individuals who receive Clinical Privileges pursuant to the terms of these Bylaws shall be subject to these Bylaws, to Medical Staff Rules and Regulations, to review by the Labette Health Risk Management Program, and to final decisions obtained by the Fair Hearing Plan.

2.3. **Peer Review Designation.**

2.3.1 In recognition of the responsibility of the Medical Staff to evaluate and improve the quality of care provided by its Members within the Hospital and to perform or assist in peer review functions in accordance with K.S.A. 65-4915 and 65-4923, as amended, the Medical Staff as a whole is hereby designated as a peer review committee. In addition, committees established or appointed pursuant to the provisions of these Bylaws, in recognition of their obligation to perform or assist in the performance of the peer review functions specified in K.S.A. 65-4915 and 65-4923, are hereby designated as peer review committees.

2.3.2 In recognition of the obligation of each Member of the Medical Staff to assist in the evaluation and improvement of the quality of care provided within the Hospital, and in the performance of other peer review functions specified in K.S.A. 65-4915, as amended, and to report knowledge of reportable accidents pursuant to the Risk Management Plan, each Member of the Medical Staff is hereby designated as a peer review officer pursuant to K.S.A. 65-4915, as amended.

2.4. **Construction of Terms and Headings.** The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. Words used in the Bylaws shall be read as the masculine, feminine, or neuter gender, and as singular or plural, as the context requires.

2.5. **Definitions.**

2.5.1 **NON-PHYSICIAN PROVIDERS (NPPs)** means those persons other than Physicians and Dentists who, by virtue of state law, are qualified to provide independent medical care within the scope of their training and licensure or certification; or who are qualified by state regulation to provide medical care on the behalf of, and under the oversight of, a physician.

2.5.2 **ATTENDING PHYSICIAN** means a Member of the Active Staff, Associate Staff, Contract Staff and Dentists under limited circumstances or a Hospitalist who is designated as the primary individual responsible for the patient's medical care during the patient's inpatient or outpatient admission. Under most circumstances, the Attending Physician should be the Member of the Active or Associate Medical Staff identified as the patient's primary care physician or a Hospitalist. In the case of an inpatient admission or outpatient stay for a surgical procedure, the surgeon responsible for the procedure may be designated as the patient's Attending Physician.

2.5.3 **BOARD or BOARD OF TRUSTEES** means the governing body of the Hospital.

2.5.4 **BYLAWS** mean this document, which is an instrument of self-governance that allows the governing board of the Hospital to delegate to the Medical Staff the power to set up a form of organization by which the Medical Staff can assure quality Hospital care.

- 2.5.5 CHAIR means the Member appointed by the incoming Chief of Staff to head a Clinical Department or other Medical Staff committee.
- 2.5.6 CHIEF EXECUTIVE OFFICER or CEO means the person appointed by the Board to serve in the top administrative position of the Hospital.
- 2.5.7 CLINICAL DEPARTMENT means an organized group which consists of all Members of the Medical Staff with the same or similar training and practice patterns.
- 2.5.8 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to render specific services to patients.
- 2.5.9 DENTIST means an individual with a D.D.S. or D.M.D. degree who is currently licensed to practice dental surgery or dental medicine in the State of Kansas.
- 2.5.10 EMERGENT means a situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent would further jeopardize the life, health, or safety of the patient.
- 2.5.11 EMERGENCY means a serious, unexpected, and often dangerous situation requiring immediate action.
- 2.5.12 FAIR HEARING PLAN means the section titled *Fair Hearing Plan* attached to these Bylaws.
- 2.5.13 GOOD STANDING means the staff Member, at the time the issue is raised, has attended and participated in those committees and Clinical Department meetings he/she was assigned to during the previous Medical Staff year in accordance with the standards set forth in these Bylaws, is not in arrears in dues payment, has no current or pending disciplinary action, and has not received a suspension or curtailment of his/her appointment or admitting privileges in the previous twelve (12) months.
- 2.5.14 HOSPITAL or MEDICAL CENTER means Labette Health.
- 2.5.15 Labette Health RISK MANAGEMENT PLAN means the section titled *Labette Health Risk Management Plan* attached to these Bylaws.
- 2.5.16 MEDICAL EXECUTIVE COMMITTEE means the Committee established pursuant to these Bylaws to act on behalf of the Staff to perform certain functions as specified by these Bylaws.
- 2.5.17 MEDICAL STAFF or STAFF means the organization of those Physicians and Dentists to whom Privileges have been granted as Members pursuant to the terms of these Bylaws.

- 2.5.18 MEDICAL STAFF YEAR means the period from January 1 to December 31.
- 2.5.19 MEMBER means any Physician or Dentist who has applied for and been accepted for inclusion in the Medical Staff according to the procedure set forth in these Bylaws.
- 2.5.20 PHYSICIAN means an individual with an M.D. or D.O. degree who is currently licensed to practice in the State of Kansas.
- 2.5.21 PRACTITIONER means an individual who is actively engaged in his/her art, discipline, or profession which shall include medicine, nursing, dentistry, and podiatry.
- 2.5.22 RULES AND REGULATIONS means the section titled *Rules and Regulations* attached to these Bylaws.
- 2.5.23 WORKING DAYS means the days of the week Monday through Friday excluding nationally recognized holidays.

ARTICLE III MEMBERSHIP

- 3.1. **Nature of Membership.** Every Practitioner who seeks or enjoys Medical Staff appointment must, at the time of application and initial appointment and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and of the Board the following qualifications and any additional qualifications and procedural requirements as are set forth in other sections of these Bylaws. No Practitioner, including those in a medical-administrative position by virtue of a contract of employment with the Hospital, shall admit or provide medical or dental services to patients in the Hospital unless he or she is a Member of the Medical Staff or has obtained Privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such Clinical Privileges and prerogatives as have been granted in accordance with these Bylaws and no Practitioner shall provide services to Hospital patients for which Privileges have not been granted.
- 3.2. **Qualifications of Membership.** The following qualifications shall not be held to be exclusive of other qualifications and conditions that the Medical Center or Medical Staff may consider to be relevant to a Practitioner's application; however, to be qualified for membership, an applicant must:
- 3.2.1 Be a Physician or Dentist who practices a branch of the healing arts which is scientifically based and consistent with the purposes, treatment, philosophy, methods, and resources of its Medical Staff;
- 3.2.2 Demonstrate that he or she is professional and ethically competent and that patients treated by him or her may expect to receive quality medical care by documenting his or her (1) current licensure by the Kansas State Board of Healing Arts; (2) adequate experience, education, and training; (3) current professional competence

in his or her specialty (including, but not limited to ABMS certification in the Practitioner's specialty); (4) ability to perform the Privileges requested; (5) good judgment; (6) continuing medical education as required by statute in the State of Kansas; and (7) individual judgment;

- 3.2.3 Establish that he or she (1) is of high moral character and adheres to generally recognized standards of medical and professional ethics; (2) is able to work cooperatively with others; and (3) will participate in and properly discharge those responsibilities determined by the Medical Staff;
 - 3.2.4 Demonstrate that he or she is free of or has under adequate control any significant physical or mental health impairment and be free from abuse of any type of substance or chemical that affects cognitive, motor, or communication ability in a manner that interferes with, or presents a reasonable probability of interfering with clinical performance, cooperativeness, satisfaction or membership obligations, or professional ethics and conduct, or otherwise renders the applicant unable to perform the essential functions of membership on the Medical Staff, even with reasonable accommodation;
 - 3.2.5 Obtain and maintain professional liability insurance coverage to meet or exceed such minimal amounts as shall be required or approved by the Hospital Board from time to time;
 - 3.2.6 Agree to be bound by the current Medical Staff Bylaws of Labette Health and all other lawful standards, policies, and rules of the Medical Staff and Medical Center.
 - 3.2.7 Have the ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner;
 - 3.2.8 Document a current DEA license registration unless the applicant's Clinical Privileges are such that the ordering of controlled substances was not requested and not necessary; and
 - 3.2.9 Demonstrate the ability to work cooperatively and professionally with the Medical Center, its employees, and its Medical Staff, and refrain from disruptive behavior which could interfere with patient care or the operation of the Medical Center.
- 3.3. **Effect of Other Affiliations.** No person shall be entitled to membership in the Medical Staff merely because he or she holds a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any clinical board, or had, or presently has, staff membership or privileges at another health care facility.
- 3.4. **Nondiscrimination.** No aspect of Medical Staff appointment for particular Clinical Privileges shall be denied on the basis of age, sex, race, creed, color, national origin, or any handicap unrelated to the ability to fulfill patient care and required Staff obligations.

3.5. Burden of Information and Exclusivity.

3.5.1 The applicant shall have the burden of producing adequate information for a proper evaluation of his or her professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. The foregoing qualifications shall not be deemed exclusive of other qualifications and conditions deemed by the Hospital or Medical Staff to be relevant in considering an applicant's or Practitioner's qualifications for exercising Privileges in the Hospital.

3.6. Membership Organization.

3.6.1 The Medical Staff shall consist of the following categories: (1) active; (2) associate; (3) consulting; (4) contract/telemedicine; (5) honorary; (6) dentist; and (7) hospitalists (Class A and B).

3.6.2 Designation of the appropriate category of the Staff will be made by the Medical Staff Credentials Committee at the time of initial appointment and at each time of reappointment.

3.6.3 All initial appointments to any category of the Medical Staff, except Honorary Staff, shall be provisional. The period of provisional membership shall be for at least six (6) months and not more than one (1) year for all applicants, at which time the appointee to provisional membership may request advancement from provisional to regular Staff status. Failure of an appointee to advance from provisional to regular Staff status shall be deemed a termination of his or her appointment. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a Member of the Medical Staff who has been denied reappointment. Provisional Staff Members shall be assigned to a Clinical Department where their performance shall be observed by the Chair of the Clinical Department or his or her representative to determine the eligibility of such provisional Members for regular Staff membership and for exercising the Clinical Privileges provisionally granted them. Provisional Staff Members must adhere to all requirements of the Staff category in which they have been placed. Provisional Staff Members are not eligible to serve as officers of the Medical Staff.

3.7. Categories of Membership.

3.7.1 *Active Staff.*

A. Qualifications. The Active Staff shall consist of Medical Staff Members who:

1. Meet the general qualifications for membership set forth in Section 3.2. If a Physician presents written documentation of a physical disability from his or her personal physician, the Medical Staff may amend active membership duties and Physician's obligation on a case-by-case basis;

2. Have offices and residences which are located sufficiently close enough to the Hospital such that continuous timely care can appropriately be provided to patients and the member is able to respond to an emergency situation generally within thirty (30) minutes of notification;
3. Utilize the Hospital as the Practitioner's primary treatment facility consisting of at least twelve (12) Hospital admissions yearly or demonstrate a major clinical affiliation with the facility through the use of the hospitalist program and/or through actual practice patterns;
4. Regularly demonstrate a significant affiliation with the Hospital through a substantial and continuing involvement in the administrative requirements of the Medical Staff, including, but not limited to, attendance at meetings, service on committees, and discharge of assigned responsibilities as may be assigned from time to time as defined in Article XI and elsewhere in these Bylaws; and
5. Serve on the Active Staff in a provisional status for a minimum of six (6) months, but not more than twelve (12) months.

B. Prerogatives. Except as otherwise provided, the prerogatives of an Active Staff Member shall be to:

1. Admit patients and exercise such Clinical Privileges as are granted pursuant to Article V.
2. Attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he or she is a duly authorized voting Member.
3. Hold Staff office and serve as a voting Member of committees of which he/she is duly appointed or elected by the Medical Staff or of which he/she is a duly authorized voting representative thereof.

C. Maintenance. Maintenance of Active Staff status shall require compliance with established requirements of the Medical Staff, as set forth in the Medical Staff Bylaws and Rules and Regulations. Failure to meet these requirements shall result in a six (6)-month probationary period after which, if compliance is still lacking, the Members will be transferred to another appropriate Medical Staff category, or membership will be terminated in accordance with the Bylaws.

D. Transfer of Active Staff Membership. A Member of the Active Staff who fails to regularly care for twelve (12) patients in the Hospital for one (1) year, or no longer demonstrates a major clinical affiliation with the Hospital,

shall be automatically transferred to another appropriate category or removed from Medical Staff membership.

- E. Emeritus Status. Any Member of the Active Medical Staff who has maintained membership in good standing for a minimum of ten (10) years prior to that time, shall be offered emeritus status upon reaching age sixty-five (65). Emeritus status will exempt the Member from paying Medical Staff dues and will exempt him or her from obligatory call schedules. The Member with emeritus status shall still be obliged to attend regular Medical Staff meetings, committee meetings of which he or she is a member, and Clinical Department meetings of the Clinical Department of which he or she is a member. The Member shall agree to abide by all obligations of these Bylaws and Rules and Regulations, except for the specific exemptions noted above.

3.7.2 *Associate Staff.*

- A. Qualifications. The Associate Staff shall consist of Medical Staff Members who:
1. Meet the general qualifications for membership set forth in Section 3.2;
 2. Have offices and residences which are located sufficiently close enough to the Hospital such that continuous and timely care can appropriately be provided to patients and the Member is able to respond to an emergency situation generally within forty-five (45) minutes of notification;
 3. Possess adequate clinical and professional competence within their area of expertise; and
 4. Serve on the Associate Staff in a provisional status for a minimum of six (6) months, but not more than twelve (12) months.
- B. Prerogatives. Except as otherwise provided, the Associate Staff Member shall be entitled to:
1. Admit, consult, and/or attend to patients, not to exceed 40 inpatient admissions or observation admissions, during a two (2)-year appointment cycle, and exercise such Clinical Privileges as are granted pursuant to Article V.
 2. Attend, in a non-voting capacity, meetings of the Medical Staff or committees of which he or she is a member, including open committee meetings and educational programs. Associate Staff Members shall not be eligible to hold office in the Medical Staff.

- C. Maintenance. Associate Staff Members shall remain in the Associate Staff category until such time as they may apply for and meet the requirements of another Staff category as defined in these Bylaws. Failure to comply with established requirements as set forth in the Bylaws will result in termination of membership.
- D. Transfer of Associate Staff Membership. The Credentials Committee may require that any Associate Staff Member who admits, consults and/or attends more than 40 inpatient admissions or observation admissions during a two (2)-year appointment cycle seek appointment to the Active Staff.

3.7.3 *Consulting Staff.*

- A. Qualifications. The Consulting Staff shall consist of such Practitioners who:
 - 1. Are not otherwise Members of the Medical Staff but meet the general qualifications for membership set forth in Section 3.2, which requires Kansas licensure.
 - 2. Possess adequate clinical and professional competence within their area of expertise;
 - 3. Are willing and able to come to the Hospital on schedule, or promptly respond when called to render clinical services within their area of expertise;
 - 4. Are members of the Medical Staff of another licensed hospital; and
 - 5. Serve on the Consulting Staff as a provisional status for a minimum of six (6) months, but not more than twelve (12) months.
- B. Prerogatives. The Consulting Staff Member shall be entitled to:
 - 1. Exercise such Clinical Privileges as are granted pursuant to Article V, but are not entitled to admit patients;
 - 2. Attend meetings of the Medical Staff and the committees of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings. Consulting Staff Members shall not be eligible to hold office in the Medical Staff.
- C. Maintenance. Consulting Staff Members shall remain in the Consulting Staff category until such time as they may apply for and meet the requirements of another staff category as defined in these Bylaws. Failure to comply with established requirements as set forth in Bylaws will result in termination of membership.

3.7.4 *Contract/Telemedicine Staff.*

A. Qualifications. The Contract/Telemedicine Staff shall consist of those Practitioners who:

1. Meet the general qualifications for membership set forth in Section 3.2, and hold Clinical Privileges appropriate for their contractual/telemedicine duties delineated in accordance with Article V;
2. Possess adequate clinical and professional expertise within the provisions of their contract;
3. Are physically present at the Medical Center facility or, with respect to telemedicine staff, provide assistance in the care of patients through the means of electronic communication, but are not physically present in the Medical Center facility;
4. Serve a specific function as delineated by a written contract with the Hospital and/or as requested on his/her credentialing application and as designated in his/her credentialing file;
5. Serve as Contract/Telemedicine Medical Staff in a provisional status for a minimum of six (6) months, but not more than twelve (12) months;
6. Do not seek membership in other Staff categories; and
7. Telemedicine Practitioners shall not be required to: reside in proximity to the Hospital; complete on-call responsibilities; attend Medical Staff, department, or committee meetings except as required by the Medical Executive Committee (and, if so requested, may attend by teleconference); pay Medical Staff dues; or take other actions that are inconsistent with their remote status.

B. Prerogatives. Contract/Telemedicine Staff Members are not eligible to vote or to hold a position as a Medical Staff officer. Contract/Telemedicine Staff Members shall be entitled to:

1. Under limited circumstances, as approved by the Medical Staff and as designated in the Member's credentialing file, admit patients to the hospital so long as the Practitioner is available to serve as the patient's Attending Physician;
2. Under limited circumstances, as approved by the Medical Staff and as designated in the Member's credentialing file, write admission orders for patients to be admitted to the hospital at the direction of the patient's Attending Physician who will promptly assume

responsibility for the medical evaluation, history, and physical, and overall medical responsibility for the patient's course of care in Hospital;

3. Serve, without a vote, on any appropriate Medical Staff committee(s); and
4. Attend Medical Staff meetings and educational meetings.

C. Contracts. A Practitioner, who provides specified professional services as a Member of the Contract/Telemedicine Staff, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and Clinical Privileges in the same manner and must fulfill all of the obligations of his or her category as any other applicant or Medical Staff Member.

D. Telemedicine Contracts. If the Medical Executive Committee relies on the credentialing and privileging decisions of a distant-site telemedicine entity, the Medical Staff will review the Telemedicine Practitioner's performance of his or her privileges performed at Labette Health and as reported from distant-site entity. If the Telemedicine Practitioner's distant-site entity is a Medicare-certified hospital or has credentialing and privileging processes and standards that meet or exceed the standards of the applicable Medicare Conditions of Participation for hospitals (including 42 C.F.R. 482.12(a)(1) through (7) and 42 CFR 482(a)(1) and (2)), the Medical Executive Committee may rely on credentialing and privileging decisions made by the distant-site telemedicine entity when it makes its recommendation to the Board regarding privileging of the Telemedicine Practitioner so long as it ensures through a written agreement with such distant-site entity certain conditions are met. The written agreement must contain provisions that ensure the following:

1. The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet those identified in the Medicare Conditions of Participation (including 42 C.F.R. 482.12(a)(1) through (7) and 42 CFR 482(a)(1) and (2));
2. The distant-site Telemedicine Practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services and the distant-site telemedicine entity provides Hospital with a current list of these privileges;
3. The Telemedicine Practitioner holds a license issued or recognized by the state of Kansas;
4. The distant site will provide Hospital evidence of the Telemedicine Practitioner's performance of his/her privileges which shall include, but is not limited to, completing a reappointment activity summary

and/or providing quality data as identified in Section 4.6.1, providing information on all adverse events that result from telemedicine services performed, and providing information regarding all complaints the distant-site entity has received about the Telemedicine Practitioner; and

5. Hospital will perform an internal review of the Telemedicine Practitioner's performance of his or her Clinical Privileges at Hospital and send the distant-site telemedicine entity such performance information for use in appraisal of the Telemedicine Practitioner.
- E. Appointment Termination. Because practice at the Hospital is contingent upon continued Staff appointment and is also constrained by the extent of Clinical Privileges granted, a Practitioner's right to use the Hospital facilities is automatically limited to the extent that pertinent Clinical Privileges are granted or revoked. The effect of an adverse change in Clinical Privileges on continuation of the contract is governed solely by the terms of the contract.
- F. Contract Termination. The Staff appointment and Clinical Privileges of any Staff Member who has a contractual relationship with the Hospital, or is either an agent, employee, or principal of, or partner in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon:
1. The expiration or other termination of the contractual relationship with the Hospital; or
 2. The expiration or other termination of the relationship of the Staff Member with the entity that has a contractual relationship with the Hospital.
- G. Contract Termination Rights. The Practitioner whose appointment and Privileges are terminated or altered in accordance with this section shall not be eligible for process under the Fair Hearing Plan.

3.7.5 *Honorary Staff.*

- A. Qualifications. The Honorary Staff shall consist of Practitioners who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous service to the Hospital. Honorary status shall also be accorded those Members who have retired from active practice and, at the time of their retirement, were Members in good standing of the Active Medical Staff.

- B. Prerogatives. Honorary Staff Members are not eligible to admit patients to the Hospital, to exercise Clinical Privileges in the Hospital, or to vote or hold office in the Medical Staff, but they may serve upon committees without vote at the discretion of the Chief of Staff. They may attend Staff meetings, including open committee meetings and educational programs.

3.7.6 *Dentists.*

- A. Qualifications. Privileges granted to Dentists by the Board of Trustees shall be granted according to the procedures and criteria set forth in Article V.

- B. Prerogatives. Dentists admitted to the Medical Staff:

1. Shall have all rights, Privileges, and responsibilities set forth in the Section of this Article applicable to his or her Staff category except as hereinafter limited and as limited in Article V, Section 5.11, of these Bylaws entitled “Special Conditions for Dentist.”
2. Shall be subject to the limitations described in Subsection 3.7.6.B.1 above and in this paragraph. Dentist Members of the Medical Staff may admit patients directly to the Hospital if the Dentist Member requested admitting privileges and is appropriately credentialed. Consultation with a qualified Physician who is a Member of the Medical Staff may be required for patients admitted for other medical services and such consultation shall be documented in the medical record. Dentists are responsible for documentation of the complete dental history and dental physical examination. Patients for dental care, whether admitted as inpatients or as outpatients, shall be under the care of a Member of the Medical Staff. The Dentist Medical Staff Member must request appropriate consultation when unusual or non-dental complications are encountered.

- C. Obligations. Dental Members of the Medical Staff:

1. Shall be responsible for the completion of records in their field, and shall record the dental history and dental examination and a simple statement on the patient’s general health.
2. May write orders within the scope of their license, as limited by applicable law, as consistent with Medical Staff Rules and Regulations and Hospital policies and procedures and within the scope of their Privileges as granted pursuant to these Medical Staff Bylaws.

3.7.7 *Hospitalist Staff.*

- A. Qualifications. The Hospitalist Staff shall consist of Practitioners who:

1. Meet the general qualifications for membership set forth in Section 3.2;
2. Serve as hospitalists as delineated by a written contract with the Hospital;
3. Possess adequate clinical and professional expertise within the provisions of their contract with the Hospital;
4. Serve on the Hospitalist Staff in a provisional status for a minimum of six (6) months, but no more than twelve (12) months; and
5. Do not seek membership in other Staff categories.

B. Prerogatives. The prerogatives of Hospitalist Staff Member shall be to:

1. Admit, attend to, and discharge patients and exercise such Clinical Privileges as are granted pursuant to Article V;
2. Attend meetings of the Medical Staff or committees which are designated in these Bylaws or by the Medical Executive Committee as having a Hospitalist seat on the committee. Hospitalists' voting rights at Medical Staff meetings and committee meetings shall be determined by their Hospitalist class as follows:
 - (a) Class A Hospitalists shall consist of Hospitalists who provide all their professional hospitalist services at Medical Center. Class A Hospitalists will each have one (1) vote at Medical Staff meetings and at meetings of any committee that includes a Hospitalist seat on the committee. Class A Hospitalists may hold office in the Medical Staff.
 - (b) Class B Hospitalists shall consist of Hospitalists who also provide hospitalist services at facilities other than Medical Center. Class B Hospitalists will have one (1) collective vote at Medical Staff meetings and at meetings of any committee that includes a Hospitalist seat on the committee. The Class B Hospitalist vote will be cast by the Class B Hospitalist member in attendance at the meeting when the vote is taken and will be presumed to represent the unanimous vote of all Class B Hospitalists unless another Class B Hospitalist attends and casts a conflicting vote. If a conflicting vote is cast, then no Class B Hospitalist vote will be counted and the Class B Hospitalist vote will not be included, either in the quorum requirement or for voting on a particular matter. Attendance requirements set forth in Section 9.7 for Staff and Committee Members shall be applied to the Class B Hospitalist seat, such that the

attendance requirement may be satisfied by the attendance of any Class B Hospitalist at a given meeting. Class B Hospitalist Medical Staff shall not hold office in the Medical Staff.

- C. **Maintenance.** Hospitalist Staff shall remain in the Hospitalist category until such time as they apply for and meet the requirements of another Staff category as defined in these Bylaws, until they fail to satisfy the qualifications for membership, or until their written contract with the Hospital is terminated or expires for any reason. Upon expiration or termination of a Hospitalist's contract with the Hospital, the Hospitalist's Medical Staff appointment and clinical privileges at Hospital shall terminate automatically and immediately and without, to the extent permitted by applicable law, any right he/she may have to any hearing or appeal procedures available under these Medical Staff Bylaws and/or bylaws, rules, or regulations, and/or policies of the Hospital; the Health Care Quality Improvement Act of 1986; or any other federal or state statute, regulation, or judicial or administrative decision.

- 3.8. **Limitations of Prerogatives.** The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, by the Medical Staff Rules and Regulations, and by Hospital policy.

ARTICLE IV APPOINTMENT AND REAPPOINTMENT

- 4.1. **General.** Except as otherwise specified herein, no person shall exercise Clinical Privileges in the Hospital unless and until he or she (1) applies for and receives appointment to the Medical Staff and such Privileges are granted, or (2) obtains temporary, emergency, or Disaster Privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of Members of Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout the period of membership he or she will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer only such Clinical Privileges as have been granted in accordance with these Bylaws.
- 4.2. **Burden of Producing Information.** In connection with all applications affecting Medical Staff membership or Clinical Privileges, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the Clinical Privileges and Staff category requested. Submission of an incomplete application, or an application that is not acceptable under the requirements set forth in these Bylaws, is cause for rejection of the application. Rejection for such cause will not entitle the applicant's right to a fair hearing as provided in the Fair Hearing Plan.

- 4.3. **Appointment Authority.** Appointments, denials, and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after a recommendation from the Medical Executive Committee to the Board of Trustees. Final authority for all appointments and reappointments rests with the Hospital Board.
- 4.4. **Duration of Appointment and Reappointment.** Provisional appointments shall be for the period provided in Section 3.6. Appointments after the completion of provisional status shall be for a period of time not to exceed two (2) years (inclusive of the provisional period). Reappointment thereafter shall be for a period of time not to exceed a two (2)-year period.
- 4.5. **Application for Initial Appointment.**
- 4.5.1 **Application Form.** An application form shall be developed by the Credentials Committee. The form shall require detailed information that shall include, but not be limited to, the following:
- A. The applicant's qualifications, including, but not limited to, medical education, professional training and experience, and specialty board status if applicable;
 - B. Proof of current licensure, current DEA registration, and continuing education related to the Clinical Privileges to be exercised by the applicant;
 - C. A minimum of three (3) appropriate references by persons familiar with the applicant's professional competence, ethical character, and individual judgment and/or evidence of clinical activity with outcomes to support the Clinical Privileges requested if not attested to by references;
 - D. Requests for membership category, Clinical Privileges, and Clinical Department assignments;
 - E. Documentation of adequate professional liability coverage;
 - F. Citizenship or visa status;
 - G. Past or pending professional disciplinary actions, previously successful or currently pending challenges to any professional licensure or registration, or voluntary relinquishment of any such licensure or registration for the purpose of avoiding such disciplinary action;
 - H. All voluntary or involuntary terminations of medical staff membership, disciplinary actions from other hospital medical staffs, or involuntary limitations, reductions, or loss of clinical privileges at another hospital;
 - I. Involvement in professional liability action in which there was an adverse judgment or settlement;

- J. Clinical logs where appropriate for physicians who recently completed a training program;
- K. Health care employment and appointment history; and
- L. Any criminal conviction other than minor traffic offenses.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by a complete explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, he or she shall be given or provided access to a copy of these Bylaws by the Medical Staff Credentialing Office.

An applicant for Medical Staff appointment shall have the duty to provide current, updated information that is relevant to any question on the application form, even after the application has been completed. Any misrepresentation, misstatement, or omission from the application is cause for rejection.

4.5.2 ***Application Agreement.*** In addition to the matters set forth above, the application form shall also contain an agreement to be signed and dated by the applicant. By signing the agreement the applicant agrees to:

- A. Appear for interviews in regard to the application if requested;
- B. Authorize Labette Health to obtain a current report on the applicant from the National Practitioner Data Bank;
- C. Authorize inspection and copying of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out Clinical Privileges requested, and authorization of all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- D. Release and hold harmless of all persons from any liability for their acts performed in connection with investigating and evaluating the applicant, and any credentials or peer review activities relating to him or her;
- E. Release from any liability all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- F. Authorize Labette Health to disclose to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, of any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

- G. Pay Medical Staff dues, as required;
- H. Provide continuous quality care for his or her patients;
- I. Maintain an ethical practice, including but not limited to, treating patients based on medical necessity, refraining from accepting illegal inducements for patient referrals, abstaining from engaging in any fraudulent practices related to health care services provided or otherwise, documenting appropriately and accurately all medical care and treatment provided to patients, seeking consultation whenever necessary, refraining from inappropriately claiming to perform or documenting the performance of a surgery or another medical procedure or when not participating in the actual procedure, providing proper oversight and supervision for allied health professionals and refraining from delegating patient care responsibility to non-qualified or inadequately supervised Practitioners;
- J. Abide by the Bylaws and Rules and Regulations of the Medical Staff of Labette Health as shall be in force during the time the applicant is a Member of the Medical Staff;
- K. Bear the burden of producing adequate information for a proper evaluation of the applicant's competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications to the satisfaction of the Credentials Committee and/or the Medical Executive Committee;
- L. Allow access to the applicant's criminal history record information for purposes of determining the applicant's fitness for Medical Staff membership;
- M. Submit to a physical and/or mental health evaluation by a licensed third-party physician who is not a Member of the Medical Staff, at the applicant's expense, if requested by the Medical Executive Committee and in accordance with Section 3.2.4;
- N. Report any changes to his/her application for appointment that may affect appointment to the Medical Staff, including but not limited to the following: (1) notice of initiation of any action by a state or federal agency that could result in changes to the applicant's professional licensure status, ability to prescribe controlled substances, and/or participation in any federal or state health care program such as Medicare or Medicaid; (2) felony conviction; (3) voluntary withdrawal, surrender, change or limitation in the applicant's staff privileges, licensure, registration or provider status; and (4) any modification to the applicant's professional liability insurance other than change of carrier; and
- O. Comply in full with all applicable Labette Health policies and procedures, including but not limited to, Labette Health's Corporate Compliance Plan and Code of Conduct.

4.5.3 **Verification of Information.** The applicant shall deliver a completed application to the Medical Staff credentialing office. The Medical Staff Office shall expeditiously collect or verify the references, licensure status, and other evidence submitted in support of the application. The applicant shall be notified of any problems in obtaining the information required, and the applicant shall be obligated to obtain the required information. Information about the applicant shall also be requested in the form of a criminal background check and from any data base established by or under authority of the Secretary of Health and Human Services or the Office of the Inspector General of the Department of Health and Human Services, including but not limited to the National Practitioner Data Bank, the OIG Exclusion Database, the System for Award Management Database, and/or other state Medicaid exclusion lists as necessary. All such information shall be transmitted to the appropriate Clinical Department Chair(s).

4.5.4 **Review by Clinical Department Chair(s).** The appropriate Clinical Department Chair(s), or appropriate designee, shall review the application, evaluate and verify the supporting documentation and other relevant information at the meeting of the Credentials Committee, and discuss any concerning action to be taken on the application.

4.5.5 **Credentials Committee Action.** After review of the Department Chair(s) recommendation(s), the application and any other relevant information, the Credentials Committee shall take one or more of the following actions:

- A. Request additional information;
- B. Undertake further investigation, including an interview with the applicant;
or
- C. Make recommendation to the Medical Executive Committee as follows: (1) approve the application; (2) approve the application subject to the completion of additional requirements such as training, monitoring or proctoring; (3) approve the application subject to modifications or restrictions; or (4) reject the application.

All recommendations by the Credentials Committee shall be made to the Medical Executive Committee within sixty (60) days of receipt of a completed application.

4.5.6 **Executive Committee Action.** At its next regular meeting after receipt of a recommendation from the Credentials Committee concerning an application for Medical Staff membership, the Medical Executive Committee shall review such recommendation. The Medical Executive Committee may concur with the Credentials Committee's recommendation, modify such recommendation, or refer the matter back to the Credentials Committee for further review. The final recommendation of the Medical Executive Committee with respect to an application for Medical Staff membership shall be promptly transmitted to the Board of Trustees. The recommendation shall include proposals as to the category

of Staff appointment for the applicant, Clinical Privileges, Clinical Department appointments, and any modifications or special conditions to be fulfilled, such as additional education, training, monitoring or proctoring, attached to the appointment. The reasons for each recommendation shall be stated.

4.5.7 ***Action of the Board of Trustees.*** The Board of Trustees may accept or reject the recommendation of the Medical Executive Committee, or may refer the application back to the Medical Executive Committee for further consideration, stating the purpose for such referral. Action shall be taken by the Board at the next regularly scheduled meeting after receipt of a recommendation from the Medical Executive Committee.

4.5.8 ***Notice of Adverse Action.*** Notice of any adverse recommendation or action by the Medical Executive Committee or the Board of Trustees shall be given in compliance with Section 1.3 of the Fair Hearing Plan, and such applicant shall be entitled to the procedural rights provided in Article XII and the Fair Hearing Plan.

4.5.9 ***Notice of Final Decision.***

A. Notice of the final decision of the Board of Trustees shall be given to the Chief of Staff, the Medical Executive Committee, the applicant, and the Hospital CEO.

B. A decision and notice to appoint shall include: (1) the Staff category to which the applicant is appointed; (2) the Clinical Privileges granted; (3) the Clinical Department to which the applicant is appointed; and (4) any special conditions attached to the appointment.

C. An appointment to the Medical Staff made by the Board of Trustees shall be provisional for a period of at least six (6) months and not more than one (1) year, and shall confer upon the appointee only such Privileges as have been approved including the identification of any additional restrictions, requirements or modifications to such Privileges and/or any conditions precedent that must be satisfied prior to the appointee's exercise of such Privileges. All newly granted Clinical Privileges shall be subject to focused profession practice evaluation as defined herein.

4.5.10 ***Reapplication After Adverse Appointment Decision.*** An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any reapplication thereafter shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5.11 ***Timely Process of Applications.*** Applications for staff appointments shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good

cause and warrant exceptions, this entire process shall not take more than one hundred eighty (180) days.

4.6. **Reappointments and Requests for Modifications of Staff Status or Privileges.**

4.6.1 *Application.*

- A. At least four (4) months prior to the expiration date of the current Medical Staff appointment (except for temporary appointments), an application form for reappointment shall be mailed or delivered to each Member (including Telemedicine Practitioners) by the office of the Medical Staff. If the application is not returned at least ninety (90) days prior to such Medical Staff appointment expiration date, the applicant will be notified advising that the application has not been received by the Medical Staff Office. At least sixty (60) days prior to the expiration date, each Medical Staff Member due for reappointment shall submit to the Medical Staff Office a completed, signed, and dated application for reappointment to the Staff. Such reapplication may also be submitted at any time prior to the applicant's appointment expiration date if the applicant wishes to request a modification of Clinical Privileges or Medical Staff membership category. The reapplication form shall be developed by the Credentials Committee and shall include, but not be limited to, the following:
1. Any changes in information from the original application;
 2. An accounting, including copies of attendance certificates, of continuing medical education (CME) since the last application;
 3. Proof of continuing professional liability coverage;
 4. A request for renewal of, or modification of, previously granted Clinical Privileges;
 5. A report of any previously successful or currently pending challenges to any professional licensure or registration, or voluntary relinquishment of such licensure or registration;
 6. A report of any voluntary or involuntary termination of Medical Staff membership or reduction, limitation, or loss of Clinical Privileges at another hospital;
 7. Involvement in any professional liability action in which there was an adverse judgment or settlement; and
 8. Current citizenship or visa status.
- B. A Physician Quality Profile Report (PQPR) shall also be prepared by the Medical Staff Office and reviewed by the Credentials Committee. If the

reappointment applicant is a Telemedicine Practitioner providing services through a distant-site telemedicine entity upon which the Credentials Committee and Medical Executive Committee relies for credentialing and privileging decisions, the distant-site telemedicine entity will provide a reappointment activity summary and/or provide quality data as identified in Section 4.6.1. The form shall be completed at least sixty (60) days prior to the expiration date of the applicant's appointment. The form shall include all information necessary to update and evaluate the qualifications of the applicant, including, but not limited to, the following:

1. Ethical behavior, professional performance, judgment, and clinical or technical skills;
2. Attendance at Medical Staff and committee meetings and compliance with administrative requirements as given elsewhere in these Bylaws;
3. Compliance with Hospital policies and Medical Staff Bylaws and Rules and Regulations;
4. Behavior in the Hospital, including cooperation with Medical Staff Members and Hospital personnel relating to patient care and the orderly operation of the Hospital;
5. Appropriate use of Hospital facilities for patient care, taking into consideration the Member's comparative utilization patterns;
6. Capacity to satisfactorily treat patients as indicated by results of the Hospital's quality improvement and risk management activities and other reasonable indicators of continuing competence;
7. Level of activity, including frequency of performance of credentialed procedures;
8. Technical skill in the performance of credentialed procedures;
9. Ongoing professional practice evaluation data as defined herein;
10. Undiminished capacity to care for patients appropriately in terms of health status, stamina, and psychiatric stability to perform the essential functions of Medical Staff membership with reasonable accommodation, including the appropriate care of patients; and
11. Freedom from abuse of substances or chemicals which would affect cognitive or motor ability in a manner which has resulted, or reasonably could result, in less than optimal patient care, or in behavior affecting coordination and cooperation with other Medical Staff Members or Hospital personnel.

- 4.6.2 ***Effect and Procedure for Review.*** An application for reappointment or for modification of Clinical Privileges shall be handled in the same manner as set forth for initial applications in Sections 4.5.3 through 4.5.9.
- 4.6.3 ***Extension of Appointment.*** If an application for reappointment has been duly received before the sixty (60) day deadline prior to the appointment expiration date, but has not been fully processed by the expiration date, the Staff Member shall maintain membership status and Clinical Privileges until such time as the processing is completed. If the delay is due to the Member's failure to complete and return the reappointment application form, provide other documentation, or cooperate in any other way with the application process, the appointment shall terminate. Any extension of any appointment pursuant to this section does not create a vested right in the Member for continued appointment through the entire next term, but only until such time as processing of the application is concluded.
- 4.6.4 ***Failure to File Reappointment Application.*** Failure to file a completed application for reappointment in a timely manner shall result in the automatic suspension of the Member's admitting Privileges and expiration of other practice Privileges and prerogatives at the end of the current Staff appointment. Upon a showing of good cause, the Hospital, within its discretion, may grant a sixty (60)-day grace period for the submission of the Member's completed reappointment application. If the Member fails to submit a completed application for reappointment within this grace period and within sixty (60) days after the expiration date of his/her Medical Staff appointment, the Member shall be deemed to have resigned his/her membership on the Medical Staff. In the event membership terminates for the reasons set forth in this Section 4.6.4, the procedures set forth in Article XII and the Fair Hearing Plan shall not apply.
- 4.6.5 ***Staggered Reappointments.*** To the extent reasonably possible, one-half (1/2) of the Staff shall be appointed in even-numbered years and the other one-half (1/2) in odd-numbered years. April and October have been designated as the "cycle months" for reappointment. The specialties have been divided as equally as possible for an April or October appointment/reappointment month. The Member's specialty determines the even/odd year rotation in which the Member will be placed. To ensure all providers of like specialty fall into the even/odd year reappointment rotation, some providers, when initially credentialed, may need to be credentialed for a shorter timeframe as an appointment cannot exceed a two (2)-year cycle but regulations do allow for a shorter cycle if needed or desired by the facility.
- 4.7. ***Leave of Absence.*** At the discretion of the Medical Executive Committee, a Medical Staff Member may obtain a voluntary leave of absence from the Staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the Member shall not exercise Clinical Privileges at the Hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue. A leave of absence for mandatory military duty shall be for whatever length of time required

and shall result in an automatic return to the Member's prior Medical Staff category following an honorable cancellation of these duties. If the leave of absence is due to health or psychiatric reasons, the Member must document his or her status prior to returning to the previous Medical Staff category. At least thirty (30) days prior to the expected expiration of the leave of absence, the Practitioner shall submit a request to the Medical Executive Committee for reinstatement of previously enjoyed Privileges, after which the Medical Executive Committee shall evaluate the Practitioner's continued qualification for such Privileges and shall make a recommendation to the Board concerning such request. No Privileges shall be deemed reinstated until such request has been approved by the Medical Executive Committee and the Board. Any absence of greater than one (1) year, except for mandatory military duty, will require a new initial application as per Section 4.5. Prior to any leave of absence, the Medical Staff Member shall coordinate with the Chief of Staff to assure that the Member's patients are assigned to another Medical Staff Member during the leave of absence.

- 4.8. **Death.** In case of death of a Medical Staff Member who has patients in the Hospital at the time of his or her death, the Chief of Staff will assign the care of the patients to an appropriate Medical Staff Member.

ARTICLE V CLINICAL PRIVILEGES

5.1. **Exercise of Privileges.**

5.1.1 **General.** Except as otherwise provided in these Bylaws, a Member providing clinical services at this Hospital shall be entitled to exercise only those Clinical Privileges specifically granted. Such privileges and services must be within the scope of any license, certificate, or other legal credential authorizing practice in this state and consistent with any restrictions thereof, and shall be subject to the authority of the Medical Staff and the Board.

5.1.2 **Limitation.** No individual shall exercise Clinical Privileges except in accordance with and as granted pursuant to these Bylaws.

5.2. **Delineation of Privileges.**

5.2.1 **Requests.**

- A. Each application for appointment to the Medical Staff must contain a request for the specific Clinical Privileges desired by the applicant. Such requests must be accompanied by documentation of training, experience, and references supportive of the request.
- B. The application for reappointment shall also contain a request for any desired addition or deletion in Clinical Privileges. Any request for additional Privileges shall be accompanied by documentation of training, experience, and supportive references that would establish competency. Clinical Privileges which have been unused for a period of time or

considered inappropriate by the relevant Clinical Department shall also be accompanied by a request for continuation, and shall likewise be supported by documentation of continued training, experience, and updated references.

- C. All requests for Clinical Privileges shall be reviewed by the appropriate Department Chair, or an appointed Medical Staff designee as appropriate, and his/her recommendations regarding approval or denial related to such privileges will be presented at the Credentials Committee meeting.
- D. Any request to perform procedure(s) or a request for Clinical Privileges that are either new to the Hospital or that overlap more than one Clinical Department shall initially be reviewed by the Credentials Committee. The Credentials Committee may request information from one (1) or more Clinical Departments or Practitioners, or may create an ad hoc committee as deemed necessary to establish credentialing criteria. The Medical Executive Committee will have the final responsibility for approving the credentialing requirements for a new procedure or a procedure that involves more than one Clinical Department based on the recommendation of the Credentials Committee.

5.2.2 ***Basis for Privileges Determination.*** Requests for Clinical Privileges shall be evaluated on the basis of the Member's education, training, experience, demonstrated professional competence and judgment, clinical performance, references from those familiar with the applicant's performance, the documented results of patient care, and other quality review and monitoring that the Credentials Committee and/or the Medical Executive Committee deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially institutions and health care settings where a Practitioner has received training or has exercised Clinical Privileges. On application for reappointment, a review of the applicant's performance shall also be given by the appropriate Department Chair(s). If the applicant is the Department Chair, the Credentials Committee shall review the applicant's performance and follow-up as needed with other Members as appropriate.

5.3. **Focused Professional Practice Review/Proctoring.**

5.3.1 ***Focused Professional Practice Review (FPPE).***

- A. The Medical Executive Committee, or its designee, shall conduct FPPE:
 - 1. For all initially requested Clinical Privileges, including modifications to Clinical Privileges; and
 - 2. When issues/concerns affecting safe, high-quality patient care are identified.

- B. The Medical Executive Committee, or its designee, shall determine when monitoring is required for patient care issues. Monitoring may be triggered by a single incident or evidence of a clinical practice trend. Factors in determining the need for monitoring may include, but are not limited to the following:
1. A Practitioner's clinical competence;
 2. Ability to perform the requested Clinical Privilege;
 3. Practice behavior including, but not limited to: (a) higher than normal infection rates, (b) low volume admissions; (c) procedures over an extended period of time; (d) increased length of stay; (e) increased number of returns to surgery; and/or (f) increased patient readmission rate;
 4. Confirmed reports of failure to follow approved clinical practice guidelines or unsafe practices in clinical or procedural areas of the Medical Center;
 5. Adverse and/or Sentinel Events;
 6. Substantiated reports or complaints regarding inappropriate interactions with patients, family or staff;
 7. Evidence of incomplete or inadequate medical record documentation; and
 8. Issues identified as a result of peer review and/or ongoing professional performance evaluation (OPPE).
- C. The Medical Executive Committee, or its designee, shall monitor:
1. Initially requested Clinical Privileges for a time period acceptable to confirm the Practitioner's competence to perform the newly granted Clinical Privilege. The time for such monitoring shall be based on the Clinical Privilege requested and shall take into account the volume, the risk, and the complexity of such privilege.
 2. Patient care issues for a time period acceptable to confirm the Practitioner is capable of delivering safe, high-quality patient care.
- D. FPPE may include medical record/chart reviews, observing clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of the Practitioner's patients. The length of prescribed monitoring period, either a period of time or a number of cases/procedures, will be determined by the Medical Executive Committee, or its designee, at the time it determines FPPE is required. The

Medical Executive Committee shall examine the facts and circumstances for the FPPE including, but not limited to the volume, level of risk, frequency rate of the requested privilege, conduct or patient care issue being reviewed. This period may be extended as needed so long as it is not in conflict with any other provisions in these Bylaws.

- E. The Medical Executive Committee shall, depending on the facts and circumstances of a particular situation, determine when FPPE monitoring by an external source is required. Factors to be considered include, but are not limited to any potential or perceived conflicts of interest or any limitations in the qualifications of the Members of the Medical Staff to appropriately perform the monitoring.
- F. Unless FPPE is being performed for a newly requested Clinical Privilege, Practitioners undergoing monitoring shall be notified by the Medical Executive Committee in writing and such notification shall identify the terms of the FPPE including the cause, the duration, and the method(s) being utilized.
- G. Performance issues identified in the FPPE process will be addressed through appropriate measures including, but not limited to the following: (1) necessary education; (2) proctoring/assisting for a defined Privilege; (3) counseling; (4) Practitioner assistance programs; (5) suspension or revocation of all or specific Privileges; and/or (6) suspension or revocation a Practitioner's participation on the Medical Staff.
- H. The Medical Executive Committee, or its designee, shall analyze FPPE outcomes and ensure appropriate documentation of all monitoring is completed in the time-frame established by the Medical Executive Committee for practitioner being monitored. As appropriate, the Medical Executive Committee, or its designee, shall submit recommendations to the Board for Practitioners requiring continued FPPE and monitoring (not to exceed twenty-four (24) months without a review), Practitioners whose privileges should be limited or revoked, and Practitioner's whose privileges require Board approval.

5.3.2 **Proctoring.** As a part of, or in addition to FPPE, the Medical Executive Committee may require that a Member of the Staff be proctored at any time. The purpose of proctoring shall be to verify the clinical competence of a Member of the Staff or to otherwise evaluate the qualifications of a particular individual for Clinical Privileges. The proctor shall be responsible solely to the Medical Executive Committee to observe the Practitioner who is being proctored and to provide an appropriate report. The proctor shall be knowledgeable and experienced within the area of Clinical Privileges being monitored. The proctor may be, but need not be, a Member of the Medical Staff.

5.4. Temporary Clinical Privileges.

5.4.1 *Circumstances.*

- A. Temporary admitting and Clinical Privileges may be granted to a Physician when good cause exists for the care of specific patients, but for not more than ninety (90) days, unless renewed.
- B. Temporary Privileges may be granted to a person serving as a *locum tenens* for a current Member of the Medical Staff. Such person may attend only patients of the Member or Members for whom he or she is providing coverage for a period not to exceed ninety (90) days, unless the Medical Executive Committee recommends a longer period.
- C. Temporary Privileges may be granted to a person for times of emergency and/or disaster in accordance with the Hospital's plan for dealing with clinical volunteers during such times which shall include primary source verification from the volunteer's hospital.
- D. Temporary Privileges may be granted to an applicant for Medical Staff membership during the time the application is being verified and processed. Such temporary Privileges will terminate immediately upon final action of the Board of Trustees.

5.4.2 *Application and Review.*

- A. Upon receipt of a completed application, supporting documentation, and query of the National Practitioner Data Bank, the Chief of Staff or his/her designee shall review the applicant's qualifications and professional peer references to ensure professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.
- B. The office of the Hospital CEO or his/her designee shall confirm that the applicant is currently licensed in the State of Kansas, that he or she has the required malpractice insurance coverage, and has a valid DEA registration.
- C. The Chief of Staff, on behalf of the Medical Executive Committee, may then recommend granting temporary Privileges.
- D. The applicant shall sign an agreement to abide by Hospital policies and the Medical Staff Bylaws and Rules and Regulations.
- E. Upon receiving the recommendation from the Chief of Staff, the Hospital CEO, on behalf of the Board, may grant temporary Privileges to the applicant who appears to have the qualifications of individual character, individual competence, individual training, individual experience, and individual judgment required by Section 3.2

- 5.5. **Emergency Privileges.** In the event of an emergency and/or disaster, the Hospital shall use volunteer practitioners as appropriate within the scope of their license or certification as verified through the appropriate licensing agency and/or through primary source identification from the volunteer's hospital in accordance with Hospital's policies and procedures governing emergency planning. Notwithstanding the forgoing, any Practitioner shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such Practitioner shall promptly yield such care to qualified Members of the Medical Staff when such individuals become reasonably available.
- 5.6. **Modification of Clinical Privileges.** On its own, or pursuant to an application by a Member, the Credentials Committee may recommend a change in the Clinical Privileges of a Member. The Credentials Committee may also recommend that the granting of additional Privileges to a current Medical Staff Member be made subject to proctoring in accordance with procedures outlined under this Article.
- 5.7. **Lapse of Application.** If a Medical Staff Member applying for a modification of Clinical Privileges fails to furnish the information necessary to evaluate the application within sixty (60) days of a request for such information, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in Article XI and the Fair Hearing Plan.
- 5.8. **Privileges Granted.** Clinical Privileges shall be granted at the time of the initial appointments as provided by Section 4.5.
- 5.9. **Voluntary Relinquishment.** A Member who has Clinical Privileges which are no longer needed, or are not used with a sufficient frequency so as to keep the Member proficient, may request voluntarily to have those Privileges removed. Such a request shall be accepted and noted in the Member's credentials file. Furthermore, specific notice shall be made that such a relinquishment was voluntary and was not part of disciplinary action against the Member.
- 5.10. **Medical Staff Credentials Files.**
- 5.10.1 ***Maintenance of Single Files.*** All information regarding the initial application for appointment and subsequent applications for reappointment shall be kept in a credentials file. Only one (1) credentials file shall be maintained on each Medical Staff Member, except for any records that may be required by the Americans with Disabilities Act to be maintained separately. Separate credentialing files shall not be maintained by both Medical Staff and by administration on any Medical Staff Member.
- 5.10.2 ***Access to File.*** A Member shall have access to his or her credentials file pursuant to procedures described in Section 13.2.3 of these Bylaws.
- 5.10.3 ***Correction and Deletion of Information.*** A Member who has reviewed his or her file pursuant to the procedures specified in Section 13.2.3 may address a written request for correction or deletion of information to the Chief of Staff. The request

shall include a statement of the basis for the requested action. The request shall be reviewed by the Chief of Staff who shall make a recommendation to the Medical Executive Committee concerning the requested correction or deletion. The Member shall be notified promptly in writing of the decision of the Medical Executive Committee. In any event, a Member shall have the right to add a statement responding to any information contained in the file.

5.10.4 **Confidentiality.** The following applies to all records of the Medical Staff:

- A. Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained;
- B. Access to such records shall also be granted to the Board, the Hospital CEO, and their designees, so that they may discharge their lawful obligations and responsibilities with regard to the operation of the Hospital, but confidentiality shall be maintained during such obligations and responsibilities; and
- C. Information contained in the credentials file of any Member may be disclosed without the Member's consent to the Kansas State Board of Healing Arts when legally required, or as otherwise required by applicable law. The affected Member shall be notified, however if such a request is received.

5.11. **Special Conditions for Dentists.** Clinical Privileges requests received from Dentists shall be reviewed in accordance with the procedures contained in this Article. Surgical procedures shall be reviewed and supervised by the Surgery Department Chair. Patients of Dentists must receive a basic medical evaluation by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff also shall be responsible for the medical care of any patient during the patient's hospitalization and will advise on the risk and effect of any procedure on the patient's total health status. The Physician consultant and the Dentist must agree on the performance of any surgical procedure if a significant medical abnormality is present. The Surgery Department Chair will decide the issue in case of dispute. The Dentist is responsible for the dental history and physical and all appropriate elements of the patient's record. A Dentist specialist may write orders within the scope of his or her license as limited by law and as consistent with the Medical Staff Rules and Regulations. He or she shall agree to comply with all applicable Medical Staff Bylaws and Rules and Regulations, and Hospital Bylaws and policies and procedures.

ARTICLE VI OFFICERS

6.1. **Officers of the Medical Staff.**

6.1.1 **Identification.** The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer.

- 6.1.2 ***Qualifications.*** Officers must be Members of the Active Medical Staff or Hospitalist A Medical Staff categories at the time of their nomination and election, and must remain Members in good standing during their term of office. An officer shall be removed for failure to maintain such status which shall create a vacancy in the office involved.
- 6.1.3 ***Chief of Staff Term of Office.*** The then-Vice Chief of Staff shall assume the office of Chief of Staff upon the conclusion of the then-Chief of Staff's term. If a Chief of Staff vacates the office for any reason prior to the end of his or her two (2)-year term, the then-Vice Chief of Staff shall complete the Chief of Staff's term and then serve his or her two (2)-year term as Chief of Staff.
- 6.1.4 ***Election and Term of Office of Vice Chief of Staff and Secretary-Treasurer.*** The Vice Chief of Staff and Secretary-Treasurer shall be nominated every other year on even years with elections to be held at the October meeting of the Medical Staff. A single nomination for each office is to be submitted by the Nominating Committee in accordance with Section 7.5.2. Nominations from the floor are also permitted. Each officer shall be elected upon receiving a majority of the valid votes cast. Voting may be by written ballot, with any nominations from the floor written in. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes. A tie vote shall result in the person selected by the Nominating Committee achieving that office. Voting shall be limited to Active Staff Members present at that meeting. The Vice Chief of Staff and the Secretary-Treasurer each shall serve a two (2)-year term, commencing on the first day of the Medical Staff Year following his or her election. Each officer shall serve in each office until the end of his or her tenure, unless the officer shall sooner resign, be removed from office, or, in the case of the Vice Chief of Staff, assume the office of Chief of Staff. No officer shall serve two (2) consecutive terms in any given office. An officer may, however, be elected for a full term after completing a partial term following a vacancy in office.
- 6.1.5 ***Resignation and Removal from Office.***
- A. Any Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date the letter is accepted by the Medical Executive Committee. The vacancy created by a resignation under this paragraph shall be filled in accordance with Section 6.1.6.
 - B. Any officer of the Medical Staff may be removed if he or she fails to perform the duties of that office as described in Section 6.2, or if his or her behavior is such that results in a lack of confidence in the leadership of that individual.
 - C. The removal of any officer of the Medical Staff may be effected by the following method:

1. A signed petition must be presented to the Hospital CEO by no less than ten (10) members of the Active Medical Staff. The CEO shall forward the petition to the Medical Executive Committee.
2. The petition for removal shall result in a vote at a regularly scheduled Medical Staff meeting or a special meeting of the Medical Staff as provided in Section 9.1.2 of these Bylaws.
3. An officer shall be removed upon the vote of at least two-thirds (2/3) of the Members of the Active Medical Staff. Such voting shall be done by written ballot and shall be limited to those Members attending that meeting. The purpose of such meeting shall be announced to all Members of the Active Medical Staff at least thirty (30) days prior to that meeting.

D. A Medical Staff officer will be removed from office automatically if he or she loses Medical Staff Privileges, or loses or foregoes Active Medical Staff membership. The removal does not pertain to temporary loss of admitting privileges for his/her failure to complete medical records and/or failure to appear at a meeting as requested by a committee.

6.1.6 ***Vacancies in Elected Office.*** Vacancies in office occur upon the death, disability, resignation, or removal of the officer, or such officer's loss of membership in the Active Medical Staff. If there is a vacancy in the office of Chief of Staff, the then Vice Chief of Staff shall serve out that remaining term. If there is a vacancy in the office of Vice Chief of Staff or Secretary-Treasurer, the Nominating Committee shall immediately convene to decide promptly upon nominees for that office. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election for that position shall occur at the next regular Staff meeting.

6.2. **Duties of Officers.**

6.2.1 ***Chief of Staff.*** The Chief of Staff shall serve as the chief officer of the Medical Staff. The Chief of Staff shall be a member of the Joint Conference Committee and the Medical Executive Committee. The duties of the Chief of Staff shall include, but not be limited to:

- A. Enforcing the Medical Staff Bylaws and Rules and Regulations, presenting to the Medical Executive Committee cases where disciplinary action may be necessary, and promoting compliance when corrective action has been initiated;
- B. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;
- C. Serving as a voting member of the Clinical Department(s) assigned at time of appointment;

- D. Serving as an ex-officio member of all other Staff Committees without vote;
- E. Appointing Members for all standing and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by these Bylaws, and except where otherwise indicated, designating the chairs of those Committees;
- F. Appointing a Chair for each Clinical Department when that position becomes vacant by reason of resignation or at the end of each two (2)-year term as incoming Chief of Staff and acting as Interim Chair for the Clinical Department during any such vacancy;
- G. Appointing, as incoming Chief of Staff, Physician Advisors to those areas of activity and Hospital departments as listed in the Medical Staff Rules and Regulations;
- H. Representing the views and policies of the Medical Staff/MEC to the Board and to the CEO, and acting in coordination and cooperation with the Hospital CEO in all matters of mutual concern within the Medical Center;
- I. Being a spokesman for the Medical Staff in external professional and public relations;
- J. Assisting other Hospital personnel where needed in continuing medical education programs, utilization review, and concurrent monitoring of practice and the continuous quality improvement process; and
- K. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

6.2.2 ***Vice Chief of Staff.*** The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee, the Joint Conference Committee, and shall Chair the Physician Peer Review/Risk Management Committee. The Vice Chief of Staff shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

6.2.3 ***Secretary-Treasurer.*** The Secretary-Treasurer shall be a member of the Medical Executive Committee and the Joint Conference Committee and shall Chair the Credentials Committee. The duties shall consist of:

- A. Maintaining a roster of Members, as well as attendance at Medical Staff meetings;
- B. Reviewing minutes of all Medical Executive Committee and Medical Staff meetings for completeness and accuracy;

- C. Determining the presence of a quorum at all meetings of the Medical Staff and the Medical Executive Committee;
- D. Certifying the results of all elections by the Medical Staff;
- E. Attending to all appropriate correspondence and notices on behalf of the Medical Staff or Chief of Staff;
- F. Maintaining a record of and safeguarding all funds of the Medical Staff, and preparing a financial report for the Annual Staff meeting;
- G. Excusing absences from Medical Staff meetings on behalf of the Medical Executive Committee;
- H. Serving as President pro tem if the Chief of Staff and the Vice Chief of Staff are absent;
- I. Reviewing the Bylaws as necessary, but not less than every three (3) years for continued relevancy to current Medical Staff practices and needs; and
- J. Performing such other duties as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

ARTICLE VII COMMITTEES

7.1. General Provisions.

- 7.1.1 **Committees.** The committees described in this Article shall be the standing committees of the Medical Staff and, where appropriate, shall be structured to qualify as peer review committees under K.S.A. § 65-4915, as amended. Special or ad hoc committees may be created by the Medical Executive Committee to perform specific tasks. Unless otherwise specified, the Chair and all committee members shall be appointed by the Chief of Staff, subject to consultation and approval of the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.
- 7.1.2 **Terms of Committee Members.** Unless otherwise specified, committee members shall be appointed by the incoming Chief of Staff for a term of two (2) years, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. If the then-Vice Chief of Staff assumes the office of Chief of Staff, he or she shall not appoint committee members until such time as his or her term as Chief of Staff would have otherwise commenced except to fill vacancies.
- 7.1.3 **Removal.** If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice Privileges, or

provides any other good cause, that member may be removed by the Medical Executive Committee.

7.1.4 ***Vacancies.*** Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

7.1.5 ***Records and Reports.*** All committees shall maintain a permanent, written record of their proceedings and actions. All committees shall make available their written records to the Medical Executive Committee. The Medical Executive Committee shall make available to the Board all minutes of the Medical Executive Committee.

7.2. **Medical Executive Committee.**

7.2.1 ***Composition.*** The Medical Executive Committee, the majority of which must be doctors of medicine or osteopathy, shall consist of the following persons:

- A. The officers of the Medical Staff: Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer;
- B. The immediate past Chief of Staff;
- C. Two (2) at-large Physician Members of the Active Medical Staff who shall be elected by the Members of the Active Medical Staff to serve two (2)-year terms at the same time and in the same manner as the Vice President and Secretary of the Medical Staff are elected. A Member may be removed from an at-large position in the same manner as an officer of the Medical Staff may be removed from such position and a vacancy in an at-large position shall be filled in the same manner as a vacancy in the office of Vice President or Secretary of the Medical Staff. No Member shall serve two (2) consecutive terms in an at-large position. A Member, however, may be elected for a full term after completing a partial term following a vacancy in the position.
- D. The CEO, or his designee, shall attend the meetings in an advisory capacity; and
- E. Any other Hospital personnel requested by the Medical Executive Committee who may be needed for the appropriate functioning of the Committee's duties shall attend the Medical Executive Committee in an advisory capacity.

7.2.2 ***Duties.*** The duties of the Medical Executive Committee shall include, but not be limited to the following duties identified below.

- A. Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

- B. Coordinating, approving, and implementing the professional and organizational activities, policies, and procedures of the Medical Staff.
- C. Receiving and acting upon reports and recommendations from Medical Staff Committees, Clinical Departments, and Clinical Council.
- D. Recommending action to the Board on matters of a medical-administrative nature including:
 - 1. The structure of the Medical Staff;
 - 2. The process used to review credentials and to delineate Clinical Privileges;
 - 3. Applications for Medical Staff membership and reappointment of the Medical Staff;
 - 4. Delineated Clinical Privileges for each Medical Staff Member;
 - 5. The organization and participation of the Medical Staff in quality improvement and utilization review activities as well as the mechanism used to conduct, evaluate, and revise such activities;
 - 6. The mechanism by which membership on the Medical Staff may be terminated; and
 - 7. The mechanism for fair hearing procedures.
- E. Evaluating the quality of medical care rendered to patients in the Hospital and the utilization of resources used in providing such care.
- F. Ensuring that the Medical Staff remains in conformity with accreditation programs.
- G. Taking reasonable steps to promote ethical conduct and competent medical performance on the part of all Members, including the initiation of Medical Staff corrective or review measures when warranted.
- H. Taking reasonable steps to promote continuing education activities and programs for the Medical Staff.
- I. Approving or rejecting appointments to Medical Staff Committees by the incoming Chief of Staff.
- J. Reporting to the Medical Staff at each regular Medical Staff meeting.
- K. Assisting in the development and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster.

- L. Appointing special or ad hoc committee(s) as necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff.
- M. Reviewing the quality and appropriateness of services provided by Contract Medical Staff Members.
- N. Reviewing, as appropriate, the quality of and approving all other contracts made by the Hospital involving the clinical care of patients.
- O. Making all final standard of care determinations following review of recommendations made by the Physician Peer Review/Risk Management Committee.
- P. Reviewing the Medical Staff Bylaws, Rules and Regulations as needed but not less than every three (3) years with input from Clinical Departments.
- Q. Evaluating quality reports as received from the Medical Staff Clinical Departments. (Exhibit D).

7.2.3 **Meetings.** The Medical Executive Committee shall meet at least six (6) times per year, coinciding with the Credentials Committee schedule as closely as possible, at the discretion of the Chair, or at the request of majority members.

7.3. **Credentials Committee.**

7.3.1 **Composition.** The Credentials Committee consists of the Secretary -Treasurer (who shall serve as Chair) and the Chairs of the Clinical Departments of the Hospital. The Hospital Quality Improvement Director, the Hospital Director of Nursing, and the Hospital CEO or his or her designee shall attend the meetings in an advisory capacity.

7.3.2 **Duties.** The Credentials Committee shall:

- A. Review and evaluate complete applications for the qualifications of each Practitioner applying for initial appointment, reappointment, or modification of Clinical Privileges; incomplete applications shall be returned to the applicant for corrections before consideration;
- B. Submit required reports and information to the Medical Executive Committee on the qualifications of each Practitioner applying or reapplying for membership or requesting particular Clinical Privileges including recommendations with respect to appointment, membership category, Clinical Privileges, Clinical Department membership, and special conditions;

- C. Designate, when necessary, the Hospital CEO or his or her designee as an agent of the Credentials Committee for peer review purposes for the purpose of collecting information and checking references as described; and
- D. Act as peer for the evaluation of each Department Chair, who sits on this committee, at the time of his/her reappointment with input as offered by the applicant's assigned Clinical Department.

7.3.3 ***Quality Improvement/Utilization Review Activities.***

- A. Pursuant to the Labette Health Performance Improvement Plan, quality improvement activities shall generally be conducted at the Department level. Similarly, the Labette Health Utilization Review Plan provides for the evaluation of utilization review data and the formulation and implementation of measures to address any identified concerns at the Department level. However, the Credentials Committee shall meet as necessary to address those quality improvement and utilization review matters that cannot be addressed by the Clinical Department or those matters that can be better handled on an interdepartmental basis.
- B. The Credentials Committee shall review relevant compiled and collected quality data. It shall also involve other Medical Staff Members and/or Hospital personnel as necessary and recommend and assist in the implementation of appropriate measures to address any identified quality issues.
- C. As a part of its quality improvement function the Credentials Committee, or its designee, shall review all mortalities in the hospital monthly. The Credentials Committee, or its designee, shall evaluate the following: (1) the appropriateness of the care provided, (2) the Attending Physician's involvement including his/her recognition of the critical nature of the case and the timeliness of orders and consultations; (3) modifications in therapeutic regimes to accommodate the patient's changing condition; and (4) the supervision of the mortality patient's care from beginning to end to determine if the patient's diagnosis can be supported. The Credentials Committee shall use educationally interesting cases to educate the Hospital and Medical Staff and shall involve other Medical Staff Members and/or Hospital personnel as needed to address any identified quality issues.
- D. The Credentials Committee, or its designee, shall also perform blood transfusion review. The Credentials Committee shall establish policies and procedures that govern the administration of blood and blood products and ensure that such policies and procedures have a system for reporting transfusion reactions. These policies and procedures will be reviewed and revised as needed, but not less than every three (3) years. As a part of its duties, the Credentials Committee, or its designee, shall also review and investigate all transfusion reactions occurring in the hospital, recommend

improvement in transfusion procedures accordingly, and shall involve other Medical Staff Members and/or Hospital personnel as needed to address any identified quality issues.

- E. The Credentials Committee will review and submit quality improvement reports/conclusions/recommendations, including reports regarding transfusion reactions and mortality reviews to the Medical Staff, Clinical Departments, Medical Executive Committee or other committees/departments as necessary.

7.3.4 *Ongoing Professional Practice Evaluation (OPPE)*

- A. The Credentials Committee shall be responsible for OPPE monitoring and ensuring that OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) and/or to revoke an existing privilege.
- B. The Credentials Committee shall evaluate the following administrative measures: (1) number of patient admissions; (2) the number of patient consultations; (3) health information management medical record documentation criteria (e.g. timely completion of discharge summaries, pre-operative assessments, and other medical record documentation); (4) risk management measures; and (5) education/CME.
- C. The following clinical measures, as applicable, shall be reviewed and evaluated by the Credentials Committee: (1) core measure data; (2) returns to surgery; (3) surgical infection rate; (4) procedure complication rate; (5) case management/utilization review; (6) pharmaceutical usage; (7) mortality rate; (8) blood usage; (9) infection control; and (10) other approved Medical Staff Department specific indicators.
- D. Data shall be collected on an ongoing basis through medical chart reviews, direct observation, diagnostic and treatment monitoring and discussions with the Medical Center staff and other individuals involved with patient care. This data shall be presented to and reviewed by the Credentialing Committee on an ongoing basis and such data will become a part of each Member's PQPR. Each Member's PQPR shall be reviewed on an ongoing basis, but not less than two (2) times per year. All data collected shall become a part of the Member's confidential credentialing file and shall only be accessed and utilized by appropriate Medical Staff members including, but not limited to the Credentials Committee, the Medical Executive Committee, Department Chairs and others, as applicable, as a part of the Medical Staff peer review function. The OPPE data shall be used as a measure of competency and will be reviewed at the time of reappointment to determine eligibility.

- E. The Credentials Committee shall use the data to the extent possible to evaluate the performance of low volume practitioners, but other means for evaluation may be necessary to fully evaluate such Member's performance for reappointment purposes or otherwise.
- F. When appropriate, the Credentials Committee shall elevate issues, including adverse findings, practice patterns or trends, or other practice or administrative issues which may require intervention or focused professional practice evaluation (FPPE) to the Medical Executive Committee and/or Peer Review Committee for further analysis and review.

7.3.5 **Reporting.** The Secretary/Treasurer, as the chair of the Credentials Committee, shall report at each regular meeting of the Medical Staff concerning the Credentials Committee's activities, including any reports and/or recommendations concerning quality improvement/utilization review and OPPE.

7.3.6 **Meetings.** The Credentials Committee shall meet every two months or at the discretion of the Chair, or at the request of majority members.

7.4. **Joint Conference Committee.**

7.4.1 **Composition.** The Joint Conference Committee shall be composed of two (2) members of the Board of Trustees, the Hospital Administrator, and all three (3) officers of the Medical Staff. The chairpersonship of the Committee shall alternate yearly between the Chairman of the Board and the Chief of Medical Staff.

7.4.2 **Duties.** The Joint Conference Committee shall meet at least twice a year and provide a forum for the discussion of matters of Hospital and Medical Staff policy, practice, and planning, operations, growth and for interaction between the Board and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board.

7.5. **Nominating Committee.**

7.5.1 **Composition.** The Nominating Committee shall consist of three (3) Members of the Medical Staff who are the three (3) most recent Chiefs of Staff. The immediate past Chief of Staff shall serve as Chair of the Committee.

7.5.2 **Duties.** Not less than thirty (30) days prior to the October meeting of the Medical Staff in even-numbered years, the Nominating Committee shall publish its nominations for Vice Chief of Staff and Secretary-Treasurer, and the two at-large members of the Medical Executive Committee as nominated by the Vice Chief of Staff. These nominations shall also be reported to the Medical Executive Committee at its September meeting.

7.6. **Critical Care Committee.** The duties of the Critical Care Committee shall be subsumed into and performed by the Medicine Department. The Medical Staff Executive Committee

shall assure that the Physician Advisor to the Intensive Care Unit and one (1) member of the Surgery Department is assigned to attend the Medicine Department meetings.

7.7. Physician Peer Review Risk Management Committee.

7.7.1 Membership. The Physician Peer Review/Risk Management Committee shall consist of the Vice Chief of Staff (who shall serve as Chair), three (3) Active Medical Staff Members representative of each Clinical Department, and the Chief of Staff for continuity of the risk management/peer review process. The Hospital CEO, the Director of Risk Management, and the Director of Nursing shall attend the meetings in an advisory capacity. The Director of Hospital Risk Management shall serve as the Medical Staff Risk Management Coordinator.

7.7.2 Duties.

A. Pursuant to the Labette Health Risk Management Plan, the Physician Peer Review/Risk Management Committee shall receive, investigate, and analyze on behalf of the Medical Executive Committee those reported acts by Medical Staff Members, Allied Health Professionals, or Hospital personnel:

1. Which were or might have been below applicable standard(s) of care;
2. Which caused, or had a reasonable probability of causing, injury to a patient;
3. Which may be grounds for disciplinary action by the Kansas State Board of Health or other applicable licensing agency;
4. Which may have caused undue disruption within the Hospital; or
5. Which were referred to the Medical Executive Committee by the Physician Health Committee in accordance with Section 7.9.2.F.

B. The Committee shall report and make recommendations to the Medical Executive Committee regarding standard of care determinations for such reported acts. When such acts involve Members of the Medical Staff, decisions regarding standard of care recommendations shall be made solely by the Medical Staff Members of the Committee.

7.7.3 Authority. The Physician Peer Review/Risk Management Committee has the authority to request information or assistance in the evaluation of data from any Member of the Medical Staff, Allied Health Professional, employee of the Hospital, or from any authority outside the Medical Staff or Hospital. The Committee may collect data, as needed, from any area of the Hospital. The Committee may request assistance in the evaluation of data from any Member of the Medical Staff or from any authority outside the Medical Staff or Hospital.

7.7.4 **Meetings.** The Physician Peer Review/Risk Management Committee shall meet monthly or at the discretion of the Chair, or at the request of majority members.

7.8. **Ethics/Physician Health Committee.**

7.8.1 **Membership.** The Ethics/Physician Health Committee shall consist of three (3) Members of the Active Medical Staff appointed by the incoming Chief of Staff. Members of this Committee shall not serve on the Medical Executive Committee or the Physician Peer Review/Risk Management Committee while serving on the Ethics/Physician Health Committee. Such appointees shall include the Physician Advisor to the Hospital Chaplaincy Program who shall act as Chair. Other members shall include a representative from nursing services, a representative from social services, the Hospital CEO or his or her designee, and other ad hoc members as appropriate.

7.8.2 **Duties.** The duties of the Ethics/Physician Health Committee shall include the following:

- A. Review any case presented to the Committee which involves an ethical or moral dilemma;
- B. Offer guidance and suggestions regarding patient care based on discussion of such case(s);
- C. Obtain consultation from outside sources as needed;
- D. Make recommendations to the Medical Executive Committee (and, when requested, prepare policies and procedures) regarding organizational response, patients' rights, clinical care, resource allocation and usage (including PPE, beds, ventilators, medications, etc.), personnel and staffing, grievance or appeal mechanisms, and any other ethical issues that may arise in a public health emergency, such as shortage of supplies (e.g., personal protective equipment), shortage of patient care resources (e.g., testing supplies, beds, ventilators), and shortage of personnel (e.g., nursing staff, primary care physicians, specialists); the Committee shall also oversee, revise, and develop, as necessary, policies related to other medical ethics scenarios, such as end-of-life situations;
- E. During any declaration of a public health emergency, assist with implementation of the modified triage protocol (https://www.kdheks.gov/cphp/download/Crisis_Protocols.pdf), acting as the Scarce Resource Allocation Team, and/or in such other role as assigned by Administration and/or the Medical Executive Committee;
- F. Report all committee activities to the Medical Executive Committee;
- G. Arrange for continuing education of the Medical Staff and other Hospital staff on recognizing illness and impairment specific to physicians;

- H. Receive referrals from Physicians and other Hospital staff concerning issues of illness or impairment of Medical Staff Members;
- I. Refer affected Physicians to appropriate professional internal and external resources for diagnosis and treatment of illness or impairment;
- J. Evaluate the credibility of referrals, complaints, allegations, or concerns related to illness or impairment referred to the Committee;
- K. Develop the procedure for monitoring an affected Physician and the safety of his/her patients until any rehabilitation or disciplinary process is complete; and
- L. Report to the Medical Executive Committee instances whereby a Physician is providing unsafe medical treatment.

7.8.3 **Meetings.** The Ethics/Physician Health Committee shall meet on the last Tuesday every four (4) months and/or at the discretion of the Chair.

7.9. **Utilization Review Committee.**

7.9.1 **Composition.** The Utilization Review Committee shall consist of the two (2) Physician Advisors to the Utilization Review Committee appointed by the incoming Chief of Staff and the Hospital's Director of Utilization Review. No Committee member shall (a) have a direct financial interest in the Hospital or (b) be involved in reviewing a case in which he or she has been professionally involved in the patient's care.

7.9.2 **Duties.** The Utilization Review Committee shall:

- A. Provide guidance and oversight in the implementation and operation of the Hospital's Utilization Review Plan;
- B. Regularly review and make recommendations to the Medical Executive Committee concerning revisions to the Hospital's Utilization Review Plan; and
- C. Communicate with Department Chairs and the Credentials Committee concerning utilization issues.

7.9.3 **Meetings.** The Utilization Review Committee shall meet at least four times a year and/or at the discretion of the Chair.

7.10. **Anesthesia Committee**

7.10.1 **Membership.** The Anesthesia Committee shall be appointed by the incoming Chief of Staff. Such appointees shall include the Medical Director of Anesthesia who shall act as Chair. Other members shall include members of the Surgical

Department as assigned by the Chief of Staff and the Hospital CEO or his or her designee. Other members of the Anesthesia Committee may be added at the discretion of the Chief of Staff.

7.10.2 **Duties.** The Anesthesia Committee shall:

- A. Develop appropriate policies, procedures, and protocols relating to Hospital anesthesia services; and
- B. Engage in quality improvement activities in a manner consistent with the Labette Health Performance Improvement Plan.

7.10.3 **Meetings.** The Anesthesia Committee shall meet quarterly or at the discretion of the Chair. The Anesthesia Committee shall be responsible to report to the Surgery Committee and the Medical Executive Committee.

7.11. **Other Committees.**

7.11.1 **Standing Committees.** The Medical Executive Committee may establish other standing committees for such other matters as it deems appropriate. The Medical Executive Committee shall specify in the Medical Staff Rules and Regulations the composition of each committee established pursuant to this Section, its duties, and the method by which Members are selected to serve on any such committee. All Medical Staff Committees shall be accountable to the Medical Executive Committee.

7.11.2 **Special/Ad Hoc Committees.** In addition to its standing committees, and subject to approval by the Medical Executive Committee, the Chief of Staff may appoint special or ad hoc committee(s) to undertake specific projects assigned by the Chief of Staff. Reports by such committees shall be made directly to the Chief of Staff.

ARTICLE VIII CLINICAL DEPARTMENTS

8.1. **Organization.**

8.1.1 The Medical Staff shall be organized into Clinical Departments. The current listing of the Clinical Departments shall be included in the Rules and Regulations of the Medical Staff. A Clinical Department shall consist of all Members of the Medical Staff with the same or similar training and practice patterns. When available a Clinical Department shall contain no fewer than three (3) Members. Every Member of the Medical Staff, regardless of category, shall be assigned to a Clinical Department.

8.1.2 Clinical Departments may be added or deleted by action of the Medical Staff in the same manner that the Rules and Regulations are changed. However, no Department may be added with fewer than three (3) Medical Staff Members.

- 8.2. **Assignment.** Upon granting of Privileges to the Medical Staff, each Member will be assigned to one of the Clinical Departments by the Medical Executive Committee. A Member may be assigned to two Clinical Departments for some Members if his or her training and practice patterns are compatible with more than one Department. In no case shall a Member be assigned to more than two Departments.
- 8.3. **Responsibilities.** Each Clinical Department shall be responsible for:
- 8.3.1 Developing and implementing appropriate policies, procedures, and protocols relating to patient care within the Department.
 - 8.3.2 Regularly engaging in quality improvement activities in a manner consistent with the Labette Health Performance Improvement Plan.
 - 8.3.3 Reviewing utilization review data and formulating and implementing appropriate measures to address identified issues pursuant to the Labette Health Center Utilization Review Plan.
 - 8.3.4 Recommending educational programs for Medical Staff Members and/or Hospital personnel.
 - 8.3.5 Documenting the effectiveness of educational programs in changing practice patterns in areas where a change of patient care delivery is imperative in light of the results of the quality improvement process.
 - 8.3.6 Conducting such business activities as are appropriate to the Clinical Department.
 - 8.3.7 Regularly reviewing Department specific and/or interdepartmental quality improvement reports, which include the following, and submitting reports/ conclusions/recommendations to the Credentials Committee.
 - A. Tumor/Tissue
 - B. Infection Control
 - C. Blood/Transfusions
 - D. Pharmacy/Therapeutics
 - E. Mortality
 - F. Medical Records
 - G. Restraints/Seclusions
 - H. OPPE data collected
 - 8.3.8 Advising on equipment and supply needs.

- 8.3.9 As applicable, recommending policies and reviewing quality of care in any setting in which the Department's activities occur in other areas of the Hospital (e.g., emergency medical procedures in areas outside Intensive Care).
- 8.3.10 As requested by the Medical Executive Committee, report to the Medical Executive Committee concerning operations within the Department (including semi-annual reporting concerning operations of the Intensive Care Unit).

8.4. **Clinical Department Chairs.**

- 8.4.1 A Chair of each Clinical Department shall be appointed by the incoming Chief of Staff. The appointed Clinical Department Chair must be certified by an appropriate specialty board, or must be determined through the privilege delineation process to be a person possessed of comparable competence. Each Chair shall serve for a two (2)-year term, and shall not serve for more than two (2) consecutive two (2)-year terms.
- 8.4.2 The Department Chair may resign by written notice to the Chief of Staff. A Chair may also be removed from his or her position by the Medical Executive Committee upon recommendation by the Chief of Staff or by independent action of the Committee.
- 8.4.3 The Chair of each Clinical Department is responsible for the following:
 - A. Ensuring effective operation of quality improvement and utilization review activities within the Department;
 - B. Monitoring the professional performance of all Physicians who have membership in the Department;
 - C. Reviewing applications for Medical Staff membership Clinical Privileges within that Department for both new and renewing applicants and assessing the appropriateness of such request;
 - D. Recommending delineation of Privileges to the Credentials Committee for Clinical Privileges requested by each applicant;
 - E. Orienting all new Members of the Clinical Department; and
 - F. Serving as a member of the Credentials Committee

**ARTICLE IX
MEETINGS**

9.1. **Medical Staff Meetings.**

- 9.1.1 **Regular Meetings.** There shall be regular meetings of the Medical Staff. The Chief of Staff and such other persons as the Chief of Staff or Medical Executive

Committee may designate, shall present reports on actions taken during the preceding months and on other matters of interest and importance to the Members. The regular meeting shall be held at a time established in the Rules and Regulations. Additional notice of regular meetings shall not be deemed necessary.

9.1.2 **Special Meetings.** Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or may be called upon the written request of Ten Percent (10%) of the Members of the Active Medical Staff. The person or persons calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Chief of Staff within seven (7) days after receipt of such request. Not later than four (4) days prior to the meeting, notice shall be posted. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

9.2. **Medical Executive Committee Meetings.** The Medical Executive Committee shall meet at least six (6) times per year, or as business designates. For all other Medical Staff Committees each Chair or his/her designee shall ensure that all Committee Meeting dates are disseminated to the Committee members with at least fifteen (15) days' notice. Additionally, a Committee meeting may be called by the Medical Executive Committee, the Chief of Staff, or written request of one-half (1/2) of the Active Staff Members of that Committee. Written notice of such a meeting shall be disseminated to all Committee Members at least four (4) business days prior to the date of the Committee meeting.

9.3. **Clinical Department Meetings.**

9.3.1 **Regular Meetings.** Each Clinical Department shall meet at least four (4) times per year. The Chair of the Department shall establish the time for the holding of regular meetings. The Chair shall ensure that the meeting dates are disseminated to the Department Members with at least fifteen (15) days' notice.

9.3.2 **Meetings.** A special meeting of any Clinical Department may be called by the Chair of the Department, by the Medical Executive Committee, or by the Chief of Staff. A special meeting shall also be held at the written request of one-half (1/2) of the Department Members. Notice of such a meeting shall be given at least four (4) business days in advance.

9.3.3 **Attendance.** Each Department meeting shall be attended by the Hospital CEO or his/her designee. Any Hospital employee may also be called to attend in an advisory capacity if helpful to the function of the Clinical Department.

9.4. **Quorum.**

9.4.1 **Staff Meetings.** The presence of two-thirds (2/3) of the total membership of the Active Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of amending these Bylaws or for the removal of Medical Staff officers. The presence of Fifty Percent (50%) of Active Members shall constitute a quorum for all other actions, including election of officers.

9.4.2 **Committee Meetings.** A quorum of Fifty Percent (50%) of the voting members shall be required for all Committee meetings.

9.4.3 **Clinical Department Meetings.** The presence of one-third (1/3) of total members of the Clinical Department shall be required for all Clinical Department meetings.

9.5. **Manner of Action.**

9.5.1 **General.** Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the Committee or Department. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members if any action taken is approved by at least a majority of the number of members originally present in the meeting.

9.5.2 **Other Committee or Clinical Department Action.** Valid action may be taken without a meeting by a Committee or Clinical Department if the proposed action is distributed to all Committee or Clinical Department Members in writing setting forth the proposed action and subsequently affirmed by signature by at least Fifty Percent (50%) of the Members entitled to vote.

9.6. **Minutes.** Minutes of all meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters and any conclusions, recommendations, or actions. An electronic copy of the minutes will be maintained in the Medical Staff office. The minutes shall comply with the requirements of recognized accrediting agencies.

9.7. **Attendance Requirements.**

9.7.1 **Regular Attendance.**

A. Except as stated in Section 9.7.2, each Member of the Active Staff shall be required to attend:

1. At least Fifty Percent (50%) of regular Medical Staff meetings duly convened pursuant to these Bylaws;
2. At least Fifty Percent (50%) of all meetings of each Medical Staff Committee of which he or she is a Member; and
3. At least Fifty Percent (50%) of all meetings of each Clinical Department of which he or she is a member, except any Member of a Clinical Department who has not provided services to a patient admitted as an inpatient, outpatient, or for observation within the previous twelve (12) months must only attend Twenty-Five Percent (25%) of all Clinical Department meetings.

- B. Other Members of the Staff shall be required to attend such meetings as may be determined by the Medical Executive Committee.
- C. Members of Medical Staff categories other than Active Staff that accept a Committee appointment will be required to attend Fifty Percent (50%) of the appropriate Committee meetings.
- D. Members of the Medical Staff are required to physically attend regular Staff meetings, Medical Staff Committee meetings, Clinical Department meetings, and other meetings as required under these Bylaws. Under certain circumstances, if a Medical Staff Member has demonstrated good cause as to why he/she is not able to be physically present at such meeting(s), he/she may attend such meetings by telephone or electronic conferencing. Any such request to attend a meeting by telephone or electronic conferencing shall be made in advance of such meeting and shall be subject to approval by the Medical Executive Committee, administration, and/or its appropriate designee. Good cause shall include, but is not limited to, patient care obligations, urgent professional obligations outside of the Hospital, and/or absence from the community. If a Medical Staff Member attends a meeting by telephone or electronic conferencing, he/she shall do so in a manner that maintains privacy and confidentiality of the meeting and any matters discussed at such meeting as if he/she were physically in attendance, and the Medical Staff Member may be asked and/or required to sign an attestation statement to this effect.

9.7.2 ***Absence from Meetings.*** The Medical Executive Committee and/or the Credentials Committee, or its designee, shall evaluate any Member who failed to attend at least Fifty Percent (50%) of Medical Staff Committee or Clinical Department meetings he/she was required to attend in accordance with these Bylaws at the time of reappointment. It is the responsibility of the Member to present, or demonstrate, good cause as to why he/she was unable to attend the requisite number of Medical Staff or Clinical Department meetings. Good cause shall include, but not be limited to, urgent requirements for patient care, conflicting meetings, illness, or absence from the community. The Medical Executive Committee shall take into consideration the information presented by the Member and facts and circumstances surrounding his/her absences to determine whether the Member has shown good cause as to why meeting attendance requirements were not met and/or if any further action is warranted related to reappointment or otherwise.

9.7.3 ***Special Attendance.*** At the discretion of the Chair of a Committee or Clinical Department, when a Member's practice or conduct is scheduled for discussion at a regular meeting, the Member may be asked to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting along with a general indication of the issue involved. Failure of a Member to appear at any meeting which he/she was given such notice, unless excused for illness or conflict due to emergency patient care, shall be cause for a limited suspension in the form of withdrawal of admitting privileges and other

related rights. This limited suspension shall be imposed by the Chief of Staff, or his designee, and shall continue until the appropriate arrangements have been made by the Member for his/her appearance at the committee meeting as requested and the suspension lifted by the Chief of Staff.

- 9.8. **Conduct of Meetings.** Unless otherwise specified, Medical Staff, Committee, and Clinical Department meetings shall be conducted according to *Robert's Rules of Order*; however, technical or minor departures from these rules shall not invalidate action taken at such a meeting.
- 9.9. **Confidentiality.** The following applies to all records of the Medical Staff, Committee, and Clinical Department meetings:
- 9.9.1 Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained; and
- 9.9.2 Access to such records shall also be granted to the Board, the Hospital CEO, and their designees so that they may discharge their lawful obligations and responsibilities with regard to the operation of the Hospital, with the requirement that all such records shall be maintained as confidential.

ARTICLE X CONDUCT

10.1. **Disruptive Behavior.**

- 10.1.1 **Policy.** It is the policy of the Medical Staff that all individuals within the Hospital be treated courteously, respectfully, and with dignity. To that end, the Medical Staff and the Board of Trustees require that all Members of the Medical Staff conduct themselves in a professional cooperative manner.
- 10.1.2 **Objective.** The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional health care environment and to prevent or eliminate conduct which disrupts the operation of the Hospital, affects the ability of others to do their jobs, creates a "hostile work environment" for Hospital employees or other individuals, or interferes with an individual's ability to practice competently.
- 10.1.3 **Guidelines.** Unacceptable disruptive behavior includes, but is not limited to:
- A. Refusing to accept Medical Staff assignments, or to participate in committee or departmental affairs on anything but his or her own terms, unless physically or otherwise unable to do so, or do so in a disruptive manner;
 - B. Destroying or stealing of Medical Center property;

- C. Communicating impertinently or inappropriately to patients or creating entries in medical records or other official documents that compromise the quality of care delivered by Medical Staff Members, nurses, or other health care workers or otherwise go beyond the bounds of professional conduct;
- D. Exhibiting sexual, ethnic, or other type of harassment, whether verbal or physical in nature;
- E. Exhibiting criticisms presented in such a way as to purposely intimidate, humiliate, or impute stupidity or incompetency of or to others;
- F. Violating the Medical Staff Bylaws or Rules and Regulations repeatedly and/or deliberately; or
- G. Exhibiting unprofessional, rude, or abusive behavior toward patients, members of their families, nurses, colleagues, or other employees, including refusing to listen to the patients' or their families' legitimate questions and requests.

10.1.4 **Reporting.** Reporting must be in writing and shall be submitted to the Chief of Staff or one of the other Medical Staff officers.

10.1.5 **Investigation.** Once received, a report will be investigated by the Medical Executive Committee. Investigation, if necessary, may also involve other designated persons. When so designated, such persons shall serve as agents of the Medical Executive Committee for peer review purposes.

10.1.6 **Actions.**

- A. Reports which do not seem credible may be dismissed without further action by the Medical Executive Committee.
- B. A confirmed incident warrants a discussion with the offending individual initiated by the Chief of Staff and/or respective Department Chair. Such a discussion shall emphasize that such conduct is inappropriate and must be rectified. The initial approach should be collegial and designed to be helpful to the individual and the Hospital and to rectify the situation.
- C. If it appears to the Medical Executive Committee that a pattern of disruptive behavior is developing, the involved Medical Staff Member shall meet with the Medical Executive Committee for discussion of the matter. Emphasis is to be made that if such repeated behavior continues, more formal action, including restriction or suspension of Privileges, may be taken. The involved Medical Staff Member shall be given the opportunity to submit a rebuttal to the charges. All aspects of the meeting, including any rebuttal, shall be documented and kept in the Medical Staff file of the involved Member. A follow-up letter will be sent to the involved Medical Staff Member. This letter shall document the substance of the meeting and the

nature of the problem. The letter shall inform the Member that he or she shall behave in a professional and cooperative manner and shall indicate any decisions made by the Medical Executive Committee as a result of the meeting. Such a letter shall constitute the final warning for the involved Medical Staff Member.

- D. If the involved Medical Staff Member ignores the final warning and the disruptive conduct continues unabated, or if the incident is excessively egregious, then the Member's behavior shall be deemed to have met the criteria for initiation of summary restriction or suspension of Privileges as set forth in Section 12.1.1, as well as the grounds of action as set forth in Section 12.1.1.A of these Medical Staff Bylaws. The procedures for instituting disciplinary action affecting Clinical Privileges and Medical Staff membership as set forth in Article XII shall thereafter be followed.

10.1.7 **Exclusivity.** This policy shall be the sole process for dealing with egregious incidents and disruptive behavior of the Medical Staff and shall be interpreted and enforced by the Hospital Board. No other policy or procedure shall be applicable to egregious incidents or disruptive behavior.

10.2. **The Impaired Provider.** The Medical Staff is responsible for the professional conduct of its Members. The American Medical Association defines the "impaired provider" as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol."

10.2.1 **Identification.** Reports of possible impairment can be received from any source and are to be referred to the Physician Health Committee or a member thereof who will pursue the matter in accordance with Section 7.10 of these Bylaws.

10.2.2 **Actions.** Any situation or issue involving impairment or suspected impairment of a provider will be examined by the Physician Health Committee who will initiate action in accordance with Article V of the Rules and Regulations.

10.3. **Confidentiality.** All procedures and actions taken under this Article shall be considered part of the peer review process and shall remain confidential to the fullest extent permitted by law.

ARTICLE XI ADMINISTRATIVE REQUIREMENTS

11.1. **Responsibilities.**

11.1.1 **General.** All Active Staff Members shall be responsible for fulfilling administrative requirements pertaining to the Medical Staff, when requested, which include the following:

- A. Develop and maintain standards for quality medical care and for patient treatment provided within the Hospital;
- B. Participate in quality improvement, utilization review, and other care monitoring activities;
- C. Participate in Medical Staff administration, including adoption of rules and regulations and other policies and procedures as needed for its government (subject to approval by the Board of Trustees);
- D. Attend regular and special meetings of the Medical Staff, meetings of the Member's Clinical Department, and meetings of Medical Staff Committee(s) of which the Member is a member; and
- E. Participate in the peer review process when requested.

11.1.2 ***Notification of Change.*** As a condition of maintaining Medical Staff membership, each Member shall be required to notify the Hospital CEO or Chief of Staff immediately upon the occurrence of any of the following:

- A. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of the Member's professional license by any state licensing agency;
- B. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of Medical Staff membership or Clinical Privileges at any other hospital or health care institution;
- C. The cancellation or restriction of the Member's professional liability insurance coverage;
- D. The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level to prescribe any medications;
- E. Any adverse determination by a federally qualified peer review organization concerning the Member's quality of care;
- F. Notification to the Member of any formal investigation or filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state;
- G. The filing of any lawsuit or the asserting of any claim against the Member alleging professional liability; or

- H. Any other change in membership qualifications as listed in Section 3.2 of the Bylaws or as set forth in Section 4.5.2 and agreed to by the Member in the Application Agreement.

11.2. Physician Advisors.

- 11.2.1 **Appointment.** Physician Advisors shall be appointed by the Chief of Staff to various areas of Hospital activity, including various Hospital departments and Hospital-wide committees.
- 11.2.2 **Terms and Removal.** The term of appointment shall be for two (2) years. A Physician Advisor may be reappointed as desired by the Chief of Staff. An Advisor may be removed from his or her capacity by the Chief of Staff with the approval of the Medical Executive Committee.
- 11.2.3 **Areas and Departments.** Physician Advisors shall be appointed to the areas of activity and Hospital departments as listed in the Medical Staff Rules and Regulations.
- 11.2.4 **Responsibilities.** Physician Advisors will assure an appropriate level of Medical Staff involvement in Hospital department policies and procedures as required by the Medicare Conditions of Participation. Responsibilities of the Physician Advisors shall include, but not be limited to, the following:
 - A. Assisting in the development of policies and procedures;
 - B. Assisting in quality improvement activities, utilization review, and patient care monitoring;
 - C. Acting as liaison between the Medical Staff and the area of activity or Hospital department; and
 - D. Attending meetings as necessary for proper functioning of the area or department.

11.3. Rules and Regulations.

- 11.3.1 **General.** Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with this Section. The Rules and Regulations shall set standards of practice that are to be required of each individual exercising Clinical Privileges in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. The Rules and Regulations shall have the same force and effect as the Bylaws, and shall be attached as a separate section to these Bylaws.
- 11.3.2 **Proposed Changes.** Proposal for changes in the Rules and Regulations may be developed by any standing or special committee of the Medical Staff. Proposals

for changes may include additions, amendments, or deletions. The proposal shall be forwarded to the Medical Executive Committee. If approved by the Medical Executive Committee, the proposal shall then be brought to the Medical Staff for adoption.

- 11.3.3 **Adoption.** Changes to the Rules and Regulations shall be adopted by a majority vote of the Medical Staff at any regular or special meeting provided that the proposed amendments, additions, or repeals have been approved by the Medical Executive Committee. Change in the Rules and Regulations shall become effective following Board approval. If such changes are significant, revised texts shall be provided to all Medical Staff Members.
- 11.4. **Dues or Assessments.** The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. Such dues shall be payable on receipt of invoice and shall become delinquent thirty (30) days thereafter.
- 11.5. **Authority to Act.** Any Member or Members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate in accordance with Sections 12.1 and 12.2.
- 11.6. **Availability.** Any Member who admits patients or cares for patients in any other manner within the Hospital premises shall be available by phone or in person at all times within thirty (30) minutes in response to an emergency situation involving one of his or her patients until such a time as those patients are sufficiently stable to leave the Hospital premises. If the Physician cannot be available, then he or she must give notice of an alternate Staff Member who is able and has agreed to fulfill this requirement. All Active Staff Members must also be available for care of patients in the Emergency Department in a manner consistent with their specialty and predetermined availability schedule as described in the Rules and Regulations.
- 11.7. **Document Retention.**
- 11.7.1 **Bylaws.** The Medical Staff Bylaws and all associated documents shall be retained in the office of the CEO and on the hospital intranet. These documents shall be retained until they are modified or superseded. Documents that have been superseded shall be retained in the office of the CEO for an additional seven (7) years after the adoption of the new documents.
- 11.7.2 **Medical Staff Files.** Medical Staff files shall be maintained within the office of the Medical Staff Credentials Committee. They shall be maintained during the entire tenure of the Medical Staff Member, regardless of any changes in membership categories. Such files are to be maintained for a full seven (7) years after membership has been voluntarily resigned or terminated.
- 11.7.3 **Medical History and Physical Examination.** A complete medical history and physical examination for each patient shall be completed no more than thirty (30)

days before or twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services. When the history and examination were completed prior to admission, an update note must be added to the original history and physical and include any changes in the patient's condition. This note must be completed and documented in the medical record within twenty-four (24) hours following admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination and any update must be completed and documented by a physician or a mid-level provider with appropriate physician supervision.

ARTICLE XII
DISCIPLINARY ACTION AFFECTING
CLINICAL PRIVILEGES AND STAFF MEMBERSHIP

12.1. Suspension of Clinical Privileges or Revocation of Membership.

12.1.1 *Grounds for Action.*

- A. Failure to Abide by Bylaws. If a Staff Member fails to abide by the Medical Staff Bylaws or Rules and Regulations, corrective action may be requested by the Chief of Staff, by the Chair of any Clinical Department, by the Chairman of any Committee of the Medical Staff, by the Hospital CEO, or by the Board of Trustees. All such persons are designated as agents of the Medical Executive Committee for peer review purposes.

- B. Commission of a Reportable Incident. Every Member of the Medical Staff shall be required to report any direct knowledge that any other Member of the Staff has committed an act that is or may be below the applicable standard of care in this Hospital or that is or may be grounds for disciplinary action by the Kansas Board of Healing Arts or other relevant licensing agency. In addition, every Member of the Staff shall be obligated to report any direct knowledge that any other person directly involved in providing health care services to patients in the Hospital has committed an act that is or may be below the applicable standard of care within the Hospital or that may be grounds for disciplinary action by the relevant licensing agency (collectively, "Reportable Incident").

12.1.2 ***Method of Reporting.*** All requests for action or reports related to a Reportable Incident(s) shall be in writing and shall be made to the Chief of Staff, Hospital CEO, or Risk Management Director in accordance with the Labette Health Risk Management Plan. All requests and reports shall be supported by reference to the specific activity or conduct which constitutes the grounds for disciplinary action. The Risk Management Director shall advise the Chief of Staff immediately of any reported incident or request for corrective action involving a Member of the Medical Staff. The matter shall then be forwarded to the Physician Peer Review/Risk Management Committee. The Physician Peer Review/Risk Management Committee may also be asked to review incidents involving

disruptive behavior identified in accordance with Section 10.1.6.E or matters referred to it on behalf of the Medical Executive Committee by the Physician Health Committee.

12.1.3 ***Investigation of Reported Incidents.*** The Physician Peer Review/Risk Management Committee shall have the duty to investigate all such reports or requests for corrective action relating to Medical Staff Members and then to make appropriate recommendations to the Medical Executive Committee. The Physician Peer Review/Risk Management Committee may fulfill its duty of investigation by referring the matter to an appropriately qualified consultant who is not a Member of the Medical Staff. Such outside review may be deemed necessary by the Medical Executive Committee for reasons including, but not limited to obtain necessary expertise, to avoid review by individuals with a direct economic interest in the issue, to avoid any actual or perceived conflicts of interest, or to obtain an appropriate and impartial review.

12.1.4 ***Medical Executive Committee Action.***

- A. Informal Appearance. Within fifteen (15) days following the receipt of a report from the Physician Peer Review/Risk Management Committee, the Medical Executive Committee may arrange for an informal meeting. The affected Member shall be notified by special notice of such meeting, and that he or she will be permitted to make an appearance before the Medical Executive Committee prior to its taking further action. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Medical Staff Fair Hearing Plan shall be required.
- B. Subsequent Action. As soon as practicable after the investigation and the initial informal appearance, if any, the Medical Executive Committee shall take action which may include the following, without limitation:
 - 1. Determining that no corrective action need be taken and, if the Medical Executive Committee determines there was not credible evidence for complaint in the first instance, removing any adverse information from the Member's file;
 - 2. Deferring action for a reasonable time when circumstances warrant;
 - 3. Issuing a letter of admonition, censure, reprimand, or warning – in the event such letters are issued, the affected Member may make a written response which shall be in the Member's file;
 - 4. Recommending to the Board the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for training or education, co-admissions, mandatory consultation, or proctoring;

5. Recommending to the Board the reduction, modification, suspension, or revocation of Clinical Privileges;
6. Recommending to the Board the reduction of membership status or the limitation of any prerogatives directly related to the Member's delivery of patient care;
7. Recommending to the Board the suspension, revocation, or probation of Medical Staff membership; or
8. Taking other actions deemed appropriate under the circumstances.

12.1.5 ***Right to Hearing.*** Any recommendation by the Medical Executive Committee for restriction, suspension, or revocation of Clinical Privileges, or revocation of Medical Staff membership, shall entitle the affected Medical Staff Member to the procedural rights provided in the Medical Staff Fair Hearing Plan.

12.2. **Summary Restriction or Suspension.**

12.2.1 ***Criteria for Initiation.*** Whenever a Member's conduct appears to reasonably require that immediate action be taken to protect the life or well-being of any patient or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person, the CEO of the Hospital, acting as an agent of the Medical Staff for peer review purposes, or the Chief of Staff may summarily restrict or suspend the Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and written notice shall be promptly provided to the Member, Chief of Staff, the Board of Trustees, and the CEO. The summary 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. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Staff Member by the Chair of the Clinical Department or the Chief of Staff.

12.2.2 ***Informal Hearing.*** A Member who has had Clinical Privileges summarily suspended shall be entitled to request within ten (10) working days, in writing, that the Medical Executive Committee hold an informal hearing and recommendation on the matter.

With or without such a request, a meeting of the Medical Executive Committee shall be convened to review and consider the action not later than fifteen (15) working days after such summary restriction or suspension has been imposed.

In no event will the initial meeting of the Medical Executive Committee, with or without the Member, constitute a hearing within the meaning of the Fair Hearing Plan, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but, in any event, it shall furnish notice of its decision to the Member.

12.2.3 ***Right to Hearing.*** Unless the Medical Executive Committee terminates the summary restriction or suspension within fourteen (14) working days after its imposition, the Member shall be entitled to the procedural rights afforded by the Fair Hearing Plan.

12.3. ***Automatic Suspension or Limitation.*** In the following instances, the Member's Privileges or membership shall be suspended or limited as described, which action shall be final without a right to hearing or further review, except when a bona fide dispute exists as to whether the circumstances have occurred.

12.3.1 ***Licensure.***

- A. Whenever a Member's license authorizing practice in this state is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked and suspended as of the date such action becomes effective, irrespective of whether such license may be reinstated retroactively.
- B. Whenever a Member's license authorizing practice in this state is limited or restricted by the applicable licensing authority, any Clinical Privileges granted to the Member within the scope of such 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.

12.3.2 ***Controlled Substances.***

- A. Whenever a Member's DEA certificate is revoked, limited, or suspended, the Member 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. Whenever a Member's DEA certificate is subject to probation, the Member'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.

12.3.3 ***Insurance.*** Whenever a member's professional liability coverage has lapsed, been suspended, revoked, or limited, the member's privileges will be automatically suspended as of the date such action becomes effective.

12.3.4 ***Unprofessional Conduct.*** Engagement in unprofessional conduct as defined and in violation of K.S.A. 65-2837, as amended, by Members of the Medical Staff is forbidden and any such violation shall be cause for suspension from the Medical Staff.

12.3.5 ***Commission of Fraud.*** Any Medical Staff Member who is convicted of fraud involving the practice of medicine or dentistry under current federal or state

regulation shall automatically have his or her Clinical Privileges revoked and suspended.

12.3.6 **Medical Records.** A limited suspension in the form of withdrawal of admitting privileges and other related rights until medical records are completed may be imposed by the Chief of Staff, or his designee, or the Medical Executive Committee after notice of delinquency for failure to complete medical records in accordance with the Rules and Regulations. The suspension shall continue until the medical records have been completed and the suspension lifted by the Chief of Staff.

12.3.7 **Reinstatement.** Except as provided for in Section 12.3.5, reinstatement of membership and revoked or restricted Clinical Privileges would require a new application process as described in Article IV. The applicant would bear the burden of proof that his or her previous difficulties had been satisfactorily resolved.

12.4. **Reporting.**

12.4.1 **Reports Regarding Privileges.** Whenever the Clinical Privileges of any Physician are terminated, suspended, or restricted for a period longer than thirty (30) days, or whenever such Privileges are voluntarily surrendered or limited for reasons relating to such Physician's professional competence, a report shall be made in accordance with the Health Care Quality Improvement Act. Such surrender of Clinical Privileges shall include situations in which the Member is under investigation relating to possible incompetence or improper professional conduct, or in which such surrender is made in return for not conducting such an investigation.

12.4.2 **Reports Regarding Adverse Findings.** Any finding by the Medical Executive Committee that a Member of the Staff has acted below the applicable standard of care, or has committed an act that is grounds for disciplinary action pursuant to K.S.A. 65-2836, shall be reported to the Kansas Board of Healing Arts.

12.5. **Hearings and Appellate Review.**

12.5.1 An adverse action or recommendation, defined in Section 1.1-3 of the Fair Hearing Plan, shall entitle the affected Member, upon request, to a hearing and appellate review in accordance with the provisions of the Plan. All hearings and appellate reviews shall be conducted pursuant to the provisions of the Plan. Only those actions or recommendations specifically enumerated in Section 1.1-2 of the Fair Hearing Plan shall give rise to any right to a hearing or appellate review.

12.5.2 Any Member of this Medical Staff shall agree to fully exhaust all remedies afforded by the Fair Hearing Plan before resorting to any form of legal action.

ARTICLE XIII CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1. **Authorization and Conditions.** By applying for or exercising Clinical Privileges within this Hospital, an applicant:

- 13.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- 13.1.2 Authorizes persons and organizations to provide information concerning the applicant to the Medical Staff;
- 13.1.3 Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provisions of these Bylaws; and
- 13.1.4 Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership and to the exercise of Clinical Privileges in the Hospital.

13.2. **Confidentiality of Information.**

13.2.1 **General.** Medical Staff or committee minutes, files, and records, including information regarding any Member or applicant to this Medical Staff, shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where expressly required by law, or as provided for within these Bylaws.

13.2.2 **Breach of Confidentiality.** Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with other hospitals, professional societies, or licensing authorities, is outside appropriate standards of conduct. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate in accordance with Section 12.

13.2.3 **Staff Member Access.** A Medical Staff Member may obtain access to his or her credentials file subject to the following limitations:

- A. A written request for access must be made by the Member to the Chief of Staff;
- B. The Member may review and receive a copy of only those documents provided by or addressed personally to the Member;
- C. A written summary of all other information, including Peer Review Committee findings, letters of reference, proctoring reports, complaints, and other similar material shall be provided to the Member within a reasonable period of time after a request is made for access to the file
- D. The written summary shall disclose the substance, but not the source, of the summarized information; and

- E. The review by the Member shall take place in the office of the CEO or other designated location, during normal working hours, with an officer or designee of the Medical Staff or Hospital CEO present.

13.3. Immunity from Liability.

13.3.1 ***For Action Taken.*** Each Member of the Medical Staff and all Allied Health Professionals and all Hospital employees shall be exempt, and have immunity to the fullest extent permitted by law, from liability to a Practitioner, Member, or Allied Health Professional for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a representative of the Medical Staff or Hospital, their committees, members, agents, employees, advisors, counselors, consultants, attorneys, or any other persons providing services to or through the Medical Staff, Hospital, or committee in conjunction with evaluation of a Practitioner, Member, or Allied Health Professional.

13.3.2 ***For Providing Information.*** Each representative of the Medical Staff and the Hospital and all third parties shall be exempt, to the fullest extent permitted by law, from liability to a Practitioner, Member, or Allied Health Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person, provided that such representative or third party acts in good faith and without malice.

13.4. Activities and Information Covered.

13.4.1 ***Activities.*** The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- A. Applicants for appointment, reappointment, or Clinical Privileges;
- B. Peer review activities;
- C. Corrective action;
- D. Hearing and appellate reviews;
- E. Quality improvement and utilization review activities; and
- F. Other committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

13.5. **Releases.** Each applicant or Member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

- 13.6. **Cumulative Effect.** The provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to all other protections provided by law and not in limitation thereof.

ARTICLE XIV INFORMED CONSENT

- 14.1. **Responsibility.** Except in an emergency, written informed consent shall be obtained from the patient or the patient's representative prior to the performance of certain procedures and/or medical treatment in accordance with Hospital policy which may be updated from time to time.
- 14.2. **Procedure.** Informed consent shall be written legibly and be stated in plain language without use of abbreviations. At a minimum, written informed consent shall include the following:
- A. Identification of the specific procedure for which consent is being given;
 - B. Identification of the responsible practitioner who is performing the procedure;
 - C. Statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; and
 - D. Signature of the patient or the patient's legal representative.

ARTICLE XV NON-PHYSICIAN PROVIDERS

- 15.1. **Responsibility.** It shall be the responsibility of the Medical Staff to provide oversight as well as credentialing and delineation of Privileges to all NPPs who apply for such Privileges in this Hospital.
- 15.2. **Procedure.** Procedures for application, credentialing, delineation of Privileges, and suspension or revocation of such Privileges are detailed in the Policy on Allied Health Professionals appended to these Bylaws.

ARTICLE XVI ADOPTION AND AMENDMENT OF BYLAWS

- 16.1. **Procedure.** Upon the recommendation of the Medical Executive Committee, the Hospital Board, or upon timely written application signed by at least Ten Percent (10%) of the Members of the Medical Staff in good standing entitled to vote, consideration shall be given to the amendment of these Bylaws. Amendments may be considered at any regular or special meeting of the Medical Staff provided that notice of the amendments has been posted on the Medical Staff bulletin board at least twenty-eight (28) days prior to the meeting. The notice shall include the exact wording of the existing Bylaws language, if

any, and of the proposed change. Amendment of the Bylaws shall require a two-thirds (2/3) vote of the Active Medical Staff Members present at the meeting.

- 16.2. **Technical Modifications.** The Medical Executive Committee shall have the power to adopt such changes to the Bylaws as are, in the Committee's judgment, technical modifications or clarification, reorganization, or renumbering, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if approved by the Medical Staff and the Board. Immediately upon adoption, such amendments shall be sent to the Hospital CEO and posted on the Medical Staff bulletin board for fourteen (14) days.
- 16.3. **Board Action.** Bylaws changes adopted pursuant to Section 16.1 shall be reported to the Board of Trustees by the Chief of Staff. They shall become effective following approval by the Board.
- 16.4. **Exclusivity.** The mechanism described herein shall be the sole method for amendment of the Medical Staff Bylaws. These Bylaws may not be unilaterally amended by either the Board or the Medical Staff.
- 16.5. **Notification.** Except for technical modifications as described in Section 16.2, a revised text of amended Bylaws, Rules and Regulations, Fair Hearing Plan, Risk Management Plan, Performance Improvement Plan, Utilization Review Plan, or Policy on Allied Health Professionals shall be provided to all Medical Staff Members and all Members of the Hospital Board.

ARTICLE XVII ADOPTION

- 17.1. **Prior Bylaws.** These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, and, henceforth, all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws.

**LABETTE HEALTH
MEDICAL STAFF BYLAWS**

**EXHIBIT A
MEDICAL STAFF FAIR HEARING PLAN**

**SECTION I.
INITIATION OF HEARING**

1.1. ADVERSE ACTION OR RECOMMENDATION

1.1.1 The procedures set forth in this Fair Hearing Plan shall be available only for resolution on an intra-professional basis of matters pertaining to professional competency or conduct of Medical Staff Members and shall not allow for hearing or appellate review of the Hospital's organizational or administrative decisions.

1.1.2 The following actions or recommendations shall, if deemed adverse pursuant to Section 1.1.3, entitle the Staff Member thereby affected to a hearing and/or appellate review:

- A. Denial of initial staff appointment or reappointment;
- B. Suspension or revocation of staff membership;
- C. Reduction or denial of requested advancement in Medical Staff membership category;
- D. Reduction or limitation of membership prerogatives;
- E. Denial of requested clinical privileges; and
- F. Reduction, suspension, or revocation of clinical privileges.

1.1.3 An action or recommendation listed in Section 1.1.2. shall be deemed adverse only when it has been:

- A. Taken by the Board contrary to a favorable recommendation by the Medical Executive Committee (*e.g.*, Board denies a Staff Member's request for reappointment despite Medical Executive Committee's favorable recommendation); or
- B. Recommended by the Medical Executive Committee to the Board.

1.2. NOTICE OF ADVERSE ACTION OR RECOMMENDATION

A Staff Member against whom an adverse action has been taken by the Board or an adverse recommendation has been made by the Medical Executive Committee shall be given notice within fifteen (15) days of such action or recommendation. The notice shall describe the

action or recommendation and the reasons for it. The notice shall also include a copy of this Fair Hearing Plan. Such notice shall be delivered in person or by certified mail.

1.3. REQUEST FOR A HEARING/APPELLATE REVIEW

A Staff Member shall have thirty (30) days after his or her receipt of a notice pursuant to Section 1.2 to file a written request for a hearing with respect to an adverse recommendation by the Medical Executive Committee or a written request for appellate review with respect to adverse action by the Board. Such request shall be delivered to the CEO or the Chief of Staff either in person or by certified mail.

1.4. WAIVER BY FAILURE TO REQUEST A HEARING/APPELLATE REVIEW

A Staff Member who fails to request a hearing or appellate review within the time and in the manner specified in Section 1.3 waives any right to such hearing and/or to any appellate review to which he or she might otherwise have been entitled. Such waiver shall constitute acceptance of the adverse action or recommendation.

1.5. EXCEPTION TO HEARING/APPELLATE REVIEW RIGHTS

The following actions or recommendations will not entitle a Staff Member to a hearing and/or appellate review:

- A. The denial of or refusal to accept an application for initial appointment to the Medical Staff where the application is incomplete or where the application is not acceptable under the requirements set forth in the Medical Staff Bylaws;
- B. Automatic termination under Article 12, Section.3 of the Medical Staff Bylaws;
- C. Suspension from the Medical Staff or suspension or restriction of clinical privileges for a period of fourteen (14) days or less during which an investigation is being conducted as provided in the Medical Staff Bylaws or this Fair Hearing Plan;
- D. The imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;
- E. The imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation;
- F. The issuance of a letter of warning, admonition, or reprimand;
- G. Corrective counseling;
- H. The denial of a request for a waiver or reduction of the required minimum liability insurance coverage;
- I. Any recommendation or action not adversely affecting a Staff Member;

- J. Any action not based on the Staff Member's competence or professional conduct;
- K. The imposition of supervision on a Staff Member;
- L. The removal of a Staff Member from an administrative office within the Hospital or with the Medical Staff;
- M. Termination of staff membership or termination, modification, reduction, or change in clinical privileges or membership of a practitioner resulting from termination or expiration of a contract or employment arrangement in which said practitioner has been rendering services at the Hospital unless the contract or employment arrangement provides otherwise; and
- N. When any action is voluntarily imposed or accepted by the Staff Member.

SECTION II. HEARING REQUIREMENTS

2.1. NOTICE OF TIME AND PLACE FOR HEARING

Upon the timely receipt of a request for a hearing concerning an adverse recommendation by the Medical Executive Committee, the CEO shall deliver such request to the Chief of Staff. Within fifteen (15) days after receipt of such request by the CEO, the Chief of Staff shall schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the CEO or Chief of Staff shall send notice to the Staff Member of the time, place, and date of the hearing. The notice of the hearing provided to the Staff Member shall include a list of witnesses, if any, expected to testify at the hearing in support of the adverse recommendation and the names of the members of the hearing panel and/or of the hearing officer. The notice shall also contain the basis for the recommendation. The notice of the hearing shall be delivered in person or by certified mail.

2.2. CONDUCT OF HEARING

The hearing shall be held before a hearing officer and/or before a hearing committee, as determined by the Chief of Staff. The hearing officer, if used, shall be appointed by the Chief of Staff pursuant to Section 2.3. Alternatively, or additionally, a hearing committee shall be appointed by the Chief of Staff pursuant to Section 2.4.

2.3. APPOINTMENT OF HEARING OFFICER

The hearing officer, if used, may be a physician, dentist, attorney, or other individual qualified to conduct a hearing. The hearing officer is not required to be a member of the Medical Staff. The hearing officer shall have no direct financial or personal interest in the hearing outcome.

2.4. APPOINTMENT OF HEARING COMMITTEE

- 2.4.1 A hearing committee, if used, shall be appointed by the Chief of Staff and shall consist of at least three (3) members. A majority of the members of the hearing committee shall be practitioners but are not required to be members of the Medical Staff.
- 2.4.2 A Staff Member shall not be disqualified from serving on a hearing committee merely because he or she participated in initiating or investigating the underlying matter at issue or because he or she has heard of the case. However, no member of a hearing committee shall have any conflict of interest, perceived conflict of interest or personal or financial interest in the outcome of the hearing. All members of a hearing committee shall be required to objectively consider and decide the case with good faith.

SECTION III. HEARING PROCEDURE

3.1. FORFEITURE OF HEARING

A Staff Member who requests a hearing but fails to appear at the hearing without good cause, as determined by the hearing committee or hearing officer, shall forfeit his or her rights to such hearing and to any appellate review to which he or she might otherwise have been entitled.

3.2. PRESIDING OFFICER

The hearing officer, if one is appointed, shall be the presiding officer. Otherwise, an individual qualified to conduct hearings shall be designated as the presiding officer for a hearing that is heard by a hearing committee. Such individual need not be a member of the hearing committee, or Staff Member. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He or she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

3.3. REPRESENTATION

The Staff Member who requested the hearing shall be entitled to be accompanied and represented at the hearing by another Staff Member in good standing, by a member of a professional society, and/or by an attorney or other persons of the physician's choice. The Medical Staff may appoint a Staff Member and/or an attorney to represent it at the hearing, to present the facts in support of the adverse recommendation, and to examine witnesses.

3.4. RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

- A. call, examine and cross-examine witnesses;
- B. introduce any relevant evidence, including exhibits, regardless of its admissibility in court;
- C. question any witnesses on any matter relevant to the issues;
- D. impeach any witness;
- E. rebut any evidence;
- F. make a record of the hearing by use of a Kansas Certified Shorthand Reporter at the party's expense; and
- G. submit a written statement within five (5) business days following the close of the hearing.

If the Staff Member who requested the hearing does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

3.5. PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons would customarily rely on or the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party may submit memoranda concerning any issues of law or fact prior to, during, or within five (5) business days following the close of the hearing, and such memoranda shall become a part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him or her and entitled to notarize documents.

3.6. BURDEN OF PROOF

The Medical Executive Committee shall have the initial obligation to present evidence in support thereof, but the Staff Member shall thereafter be responsible for supporting his or her challenge to the adverse recommendation by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusions drawn there from are arbitrary, unreasonable, or capricious.

3.7. RECORD OF HEARING

A record of the hearing shall be kept of sufficient accuracy such that an informed and valid judgment can be made by anyone that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee or hearing officer may select the method to be used for making the record, such as court reporter, detailed transcription, or minutes of the proceedings. A Staff Member electing an alternate method shall bear the cost.

3.8. POSTPONEMENT

Requests for postponement of a hearing may be granted by the presiding officer upon a showing of a good cause.

3.9. RECESSES AND ADJOURNMENT

The presiding officer may recess the hearing and reconvene it without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

SECTION IV. REPORT AND FURTHER ACTION

4.1. REPORT

Within twenty (20) days after the hearing concerning an adverse recommendation by the Medical Executive Committee is closed, the hearing committee or hearing officer shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Medical Executive Committee. The report shall include a statement of the basis for its recommendations. A copy of the report shall be provided to the Staff Member who requested the hearing.

4.2. ACTION ON REPORT

Within fifteen (15) days after receipt of the report, the Medical Executive Committee shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. The decision shall be in writing and shall include a statement as to its basis. The decision shall be transmitted, together with the hearing record, the report of the hearing committee or hearing officer, and all other documentation considered, to the Hospital CEO.

4.3. NOTICE AND EFFECT OF RESULT

4.3.1 The Hospital CEO, as an agent of the Medical Executive Committee, shall immediately send a copy of the decision to the Staff Member and to the Board.

4.3.2 If the Medical Executive Committee's decision pursuant to Section 4.2 is favorable to the Staff Member, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Medical Executive Committee's decision in whole or in part, or by referring the matter back to the Medical Executive Committee for further consideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final

action. The CEO shall promptly send notice to the Staff Member informing him or her of the final action taken by the Board pursuant to this Section and providing copies of all reports, referrals, or recommendations. A favorable determination shall become the final decision of the Board and the matter shall be considered closed. If the Board's action is adverse as defined in Section 1.1, the notice shall inform the Staff Member of his or her right to request an appellate review by the Board as provided in Sections V and VI of this Fair Hearing Plan.

SECTION V. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

5.1. REQUEST FOR APPELLATE REVIEW

A Staff Member shall have thirty (30) days after receipt of a notice of adverse action of the Board contrary to a favorable recommendation by the Medical Executive Committee pursuant to Section 1.2 and shall have fifteen (15) days after receipt of a notice of an adverse result pursuant to Section 4.3.2 to file a written request for an appellate review. Such request shall be delivered to the Hospital CEO, either in person or by certified mail. In the case of an adverse result pursuant to Section 4.3.2, such request may include a request for a copy, at the Staff Member's expense, of the record of the hearing and all other materials, favorable or unfavorable, that were considered in making the adverse decision.

5.2. WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A Staff Member who fails to request appellate review within the time and in the manner specified in Section 5.1 waives any right to such review.

5.3. NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. Within fifteen (15) days after receipt of such request, the Board shall schedule and arrange for an appellate review. At least thirty (30) days prior to the appellate review, the CEO shall send notice to the Staff Member of the time, place, and date of the review. Such notice shall be delivered in person or sent by certified mail. The time for the appellate review may be extended by the appellate review body upon request of the Staff Member.

5.4. APPELLATE REVIEW BODY

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee composed of two (2) or more members of the Board appointed by the chairperson of the Board. If a committee is appointed, one (1) of its members shall be designated as chairperson.

**SECTION VI.
APPELLATE REVIEW PROCEDURE**

6.1. NATURE OF PROCEEDINGS

The proceedings by the appellate review body shall be in the nature of an appellate review based upon (a) in the case of an adverse action by the Board, the record generated by the Medical Executive Committee and the Board, or (b) in the case of an adverse recommendation by the Medical Executive Committee, the hearing before the hearing committee and/or hearing officer, the resulting report, and all subsequent results and actions thereon. The appellate review body shall also consider any written statements submitted pursuant to Section 6.2 (below) and such other materials as may be presented and accepted under Sections 6.4 and 6.5 of this Fair Hearing Plan.

6.2. WRITTEN STATEMENTS

The Staff Member seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he or she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the decision-making process. The statement shall be submitted to the appellate review body through the CEO at least fifteen (15) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Executive Committee at least ten (10) days prior to the scheduled date of the appellate review, and if submitted, the CEO shall provide a copy thereof to the Staff Member.

6.3. PRESIDING OFFICER

The chairperson of the appellate review body shall be the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4. ORAL STATEMENT

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

6.5. CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised in any prior deliberations or proceeding may be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

6.6. RECESS AND ADJOURNMENT

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed.

6.7. ACTION TAKEN

The appellate review body may recommend that the Board affirm, modify, or reverse the adverse action or recommendation or, in its discretion, may refer the matter back to the Medical Executive Committee, the hearing committee, or the hearing officer for further review and recommendation to be returned to it within a time frame specified by the appellate review body. Within thirty (30) days after receipt of such recommendation after referral, the appellate review body shall make its final recommendation to the Board. The appellate review body shall also notify the Staff Member in writing of the results of their recommendation, together with statement of the basis of its recommendation.

6.8. CONCLUSION

The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein shall have been completed or waived.

**SECTION VII.
FINAL DECISION OF THE BOARD**

7.1. BOARD ACTION

Within thirty (30) days after receipt of the appellate review body’s recommendation, the Board shall render its final decision in the matter in writing and shall send notice thereof to the Staff Member either in person or by certified mail, as well as to the Chief of Staff. Such written notice shall include a statement of the basis for the decision made by the Board. The Staff Member shall have no further appeal rights with respect to such decision.

**SECTION VIII.
GENERAL PROVISIONS**

8.1. WAIVER

If at any time after receipt of notice of an adverse recommendation, action, or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he or she shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he or she might otherwise have been entitled with respect to the matter involved.

8.2. EXHAUSTION OF REMEDIES

Any applicant or member of the Medical Staff must exhaust the remedies afforded by this Fair Hearing Plan before resorting to any form of legal action.

8.3. AMENDMENT

This Fair Hearing Plan shall be considered a part of the Medical Staff Bylaws of Labette Health and may be amended only in the manner provided for amendment of said Bylaws.

**LABETTE HEALTH
MEDICAL STAFF BYLAWS**

**EXHIBIT B
POLICY ON NON-PHYSICIAN PROVIDERS**

SECTION 1. NATURE OF NON-PHYSICIAN PROVIDERS.

A Non-Physician Provider (“NPP”) is an individual other than a licensed Physician or Dentist who functions in one of the following ways: in a medical support role to a Physician or Dentist; ~~or~~ exercises independent judgment within the area of his or her professional competence and who is qualified by licensure, certification, or other approval to render medical or surgical care under the supervision of a Physician or Dentist who has been accorded privileges to provide such care in the Hospital; or exercises independent judgment within the area of his or her professional competence and who is qualified by licensure, certification, or other approval to render medical or surgical care without supervision of a Physician or Dentist who has been accorded privileges to provide such care in the Hospital. The following, without limitation, may be deemed NPPs for the purposes of this Section: audiologists, advanced practice nurses, bacteriologists, chemists, chiropractors, clinical pharmacologists, dental auxiliary, independent certified nurse midwives, nuclear medicine technicians, nurse anesthetists, optometrists, orthopedic and other surgical technicians, physician’s assistants, physicists, physiologists, podiatrists, social workers, psychologists, scrub technicians, speech pathologists, and qualified therapists (e.g., occupational, physical, respiratory).

NPPs are not members of the Medical Staff and shall have only such limited duties, responsibilities and prerogatives as may be specifically set forth herein. NPPs will not be eligible to vote or hold office in the Medical Staff. NPPs may be invited to attend Medical Staff meetings. The Board shall specify by policy or regulation, the classes of NPPs that may be granted Clinical Privileges in the Hospital. In establishing such classes, the Board shall consider such factors as need in the Hospital for the types of services provided by the particular classes of NPPs and the availability of Medical Staff Members appropriately trained to oversee the type of services provided by a particular class of NPPs.

Certain categories of NPPs shall require Physician sponsors to perform any services in the Hospital. Guidelines for each NPP’s category shall set forth whether sponsorship is required, and the procedures for obtaining said sponsorship.

SECTION 2. CATEGORIES OF NPPS.

There shall be three (3) categories of NPPs:

- (1) **Licensed Independent Practitioner (LIP) NPPs.** LIP NPPs are individuals who, by license and hospital policy are permitted to practice independently without supervision or direction of a physician. LIP NPPs include, but are not limited to, audiologists, clinical

psychologists, independent certified nurse midwives¹, optometrists, social workers, and podiatrists.

- (2) **Advanced Dependent Practitioners (ADP) NPPs.** ADP NPPs are individuals who are licensed or certified by a state board and are granted clinical privileges and function in the Hospital under the supervision of, or in collaboration with, a physician Medical Staff Member. ADP NPPs include Physician Assistants, Certified Registered Nurse Anesthetists, and Advanced Registered Nurse Practitioners.
- (3) **Dependent Practitioners.** Dependent Practitioners are individuals who are not LIP NPPs or Advance Dependent Practitioners and who provide clinical care in the Hospital within their scope of practice under the direction or supervision of a Medical Staff Member.

The Medical Staff Executive Committee, based on the recommendation of the Medical Staff Family Practice Department, shall make a recommendation to the Board regarding the types of NPP to be granted Clinical Privileges in the Hospital, and the Board shall consider such recommendation prior to making its decision.

SECTION 3. QUALIFICATIONS.

To be eligible for Clinical Privileges within the Hospital, an NPP must:

- (1) Apply for an NPP category approved for Clinical Privileges by the Board;
- (2) Meet all qualifications and requirements specified by the Board for his or her applicable NPP category;
- (3) Provide evidence of adequate education, training and experience;
- (4) Hold a license, certificate, or such other credentials as may be required by applicable state law; and
- (5) Provide proof of malpractice insurance in an amount required by the Board.

SECTION 4. PREROGATIVES.

An NPP's prerogatives include the following:

- (1) Provide designated patient care services under the supervision or direction (as determined by Board policy or regulation) of a Medical Staff Member;
- (2) Write orders only to the extent specified in the Medical Staff Rules and Regulations or the position description developed for the NPP category of which the NPP is credentialed;

¹ Independent certified nurse midwives are authorized by the Kansas Board of Healing Arts to engage in the independent practice of midwifery. The provision of clinical services without a collaborative practice agreement is allowed when the clinical services provided by independent nurse midwives are limited to those associated with a normal, uncomplicated pregnancy and delivery and related care and family planning services as outlined in Kan. Stat. Ann. § 65.28b02.

- (3) Exercise such other prerogatives granted by the Medical Executive Committee (upon Board approval) to any general or specific category of NPP recommended by the Medical Staff Family Practice Department, the Credentials Committee, or otherwise;
- (4) Serve on Medical Staff committees when appointed (NPPs shall not have the privilege of voting or holding office in the Medical Staff); and
- (5) Admit patients under the supervision and direction of a qualified Member of the Medical Staff who shall be ultimately responsible for patient's general medical condition and care as an NPP may not independently admit patients.

SECTION 5. OBLIGATIONS OF NPPS.

Each NPP shall:

- (1) Meet the basic responsibilities established by the Medical Staff Medicine Department, the Credentials Committee, and/or the Medical Executive Committee;
- (2) Assume responsibility to the extent applicable under his/her scope of practice for the care and supervision of each patient in the Hospital for whom he or she is providing services;
- (3) Participate as requested in performance improvement/quality assurance program activities and in discharging related performance improvement/quality assurance duties as may be required from time to time;
- (4) Attend clinical and educational meetings of the Hospital and/or Medical Staff as requested as well as meetings committees of which he or she is a member; and
- (5) Refrain from any actions that are or may be reasonably interpreted as being beyond, or an attempt to exceed, the NPP's scope of practice under state law, as authorized by the Hospital, or as authorized in the Medical Staff Bylaws, Rules and Regulations and under this Exhibit B.

SECTION 6. APPLICATION FOR PRIVILEGES.

- (1) Every NPP who seeks Clinical Privileges must make written application for such Privileges or for any change in Privileges. Included in the application shall be the name of the Medical Staff Member who will remain the sponsor of the applicant NPP until or unless a change of sponsor is granted. The applicant or his or her sponsor shall submit a written statement of the clinical duties and responsibilities for which the NPP is requesting Clinical Privileges. The applicant shall agree to abide by these Bylaws to the extent they are applicable to NPPs and other Medical Staff and Hospital Bylaws, Rules, Regulations, policies, and procedures including, but not limited to, Hospital's Corporate Compliance Plan.
- (2) Applications for appointment or reappointment of Clinical Privileges of LIP NPPs and ADP NPPs shall be processed in accordance with the procedures established by the Medical Executive Committee and approved by the Board.

- (3) Applications for Dependent Practitioners shall be processed in accordance with the procedures set forth in the Hospital's Human Resources Department.

SECTION 7. PROCEDURE FOR SPECIFICATION OF SERVICES.

Written guidelines for specified services that may be provided by each category of NPPs will be developed by the Medical Staff Family Practice Department in conjunction with the Credentials Committee, subject to approval the Medical Executive Committee and the Board of Trustees. For each category of NPPs, such guidelines must include at least the following:

- (1) Minimum requirements for prior training and experience;
- (2) Specification of the types of patients that may be seen and treated by the NPPs;
- (3) A description of services and procedures to be provided by the NPPs, including any special equipment, procedures or protocol that may be necessary;
- (4) Medical record documentation requirements for recording medical services provided to patients;
- (5) Definition of the degree of assistance that an NPP may require from a Medical Staff Member (including the degree of supervision required for each service) in the treating of patients on Hospital premises and any limitations applicable to such service(s); and
- (6) Whether the category of NPPs requires sponsorship and, if so, procedure(s) for the designation of said sponsor.

SECTION 8. REVIEW OF CREDENTIALS.

NPP's credentials shall be reviewed six (6) months following initial appointment, twenty-four (24) months following initial appointment, and at least every two (2) years thereafter.

SECTION 9. PROCEDURAL RIGHTS.

- (1) NPPs shall not be entitled to the hearing and appellate procedures set forth in the Medical Staff Bylaws and the Fair Hearing Plan as identified in Exhibit A.
- (2) In the event that an LIP NPP or ADP NPP is not granted permission to practice in the Hospital or that permission is terminated, such NPP, and when applicable, his or her employing or supervising physician, shall have the right to appear personally before the Medical Executive Committee to discuss the adverse recommendation. A Dependent Practitioner shall not have such right to an appearance or any of the other procedural rights outlined in this Section 9.
- (3) If the LIP NPP or ADP-NPP desires to meet with the Medical-Executive Committee, he or she must make such a request in writing within thirty (30) days of his or her receipt of notification of denial or revocation of permission to practice in the Hospital. Should the LIP NPP or ADP NPP request a meeting in a timely manner, he or she will be informed of

the general nature of the information supporting the adverse recommendation at least ten (10) days prior to his/her appearance the scheduled Medical Executive Committee meeting.

- (4) At the Medical Executive Committee meeting, the LIP NPP or ADP NPP and, when applicable, his or her employing or supervising physician, shall be invited to discuss the circumstances regarding the denial or termination of the NPP's privilege to practice at the Hospital. Such meeting shall not constitute a hearing and none of the procedural rules provided for in the Medical Staff Bylaws or the Fair Healing Plan shall apply. However, minutes of the meeting shall be kept and shall be attached to the Medical Executive Committee meeting minutes.

The Medical Executive Committee shall forward its recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the recommendation, certified mail, return receipt requested, to the LIP NPP or ADP NPP.

The recommendation of the Medical Executive Committee will then be reported to the Hospital Board at their next regularly scheduled meeting. Based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital, the Board shall make a decision to accept, reject, or modify the recommendation of the Medical Executive Committee. Such decision shall be deemed to constitute final action by the Board, and the LIP NPP or ADP NPP shall not have any right to appeal such decision.

SECTION 10. AMENDMENTS.

Notwithstanding any provision to the contrary in the Medical Staff Bylaws, this Policy on NPPs may be amended in the manner set forth in this Section 10.

- (1) This policy on NPPs may be amended by a majority vote of the members of the Medical Staff present and voting at any Medical Staff meeting where a quorum exists, provided that the written recommendations of the Medical Staff Family Practice Department concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. In addition, notice of all proposed amendments shall be published in the Medical Staff newsletter at least fourteen (14) days prior to the Medical Staff meeting. No amendment to this policy shall be effective until approved by the Board.
- (2) This policy may also be amended by the Board on its own motion provided that any such amendment is first submitted to the Medical Executive Committee for review and comment at least thirty (30) days prior to any final action by the Board and subsequently approved by a majority of the Medical Staff at a Medical Staff meeting at which a quorum is present. Notice of all proposed amendments shall be published in the Medical Staff newsletter at least fourteen (14) days prior to such a meeting. Instances where Board action is warranted shall include, but is not limited to the following:
 - (a) Amendments are required for compliance with changes in federal and state laws that affect the Hospital, including any of its entities;
 - (b) Amendments are necessary to meet the requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and

- (c) Amendments are required to ensure the Hospital's compliance with state licensure requirements and the Medicare Conditions of Participation.
- (3) Within ten (10) business days of Board approval of any amendment to this Policy for NPPs, notice of such amendment shall be distributed to all NPPs with Clinical Privileges at the Hospital at that time in a manner deemed appropriate by the Medical Executive Committee.

SECTION 11. CO-SIGNING OF NPP DOCUMENTATION

Except as otherwise permitted by this Section, a physician member of the Medical Staff must co-sign medical records and charts for patients evaluated or treated by an NPP.

- (1) **Licensed Independent Practitioner(s).** An LIP's documentation of conduct within the scope of the LIP's license does not require co-signature by a physician.
- (2) **Advanced Dependent Practitioner(s):**
 - (a) **Physician Assistant.** During the first thirty (30) days of the sponsoring physician-physician assistant relationship, the sponsoring/supervising physician must review and co-sign all medical records and charts for patients evaluated or treated by the Physician Assistant within seven (7) days of the date the Physician Assistant evaluated or treated each patient.

After the first thirty (30) days of the sponsoring/supervising physician-physician assistant relationship, the sponsoring/supervising physician's co-signature is not required except as specifically required by this or other Labette Health policy or applicable law. However, the sponsoring/supervising physician shall conduct and document an annual review and evaluation of the Physician Assistant's performance, which may include the review of patient records and charts. The written review and evaluation shall be signed by the sponsoring/supervising physician and the Physician Assistant. This documentation shall be kept on file at each practice location.

At any time during the sponsoring/supervising physician-physician assistant relationship, the sponsoring/supervising physician must review and co-sign each medical record and chart for treatment provided by a Physician Assistant in an emergency situation if the treatment exceeded the authority granted to the Physician Assistant by the sponsoring/supervising physician. The Physician Assistant shall document his/her communication with the sponsoring/supervising physician in the patient's medical record. The sponsoring/supervising physician shall review and co-sign the medical records and chart as soon as clinically feasible following the emergency treatment provided by the Physician Assistant.

- (b) **Advanced Practice Registered Nurse ("APRN").** Includes all advanced practice registered nurses functioning in the roles of nurse practitioner (formerly NP or APRN), nurse-midwife (formerly NMW), nurse anesthetist, and clinical nurse specialist (formerly CNS). Except as specifically required by this or other Labette

Health policy or applicable law, an APRN's documentation does not require the co-signature of a physician.

Each APRN shall develop an authorization for collaborative practice with one or more physicians, signed by both the APRN and physicians. Each APRN and physician shall jointly review the authorization for collaborative practice annually. Each authorization for collaborative practice shall include a cover page containing the names and telephone numbers of the APRN and the physician, their signatures, and the date of review by the APRN and the physician. Each authorization for collaborative practice shall be maintained in either hard copy or electronic format at the APRN's principal place of practice.

Nurse anesthetists may perform duties and functions in an interdependent role as a member of a Physician- or Dentist-directed health care team. Upon the order of a Physician or Dentist requesting anesthesia or analgesia care, each registered nurse anesthetist shall be authorized to provide anesthesia and analgesia care in compliance with the federal or state law, rule, or regulation governing such services.

- (3) **Dependent Practitioner(s).** A physician Medical Staff Member shall co-sign all medical record entries and patient charting for patients evaluated and treated by a Dependent Practitioner.
- (4) **Entries Requiring Physician Signature.** Notwithstanding the foregoing, the following documentation in the medical record always requires co-signature by a physician:
 - (a) ***As Required by Law, Rule, or Regulation.*** Medical record documentation requiring a physician's signature in order to be in compliance with the federal or state law, rule or regulation governing such documentation or as otherwise required by an applicable accrediting agency shall be signed or co-signed by the appropriate physician.
 - (b) ***History and Physical.*** The History and Physical shall be co-signed by a physician member of the Medical Staff within the time frame required by the Medical Staff Bylaws and Medical Staff Rules and Regulations.
 - (c) ***Discharge Summary.*** The Attending Physician shall sign the discharge summary within the time frame required by the Medical Staff Rules and Regulations.
 - (d) ***Final Summary.*** The Attending Physician shall sign the final summary within the time frame required by the Medical Staff Rules and Regulations.

Transfer Certification Form. A consulted physician shall sign/countersign a completed Transfer Certification Form.

**LABETTE HEALTH
MEDICAL STAFF BYLAWS**

**EXHIBIT C
CODE OF ETHICS**

Medical Staff privileges will be granted to only those physicians, dentist, and oral surgeons who:

Comply with the Hospital's Code of Ethics and demonstrate the ethics of their respective professions.

Code of Ethics for each profession can be found at:

AMA

<http://www.ama-assn.org/>

AOA

<http://www.osteopathic.org/>

ADA

<http://www.ada.org/>

APMA

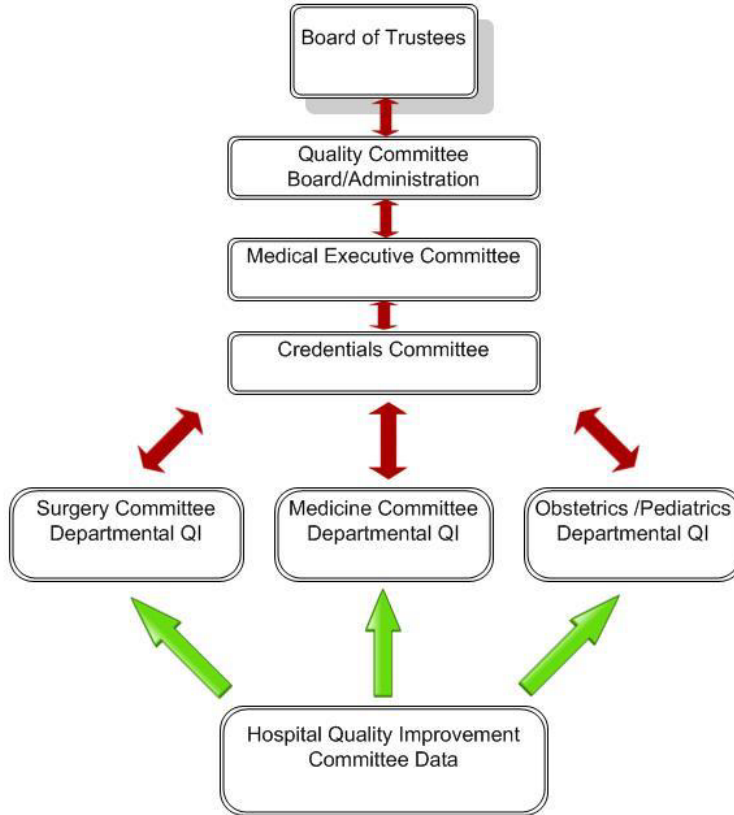
<http://www.apma.org/>

**LABETTE HEALTH
MEDICAL STAFF BYLAWS**

**EXHIBIT D
QUALITY DATA FLOW CHART**

Quality Data Flow Chart 2015

Exhibit D



Page 1

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, and, henceforth, all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws.

The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws until such time as they are amended in accordance with the terms of these Bylaws.

ADOPTED by the Medical Staff on

April 25, 2023



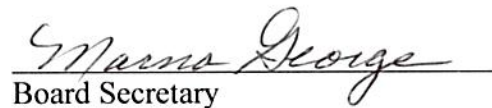
Chief of Staff


Medical Staff Secretary / Treasurer

APPROVED by the Board of Trustees on

May 4, 2023


Board President


Board Secretary


President / CEO