# MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS
OF
THE LONG ISLAND HOME

SOUTH OAKS HOSPITAL - A COMPREHENSIVE BEHAVIORAL HEALTH CENTER
BROADLAWN MANOR NURSING AND REHABILITATION CENTER –
A COMPREHENSIVE LONG-TERM AND SUB-ACUTE CARE FACILITY

DEFINITIONS

1. ADMINISTRATORS mean the Hospital Administrator and Nursing Home Administrator.

2. ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a licensed physician, nurse practitioner, dentist, or podiatrist, who is permitted by law and by the Corporation to provide specifically designated patient care services within the scope of his certificate or license, under the ultimate supervision of a physician member of the staff. Allied Health Professionals shall include, but not be limited to, physician assistants, psychologists, clinical social workers, optometrists, dieticians, physical therapists, and occupational therapists.

3. BOARD means the governing body of the Corporation.

4. CHIEF EXECUTIVE OFFICER or CEO means the individual appointed by the Board to act on its behalf in the management of the Corporation.

5. CLINICAL PRIVILEGES or PRIVILEGES means (a) in the case of physicians, physician assistants and nurse practitioners, the permission granted to a person to render specific diagnostic, therapeutic, medical, or surgical services; and (b) in the case of psychologists, dentists, podiatrists, and allied health professionals, the permission granted to a person to render specific patient care services.

6. CORPORATION means The Long Island Home d/b/a South Oaks Hospital and Broadlawn Manor Nursing and Rehabilitation Center, and the licensed operator of the Hospital and Nursing Home.

7. CREDENTIALING AND PRIVILEGING PLAN means the document that establishes the mechanism by which qualifications are defined and reviewed, and privileges are granted.

8. DENTIST means an individual with a D.D.S. degree who is fully licensed in New York to practice dentistry in all its phases. The term includes oral and maxillofacial surgeons, and does not include allied health professionals.

9. EXECUTIVE LEADERSHIP COMMITTEE means the committee established by Section 11.2 of the Medical Staff Bylaws.

10. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

11. HOSPITAL means South Oaks Hospital, of Amityville, New York, including all licensed programs, inpatient, outpatient and alternative levels of care.
12. HOSPITAL ADMINISTRATOR means the individual appointed by the CEO and the Board as administrator of the Hospital. The Vice President, Behavioral Health may serve as the Hospital Administrator.

13. HOSPITAL MEDICAL DIRECTOR means the member appointed pursuant to Article X hereof to act as the Medical Director of the Hospital.

14. HOSPITAL MEDICAL STAFF means the members of the Medical Staff who are privileged to attend patients of the Hospital.

15. MEDICAL DIRECTORS means the Nursing Home Medical Director and the Hospital Medical Director.

16. MEDICAL STAFF or CLINICAL STAFF means the formal organization of all physicians, nurse practitioners, dentists, and podiatrists who are privileged to attend patients at the Hospital and Nursing Home through the organized medical staff process that is subject to these Bylaws.

17. MEDICAL STAFF MEMBER or MEMBER means a professional who has applied for and has obtained current membership pursuant to Article III and Article VII.

18. MEDICAL STAFF YEAR means the period between the annual Medical Staff meetings.

19. NURSING HOME means Broadlawn Manor Nursing and Rehabilitation Center, including its skilled nursing facility and adult day programs.

20. NURSING HOME ADMINISTRATOR means the individual appointed by the CEO and the Board as the licensed administrator of the Nursing Home. The Vice President, Senior Services may serve as the Nursing Home Administrator.

21. NURSING HOME MEDICAL DIRECTOR means the member appointed pursuant to Article X hereof to act as the Medical Director of the Nursing Home.

22. NURSING HOME MEDICAL STAFF means the members of the Medical Staff who are privileged to attend residents of the Nursing Home.

23. NURSE PRACTITIONER means an individual with a N.P. degree who is fully licensed in the State of New York.

24. PHYSICIAN means an individual with an M.D. or D.O. degree who is fully licensed in New York to practice medicine in all its phases. The term does not include allied health professionals.

25. PODIATRIST means an individual with a D.P.M. degree who is fully licensed in New York to practice podiatry.

26. PRACTITIONER means, unless otherwise expressly defined, any professional applying for or exercising clinical privileges in the Hospital or Nursing Home.
27. PREROGATIVE means a participatory right granted, by virtue of staff status or otherwise, to a Member and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

28. PRESIDENT OF THE MEDICAL STAFF means the member appointed to act as the President pursuant to Article X.

29. PROFESSIONAL, unless otherwise expressly defined, means and includes physicians, dentists, podiatrists and nurse practitioners.

30. RULES AND REGULATIONS OF THE MEDICAL STAFF means that portion of the Bylaws containing the Rules and Regulations of the Hospital Medical Staff, for members of the Hospital Medical Staff, or the Rules and Regulations of the Nursing Home Medical Staff, for members of the Nursing Home Medical Staff.

31. SERVICE MEDICAL DIRECTORS means the members of the Hospital Medical Staff appointed pursuant to Section 10.7.

32. SPECIAL NOTICE means written notification given either by personal delivery or by certified or registered mail. Refusal to accept Special Notice sent by registered or certified mail shall constitute receipt of such notice.

33. SPECIAL STAFF OFFICER means a professional, employed by or otherwise serving the Hospital or Nursing Home on a full-time or part-time basis, whose duties include responsibilities, some of which are administrative in nature, some clinical in nature, and some both administrative and clinical in nature. The term includes the Medical Directors and each Service Medical Director(s).

34. STAFF STATUS or STATUS, unless the context otherwise provides, means the membership categories stated in Article IV.

35. UNIT means one of the service programs provided by the Hospital. This will include but not be limited to Child and Adolescent Psychiatric Units, Geriatric Unit, Adult Psychiatric Unit and Substance Use disorder Unit.
MEDICAL STAFF BYLAWS
THE LONG ISLAND HOME

PREAMBLE

The Medical Staff practicing at The Long Island Home hereby organize themselves in conformity with the Bylaws of the Medical Staff of The Long Island Home and the policies hereinafter stated. These Bylaws are adopted for the purpose of governing the actions, recommendations and functions of the professional staff of The Long Island Home. These Bylaws are not intended to be, nor shall they be interpreted in such a way as to be a delegation by the governing body to any person or group, including The Long Island Home Medical Staff, of the exclusive authority of the governing body to operate The Long Island Home’s licensed facilities, including the authority to make appointments of professional staff.

Masculine pronouns used throughout this document are generic and not intended to distinguish gender.
ARTICLE I

NAME

The name of the organized Medical Staff shall be the Medical Staff of The Long Island Home.
ARTICLE II

PURPOSES AND RESPONSIBILITIES

2.1. **PURPOSES**

The purposes of the Medical Staff are:

2.1.1 **To be** the formal organizational structure through which (a) the benefits of membership on the staff may be obtained by individual professionals and (b) the obligations of staff membership may be fulfilled.

2.1.2 **To serve** as the primary means for accountability to the Board for the appropriateness of the professional performance and ethical conduct of members and to strive toward assuring that the pattern of patient/resident care in the Hospital and Nursing Home is consistently maintained at a level of quality that is generally acceptable in the community.

2.1.3 **To ensure** that each Member provides professional services in accord with the scope of the individual clinical privileges granted.

2.1.4 **To provide** a means through which the Medical Staff may participate in the Corporation’s policy making and planning process.

2.2 **RESPONSIBILITIES**

The responsibilities of the Medical Staff are:

2.2.1 **Quality of Care**. To ensure that all patients/residents admitted to or treated at the Hospital or Nursing Home shall receive appropriate patient care by monitoring care and making recommendations thereon to the Board through the following measures:

(a) A credentials program, including procedures for appointment and reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and demonstrated performance of the applicant or staff member.

(b) A continuing medical education program, based in part on the needs demonstrated through the patient care audit and other performance improvement mechanisms.

(c) A procedure for monitoring patient/resident care practices.

(d) Review and evaluation of the quality and appropriateness of patient/resident care through a valid and reliable patient care audit or performance improvement program that is generally consistent with the standards of The Joint Commission for such programs.
(e) A program to ensure that each Practitioner provides professional services within the scope of individual clinical privileges granted and to ensure that each AHP provides patient care within the scope of specifically designated clinical services.

2.2.2 **Recommendations to Board.** To recommend to the Board action with respect to appointments, reappointments, staff status, clinical privileges and corrective action.

2.2.3 **Performance Improvement.** To account to the Board for the quality and efficiency of medical and clinical care rendered to patients/residents in the Hospital or Nursing Home through regular reports and recommendations concerning the implementation, operation, and results of performance improvement activities.

2.2.4 **Corrective Action.** To initiate and pursue corrective action with respect to professionals as provided in these Bylaws.

2.2.5 **Identification of Needs.** To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

2.2.6 **Education.** To cooperate with universities and other educational institutions as authorized, in undergraduate, graduate and postgraduate educational efforts.

2.2.7 **Authority.** To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

2.2.8 **Bylaws, Rules and Regulations and Policies.** To comply with, monitor, review, enforce and, ensure compliance with law and regulation and, if necessary or desirable, amend the Bylaws, Rules and Regulations and policies on a periodic basis.

2.3 **ACTION OF THE MEDICAL STAFF**

Except as otherwise provided by these Bylaws, actions or decisions approved by a majority of voting eligible members of the Medical Staff who are present at a meeting at which there is a quorum shall be actions or decisions of the Medical Staff.
ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

3.1.1 Qualifications/Structure. Every Practitioner who seeks or enjoys staff membership or the exercise of privileges must be a professionally competent physician, nurse practitioner, dentist, or podiatrist who (a) at the time of appointment and continuously thereafter, demonstrates to the satisfaction of the Medical Staff and of the Board that the qualifications and requirements set forth in these Bylaws have been met; (b) is professionally qualified to provide services which need to be provided at the Hospital or Nursing Home as such need is determined to exist from time to time by the Board; (c) proposes (i) to provide services to residents of the Nursing Home or (ii) to provide services to patients of the Hospital in one or more of the areas of patient care offered by the Hospital and for which the Hospital is equipped, staffed, and licensed; (d) complies with the provisions of these Bylaws, the applicable Rules and Regulations of the Medical Staff, and Board policies; and (e) has not been excluded from participation in a federal healthcare program. Appointment to and membership on the staff shall confer on the appointee or member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. All members of the Medical Staff and all Practitioners exercising clinical privileges at the Hospital or Nursing Home shall be subject to these Bylaws and the applicable Rules and Regulations of the Medical Staff and shall be subject to review as a part of the Corporation's performance improvement program.

3.1.2 Licensure. A current, valid license issued by the State of New York to practice medicine, advanced psychiatric nursing, dentistry, or podiatry is required.

3.1.3 Credentials. Applicants for membership on the Medical Staff shall be either:

(a) For the Hospital, licensed in the State of New York to practice medicine and shall be either board-certified or board-eligible to practice psychiatry as is evidenced by successful completion of requirements established by the American Board of Psychiatry and Neurology; or

(b) For the Hospital and Nursing Home, licensed in the State of New York to practice medicine, dentistry, or podiatry or licensed as a nurse practitioner.

3.1.4 Performance. Applicants for membership on the Medical Staff shall document compliance with Sections 3.1.1. through 3.1.3. as well as their professional education, training, experience, utilization history, current clinical competence, clinical results, current licensure, demonstrated ability, physical health status, and mental health status to demonstrate a continuing ability to provide quality patient care services.
3.1.5 **Attitude.** Applicants for membership on the Medical Staff shall demonstrate a willingness and capability, based on a current attitude and evidence of performance:

(a) To work with and relate to other staff members, members of other health disciplines, Hospital and/or Nursing Home management and employees, visitors and the community in general, in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality patient care; and

(b) To participate equitably in the discharge of staff obligations appropriate to staff membership category.

3.1.6 **Ethical Practice.** Acceptance of appointment to the Medical Staff shall constitute the agreement by the physician, nurse practitioner, dentist (including oral and maxillofacial surgeons), or podiatrist to abide by the principles of ethics as established by his respective national, professional organization:

(a) Physicians will abide by the Principles of Medical Ethics of the American Medical Association. In addition, psychiatrists will abide by the Principles of Ethics of the American Psychiatric Association.

(b) Nurse practitioners will abide by the Principle of Ethics of the American Nursing Association.

(c) Dentists will abide by the Code of Ethics of the American Dental Association.

(d) Oral and maxillofacial surgeons will abide by the Code of Professional Conduct of the American Association of Oral and Maxillofacial Surgeons.

(d) Podiatrists will abide by the Code of Ethics of the American Podiatric Medical Association.

3.1.7 **Disability.** Any member of the Medical Staff shall, upon request of any two of the following four individuals: President of the Medical Staff (or his designee); the Executive Director; the applicable Medical Director; or the applicable Administrator, submit to medical, psychiatric or psychological examination, and/or blood, breath or urine testing. Such testing or examination shall be performed in accordance with the applicable Rules and Regulations of the Medical Staff and where appropriate, in coordination with the Committee for Physician Health of the Medical Society of the State of New York. A record shall be made of the reason for requesting the examination and/or test and the examination or test result. If there is evidence of impairment, this will be presented to Peer Review, a subcommittee of the Credentials/Peer Review Committee.

3.1.8 **Professional Liability Insurance.** Professional liability insurance of at least $1,000,000 per occurrence and $3,000,000 annual aggregate is required., except that dentists, other than oral surgeons, may carry not less than $100,000/$300,000.
3.1.9 **Effect of Other Affiliations.** No Practitioner is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or because he is certified by a medical board, or because he is a member of the faculty of a medical school, or because he had, or presently has, staff membership or privileges at another healthcare facility or in another practice setting. Nor is any Practitioner automatically entitled to appointment, reappointment, or particular privileges merely because he had, or presently has, staff membership or those particular privileges at the Hospital or Nursing Home.

3.1.10 **Nondiscrimination.** No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of religion, age, sex, race, creed, color, disability or national origin.

3.1.11 **Participation in Medicare and Medicaid.** An applicant for an initial appointment and a reappointment must execute a statement certifying that he (i) is not presently excluded from participation in a federal healthcare program; and (ii) is not currently the subject of an investigation that may result in his exclusion from participation in a federal healthcare program.

3.2 **BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP**

Each member of the Medical Staff, regardless of his assigned staff category, and each Practitioner exercising temporary privileges under these Bylaws shall:

3.2.1 **Provide** his patients with medical care at the generally recognized professional level of quality and efficiency for this community.

3.2.2 **Recognize** that a fully licensed psychiatrist/nurse practitioner has the ultimate responsibility for the treatment and care provided to patients in the Hospital.

3.2.3 **Abide** by the Medical Staff Bylaws and all other lawful standards, policies, Rules and Regulations of the Hospital Medical Staff or Nursing Home Medical Staff, as appropriate.

3.2.4 **Discharge** such staff, committee, unit, medical and facility functions for which he is responsible by staff category assignment, appointment, election or otherwise.

3.2.5 **Prepare** and complete in timely fashion the medical and other required records for all patients/residents he admits or in any way provides care to in the Hospital or Nursing Home.

3.2.6 **Abide** by recognized standards of professional ethics appropriate to his discipline.

3.2.7 **Notify** the appropriate Medical Director if he is or becomes the subject of any investigation or proceeding that may effect his license or his ability to participate in a federal healthcare program.

3.2.8 **Notify** the appropriate Medical Director of any limitation or modification of the terms and type of his medical malpractice insurance coverage.
3.2.9 Notify the Medical Director of any medical malpractice claims made against him or any medical malpractice judgments or settlements awarded against him.

3.2.10 Ensure that a medical history and physical examination is completed and documented for each patient admitted to the Hospital within twenty-four (24) hours after admission.

3.3 TERM OF APPOINTMENT

Appointment to the Medical Staff in any category except courtesy shall be for a period of not more than two years. Members of the courtesy staff shall be appointed for an initial term of one year. The initial appointment shall be provisional as set forth in Section 7.2.

3.4 PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

The mechanisms for evaluating applications for initial appointment and for conducting periodic reappraisals for reappointment to the staff are outlined in Article VII.

3.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

Persons holding appointments to the Medical Staff who have negotiated contracts or employment relationships with the Hospital or Nursing Home shall be governed by the provisions of their contracts or terms of employment as well as by these Bylaws. In the event of a conflict between the Medical Staff Bylaws and specific contract or employment terms, the contract or employment terms shall be controlling. A Special Staff Officer must be a Member of the Medical Staff, achieving this status in accordance with Article VII. The clinical privileges of a Special Staff Officer shall be delineated in accordance with Article VI. The membership and clinical privileges of a Special Staff Officer shall not be contingent on his continuing as a Special Staff Officer, unless and to the extent otherwise provided in his agreement with the Hospital or Nursing Home. A physician employed by the Hospital or Nursing Home in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Corporation and to the terms of his contract or other conditions of his engagement and need not be a member of the Medical Staff.

The effect of expiration or termination of a contract between a professional and the Hospital or Nursing Home on a professional's staff status and clinical privileges shall be governed by the terms of the professional's contract with the Hospital or Nursing Home. No action, recommendation, or decision by the Corporation or the Board with regard to the expiration, termination or failure to renew any such contract with a professional shall be subject to or conditioned upon any proceedings or exercise of rights under Article IX of these Bylaws.
ARTICLE IV

MEDICAL STAFF COMPONENTS AND CATEGORIES

4.1 COMPONENTS AND CATEGORIES

The Medical Staff shall be comprised of member physicians, nurse practitioners, dentists and podiatrists. The Medical Staff shall be divided into two groups: the Hospital Medical Staff and the Nursing Home Medical Staff. Each group shall also be divided into active, courtesy, consulting, and on-call categories.

4.2 ACTIVE STAFF

4.2.1 General Qualifications for Active Status at the Hospital.

An active staff member of the Hospital shall be a psychiatrist, or nurse practitioner who shall:

(a) Have a contractual or employment relationship with the Hospital.

(b) Be located close enough to the Hospital to provide continuous care to his patients and to see patients as soon after admission as is required by staff regulations.

(c) Agree to assume the functions and responsibilities of appointment to the active staff. These responsibilities may include inpatient and outpatient services, taking emergency "on call" for the Hospital, voting, holding office, and serving as committee members or chairpersons.

(d) Attend Medical Staff meetings and unit or committee meetings of which he is a member as outlined in Section 4.2.5.

(e) Serve as a Special Staff Officer.

4.2.2 Specific Qualifications for Active Status at the Hospital. The following criteria shall be used when evaluating a member’s request for reappointment to the active staff of the Hospital or for a change from the courtesy staff to the active staff:

(a) Has satisfactorily served an initial appointment term and participated in the discharge of staff obligations appropriate to staff membership category.

(b) Is willing to serve as assigned during an emergency or disaster.

(c) Is a Special Staff Officer.

(d) Has entered into a contractual or employment relationship with the Hospital.
4.2.3 General Qualifications for Active Status at the Nursing Home.

An active staff member of the Nursing Home shall be a physician or nurse practitioner who shall:

(a) Have a contractual or employment relationship with the Nursing Home.

(b) Accept residents admitted to the Nursing Home as their private patients as assigned to them by the Nursing Home Administrator.

(c) Agree to assume the functions and responsibilities of appointment to the active staff. For physician members, these responsibilities may include taking emergency "on call" for the Nursing Home, voting, holding office, and serving as committee members or chairpersons.

(d) Attend Medical Staff meetings and unit or committee meetings of which he is a member as outlined in Section 4.2.5.

(e) Serve as a Special Staff Officer.

4.2.4 Specific Qualifications for Active Status at the Nursing Home.

The following criteria shall be used when evaluating a Member's request for reappointment to the active staff of the Nursing Home or for a change from the courtesy staff to the active staff:

(a) Has satisfactorily served an initial appointment term and participated in the discharge of staff obligations appropriate to staff membership category.

(b) Is willing to serve as assigned during an emergency or disaster.

(c) Is a Special Staff Officer.

(d) Has entered into a contractual or employment relationship with the Nursing Home.

4.2.5 Prerogatives of Active Staff.

4.2.5.1 Prerogatives of Physician Members of the Active Staff. An active physician staff member may:

(a) Admit patients to the Hospital or Nursing Home without limitation, except as otherwise provided in the applicable Rules and Regulations of the Medical Staff.

(b) Vote on all matters presented to general and special meetings of the Medical Staff and committees of which he is a member.

(c) Hold office at any level in the staff organization and sit on or be chairman of any committee, except as noted in other sections of these Bylaws.
(d) Exercise such clinical privileges as are granted to him.

4.2.5.2 Prerogatives of Nurse Practitioner/ Members of the Active Staff.

(a) Admit patients (to the Hospital in conjunction with a psychiatrist member of the active staff, except as otherwise provided in the Rules and Regulations of the Hospital Medical Staff.

(b) Vote on all matters presented to general and special meetings of the Medical Staff and committees of which he is a member, but not serve as an officer of the Medical Staff or chairman of a committee of the Medical Staff, nor shall they be a member of the Medical Board.

(c) Exercise such clinical privileges as are granted to him/her.

4.2.6 Obligations of Physician Members of the Active Staff.

A physician member of the active staff must, in addition to meeting the basic obligations set forth in Sections 3.1. and 3.2.:

(a) For physicians treating patients at the Hospital, retain responsibility for the daily care and supervision of each patient in the Hospital for whom he is providing services, or arrange for suitable coverage for such care and supervision.

(b) For physicians treating residents of the Nursing Home, the physician must (i) assume the principal obligation and responsibility to manage the resident’s medical condition and agree to visit the resident as often as necessary to address resident medical care needs, or arrange for suitable coverage for such services; (ii) participate as a member of the interdisciplinary care team in the development and review of the resident’s comprehensive care plan by, as a minimum, participating in a person-to-person conference with the registered professional nurse who has principal responsibility for development and implementation of the resident’s care plan; (iii) establish and maintain a schedule of visits appropriate to the resident’s medical condition and that meet the frequency requirements established by the New York State Department of Health and Centers for Medicare & Medicaid Services regulations; (iv) if permitted to substitute a N.P., ensure that he alternates required visits between personal visits by the physician and visits by the N.P.; (v) review the resident’s total program of care, including medications and treatments, at each regularly scheduled visit; (vi) prepare, authenticate and date progress notes for each resident at each visit; and (vii) provide residents and designated representatives with his name, office address and telephone number and respond to calls from residents to discuss their medical care.

(c) Contribute to the organizational and administrative affairs of the Medical Staff, including service in Medical Staff offices and on facility and Medical Staff committees, faithfully performing the duties of any office or position to which elected or appointed.
(d) Participate in the performance improvement activities and training programs required of the Medical Staff.

(e) Discharge the recognized functions of staff membership by engaging in the staff's teaching and continuing education programs, giving consultation to other staff members consistent with his delineated privileges, supervising Practitioners during the provisional period and fulfilling such other staff functions as may reasonably be required of staff members.

4.2.7 Obligations of Nurse Practitioner Members of the Active Staff.

A nurse practitioner member of the active staff must, in addition to meeting the basic obligations set forth in Sections 3.1. and 3.2.:

(a) Retain the responsibility for assessing and evaluating prospective Hospital patients for clinical information to determine level of care.

(b) Perform tasks that may delegated by a Nursing Home resident’s attending physician to an employee of the Nursing Home.

(c) Contribute to the organizational and administrative affairs of the Medical Staff, including serving on Hospital and medical staff committees.

(d) Participate in the performance improvement activities required of the Medical Staff as applicable to nurse practitioners.

(e) Discharge the recognized functions of staff membership by engaging in the staff's teaching and continuing education programs, giving consultation to other staff members consistent with his delineated privileges, supervising practitioners during the provisional period and fulfilling such other staff functions as may reasonably be required of staff members.

4.2.8 Meeting Attendance Requirements.

Each member of the active staff shall be required, unless excused pursuant to section 4.2.9., to attend:

(a) The Annual Medical Staff meeting.

(b) At least 50% of all other Medical Staff meetings duly convened pursuant to these Bylaws.

(c) At least 50% of all meetings of each committee of which he is a member.
4.2.9 **Absence from Meetings.** Any member who is compelled to be absent from any Medical Staff, unit, or committee meeting shall promptly provide, to the regular presiding officer thereof, the reason for such absence. Unless excused for good cause shown, failure to meet the attendance requirements of Section 4.2.8. may be grounds for any of the corrective actions specified in Article VIII, and removal from such committee. Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application, and such application shall be processed in the same manner as any other application.

4.3 **CONSULTING STAFF**

4.3.1 **Qualifications for Consulting Status.** The consulting staff shall consist of physicians (with a medical specialty other than psychiatry) dentists and podiatrists who are appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients and residents.

4.3.2 **Prerogatives of Consulting Staff.** A consulting staff member may exercise such clinical privileges as are granted to him. Consulting staff members are not eligible to admit patients to the Hospital or Nursing Home, or to vote at meetings of the Medical Staff. Consulting staff members are eligible to participate in committee activities on a voluntary basis without voting rights, but are not eligible to serve as members or chairmen of any such committees.

4.3.3 **Obligations of Consulting Staff.** The duties of the members of the consulting staff shall be to give their services in the care of patients and residents on request of any member of the active staff for a Hospital patient or on request of any member of the active or courtesy staff for a Nursing Home resident, or in other cases in which consultation is required by the applicable Rules and Regulations of the Medical Staff. Members of the consulting staff shall satisfy qualifications described in Section 3.1, shall fulfill obligations described in Sections 3.2.1 - 3.2.3, and 3.2.5 – 3.2.8, and shall participate in Medical Staff performance improvement activities as requested.

4.4 **ON-CALL STAFF**

4.4.1 **Qualifications.** The on-call staff shall consist of licensed physicians who have completed or are currently engaged in post-graduate training in psychiatry, who meet the qualifications in Section 3.1. and who are not members of any other category of the staff.

4.4.2 **Prerogatives.** An on-call staff physician may admit patients to the Hospital and exercise such clinical privileges as are granted to him. He may attend meetings of the staff and of committees without voting rights, but is not eligible to serve as chairman of committees.

4.4.3 **Obligations.** The obligations of the on-call staff are to perform assessments, admit patients to the Hospital and formulate initial treatment plans for such patients while on duty, handle medical/psychiatric emergencies and perform such other medical functions as are prescribed in the contractual relationship with the
Members of the on-call staff shall fulfill the obligations described in Section 3.2 and shall participate in Medical Staff performance improvement activities as requested.

4.4.4 Term of Appointment. The appointment of an on-call staff member shall be for a maximum of two (2) years and is subject to reappointment for maximum periods of two (2) years. Members of the on-call staff may apply for appointment to other categories of Medical Staff. Such applications will be considered equivalent to an initial application for staff privileges as described in Articles III and VII, rather than an advancement in staff status.

4.5 LIMITATIONS OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a Practitioner’s staff status, by other sections of these Bylaws, and by other policies of the Corporation.
ARTICLE V

ALLIED HEALTH PROFESSIONALS

5.1 QUALIFICATIONS

An AHP is an individual with credentials other than those described in Section 3.1.3. who is permitted by law and by the Corporation to provide patient care services, within the scope of his license, certificate or credentials in accordance with his job description, and under the ultimate supervision of a physician member of the staff. An AHP can be a probationary employee or regular employee of the Corporation, a contractor, or an employee of a member of the Medical Staff. The Medical Staff may establish additional or specific qualifications required of members of any particular category of AHP.

5.2 EVALUATION OF INDIVIDUAL AHP APPLICATIONS

5.2.1 Except for an application processed pursuant to 5.2.2 herein, an application for specified services for an AHP shall be submitted to and processed by the appropriate Medical Director.

5.2.2 The Board will review and approve applications from AHPs in accordance with the procedures outlined for members of the Medical Staff in Article VII herein. When an initial application or reappointment application for an AHP is processed pursuant to Article VII herein, the AHP will be considered a “practitioner” “applicant” or “reappointment applicant,” as appropriate, under Article VII.

Notwithstanding anything herein to the contrary, an AHP is not entitled to the procedural rights provided in Article IX. An AHP whose application for privileges is processed pursuant to Article VII is not entitled to the procedural rights provided in Article IX and shall not be considered a member of the Medical Staff. Corrective action with regard to AHPs who are employed by the Corporation, including termination or suspension of privileges granted, shall be accomplished in accordance with usual Hospital personnel practices and the AHP’s employment agreement, if any. AHPs shall be subject to the provisions of Section 7.5. and Article XIV.

5.3 PREROGATIVES OF ALLIED HEALTH PROFESSIONALS

The prerogatives of an AHP are to:

5.3.1 Provide specifically designated patient care services to Hospital patients under the supervision/collaboration or direction of a psychiatrist member of the Medical Staff or appropriate member of the Hospital staff.

5.3.2 Provide specifically designated services to Nursing Home residents under the supervision of the resident’s attending physician.

5.3.3 Serve on committees where his special training and knowledge are desirable and with vote when so specified.
5.3.4 Attend and conduct education programs and medical meetings related to his discipline.

5.3.5 Exercise such other prerogatives as the Medical Staff accords AHPs in general or a specific category of AHP.

5.4 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS

Each AHP shall retain appropriate responsibility within his area of professional competence for the care and supervision of each patient or resident for whom he is providing services. Each AHP shall be subject to the Medical Staff Bylaws and Rules and Regulations of the Medical Staff, and will be subject to review as a part of the Corporation's performance improvement program.

5.5 AHP RE-EVALUATION

Except for those AHPs whose reappointment applications are processed pursuant to Section 5.2.2 herein, AHPs who provide patient care in the Hospital or Nursing Home shall be evaluated at least annually, by the relevant Administrator, to determine the AHP's competence to provide patient care services. The relevant Administrator shall submit a re-evaluation report to the facility Medical Director.
ARTICLE VI

DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

A Practitioner provides clinical services at the Hospital or Nursing Home by virtue of Medical Staff membership and may exercise only those clinical privileges specifically granted to him by the Board. Regardless of the level of privileges granted, each Practitioner must obtain consultation as deemed necessary for the safety of his patients or when required by the Rules and Regulations of the Medical Staff regardless of other policies of the Medical Staff.

6.2 BASIS FOR PRIVILEGE DETERMINATIONS

Privileges governing medical practice are granted in accordance with current licensure, prior and continuing education, treatment results, training, experience and demonstrated current clinical competence and judgment and health status as documented and verified in each Practitioner's credentials file and in accordance with the criteria set forth in Sections 3.1.3 through 3.1.8 and the criteria for specific privileges established by the Medical Staff. Information regarding (a) previously successful or currently pending challenges to any license or registration or the voluntary relinquishment of such license or registration; (b) voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and (c) termination of affiliation with any hospital/health care facility, voluntary or involuntary shall also be used to determine the scope of clinical privileges granted. Observed clinical performance and documented results of the staff member's performance improvement activities shall be included as criteria in evaluating an application for reappointment or a requested change in privileges. Determinations of clinical privileges shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other hospitals and healthcare facilities where a professional exercised or has exercised clinical privileges.

6.3 PROCEDURE FOR DELINEATING PRIVILEGES

All requests for clinical privileges shall be evaluated and granted, modified, or denied pursuant to the procedures outlined in Article VII. Clinical privileges shall be granted for a period of not more than two years. All clinical privileges granted shall be specific and delineated, and shall specify the limitations, if any, on an individual's privileges to admit and treat patients or residents or to direct the course of treatment for the conditions upon which admission of a patient or resident was based.

6.4 EMERGENCY PRIVILEGES. In the case of an emergency when a practitioner qualified by these Bylaws is not available, any licensed practitioner at the Hospital, regardless of his or her Department or extent of clinical privileges approved, shall be permitted and expected to do everything reasonably possible to save a patient from imminent serious harm or death. Such practitioner shall use every available resource of the Hospital, including calling for assistance as may be available.
6.5 **DISASTER PRIVILEGES.** Disaster privileges may be granted when the Hospital's emergency management plan has been activated and the Hospital is unable to meet immediate patient care needs due to a national, State or local disaster or emergency. Such disasters and emergencies include, but are not limited to, unexpected events (whether human-made or natural or a combination of both) that result in a sudden, significantly changed or increased demand for the Hospital's services. Disaster privileges may be granted to a non-affiliated practitioner by the Executive Director or his/her authorized designee, which shall include the Medical Director and/or the Chairman of the Medical Board, upon presentation of a valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current photo identification card from a health care organization that clearly identifies professional designation; or
- A current license to practice; or
- primary source verification of licensure; or
- identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals, (ESAR-VHP), or other recognized state or federal response organization or group; or
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or
- Presentation by current administration or Medical Staff member(s) with personal knowledge regarding practitioner's identity and such individual's ability to act as a licensed independent practitioner.

A practitioner who is denied disaster privileges, or whose disaster privileges are subsequently revoked or restricted, shall not be entitled to the procedural rights set forth in Article IX of these Bylaws.

The Hospital will ensure oversight of the professional performance of practitioners who are granted disaster privileges by any of the following: direct observation, mentoring or clinical review, as appropriate under the circumstances. Reassessment to determine whether such privileges should continue will occur within seventy-two (72) hours of granting disaster privileges.

The Hospital will provide appropriate identification badges for all practitioners who are granted disaster privileges.

Primary source verification of licensure of practitioners who receive disaster privileges begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours of granting disaster privileges. In the extraordinary circumstance that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible thereafter. In this extraordinary circumstance, there must be documentation of each of the following:

- Why primary source verification could not be performed in the required time frame;
Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
Attempts to perform primary source verification as soon as possible.

Primary source verification of licensure certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.

These privileges will be in effect until the Executive Director or designee has deemed that the services of those practitioners granted disaster privileges are no longer needed for any reason. Upon termination of disaster privileges, the practitioner shall not be entitled to the procedural rights set forth in Article IX of these Bylaws and the Medical Staff Rules and Regulations.

6.6 TEMPORARY PRIVILEGES
6.6.1 Conditions. Temporary privileges may be granted pursuant to Section 6.6.2 for a provisional period of up to 120 days to a physician who has satisfied: the professional liability insurance requirements; verification of education training and experience (CV); verification of licensure; and verification of competency and ability to perform privileges (at least one letter of recommendation from another Practitioner of the same specialty.) These verifications must be obtained prior to granting temporary privileges. Special requirements of consultation and reporting may be imposed by the Medical Staff. Temporary privileges will not be granted until proof of insurance and qualifications has been determined, the National Practitioner Data Bank has been queried and the information reviewed, and the physician has agreed to abide by the rules, regulations and policies of the Staff and the Hospital or Nursing Home.

6.6.2 Circumstances. Upon the concurrence of the applicable Medical Director or his designee, the CEO or designee may grant temporary privileges in the following circumstances:

(a) To fulfill an important patient care, treatment and service need.

(b) When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Leadership Committee and the governing body.

Temporary privileges may not be renewed.

6.6.3 Termination. The applicable Administrator or Medical Director must, on the discovery of any information or the occurrence of any event of a nature which raises a question about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, and may at any other time after consultation with the CEO, terminate any or all of the Practitioner's temporary privileges, provided that where the life or well-being of a patient or resident is determined to be endangered, the termination may be effected by any person entitled to impose summary suspensions under these Bylaws. In the event of any such termination, the Practitioner's patients then in the Hospital or Nursing Home shall be assigned to another Practitioner by the applicable
Medical Director or his designee. The wishes of the patient or resident shall be considered, where feasible, in choosing a substitute Practitioner.

6.6.4 Rights of the Practitioner. A Practitioner is not entitled to the procedural rights afforded by Article IX because his request for temporary privileges is refused, because all or any portion of his temporary privileges are terminated or suspended, or because of any restriction on his exercise of temporary privileges.
ARTICLE VII

CLINICAL PRIVILEGES; APPOINTMENT AND REAPPOINTMENT

TO THE MEDICAL STAFF

7.1 DURATION OF APPOINTMENT/REAPPOINTMENT

All appointments and reappointments (except courtesy) to the Staff shall last for a maximum period of two years. Reappointments to the courtesy staff may be made, as described in Section 4.3.2. Courtesy clinical privileges shall be adjusted to reflect clinical competence at the end of the initial (provisional) appointment, or sooner if warranted. The term of appointment to the Medical Staff, except for the initial period of one year's appointment to the courtesy staff, shall be for a maximum of two (2) years, after which the appointee must be re-credentialed pursuant to Section 7.7. Upon recommendation of the Executive Leadership Committee and approval of the governing body, a qualification for staff status, other than licensure, may be waived with respect to any Practitioner if such waiver is in the best interest of the Corporation and its patients or residents.

7.2 EVALUATION DURING INITIAL APPOINTMENT

Initial appointment to the Medical Staff (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of appointment, shall be provisional. During the provision period, a Practitioner's performance will be specifically observed and evaluated by the applicable Medical Director and Service Medical Directors, and by the relevant committees of the Medical Staff and the facility as to his clinical competence and as to his general behavior and conduct in the Hospital or Nursing Home. The Credentials Committee shall determine the scope of this focused professional practice evaluation, which may include chart reviews, monitoring of the individual’s practice patterns, precepting, external review and consideration of information obtained from other members of the Medical Staff and Hospital or Nursing Home employees.

7.3 GENERAL PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

The Medical Staff, through its committees and officers, shall investigate and consider each application for appointment or reappointment to any staff status and each request for modification of staff status and shall adopt and transmit recommendations thereon to the Board. All initial applicants to join the Medical Staff shall be interviewed by the applicable Medical Director and/or Chairman of the Credentials/Peer Review Committee or designee, as part of the peer recommendation process. All procedures for appointment and reappointment to the Medical Staff, and any amendments thereto, shall be approved by the Medical Staff and the Board through the process described in Article XIII.
7.4 APPLICATION FOR INITIAL APPOINTMENT

7.4.1 Application Form. Each application for appointment to staff status shall be in writing, submitted on the prescribed form and signed by the applicant. The Medical Staff may require the payment of a reasonable application fee to accompany, and as a condition to, all applications for appointment to staff status.

7.4.2 Content. The application form shall include but not be limited to:

(a) References: The names of at least two (2) peers or supervisors who have observed the applicant's professional performance in the recent past and who can provide reliable information based on significant personal experience as to the applicant's clinical ability, ethical character, ability to work with others, current clinical competence, and other qualifications for eligibility under these Bylaws. Whenever possible, one of the persons named shall (a) have the same professional specialty as that of the applicant, and (b) shall be a member of the Medical Staff.

(b) Professional Sanctions: Information as to whether the applicant's staff status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily relinquished, terminated, or not renewed at this or any other healthcare institution or whether any proceeding is pending or has been instituted which, if decided adversely to the applicant, would result in any of the foregoing.

(c) Information as to whether any of the following have ever been suspended, revoked, terminated, voluntarily or involuntarily relinquished or denied: (1) specialty board certification; (2) license to practice any profession in any jurisdiction; (3) Drug Enforcement Administration (DEA) number; (4) affiliation with any hospital/health care facility, voluntary or involuntary; or (5) participation in Medicare, Medicaid or any other federal healthcare program. If any such actions were ever taken or instituted or are pending or if the applicant is the subject of a proceeding that, if decided adversely to the applicant, could result in any such action, the particulars thereof shall be included.

(d) Professional Liability Insurance: A copy of the insurance binder of the applicant demonstrating at least the minimum amount of professional liability insurance coverage as required by Section 3.1.8. and complete information on his malpractice claims history and experience during the past five (5) years, including a consent to the release of information by his present and any past malpractice insurance carriers and a waiver of any privilege relating thereto.

(e) Licensure & Permits: A copy of current New York State licensure and as applicable, current DEA registration.

(f) Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Sections 3.1. and 3.2. as is applicable, and of any additional qualifications specified in these Bylaws for the particular staff status to which the applicant requests appointment.
(g) **Requests:** Specific requests stating the staff status and specific clinical privileges for which the applicant wishes to be considered.

(h) **Acknowledgement and Agreement:** A statement that the applicant has received and read the Bylaws and Rules and Regulations of the Medical Staff, and that he agrees to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not the application is granted.

(i) **Notification of Release and Immunity Provisions:** Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 7.5. and Article XIV.

(j) **Administrative Remedies:** An acknowledgement whereby the professional agrees that, if an adverse ruling is made with respect to his staff status and/or clinical or service privileges, he will exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

(k) **Pledge:** The applicant's specific acknowledgement of his obligation upon appointment to the Medical Staff to provide his patients with medical care at the generally recognized professional level of quality and efficiency for the community and to abide by the code of ethics prescribed by these Bylaws.

(l) **Staff Duties:** The applicant's agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him by the Board and/or the Medical Staff.

(m) **Educational Requirements:** Evidence of having completed all educational activities required by New York State. If the applicant has not completed educational requirements promulgated by New York State, the Board may in its discretion, make an appointment provisionally for not longer than six (6) months as allowed by State regulations, during which period such educational requirements must be completed. If such educational requirements are not completed within the period of the provisional appointment, the appointment shall terminate at its conclusion and such action shall be deemed not to be an adverse action against member.

(l) **Identification:** A valid photo identification issued by a state or federal agency (e.g., driver’s license or passport).

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7.5 **EFFECT OF APPLICATION**

By applying for appointment, the applicant:

7.5.1 **Signifies** his willingness to appear for interviews in regard to his application.
7.5.2 **Authorizes** agents and employees of the Corporation to consult with peers and others who have been associated with him or who may have information bearing on his competence and qualifications, whether or not such other persons are listed as references by the applicant; and authorizes persons consulted with to provide such information.

7.5.3 **Consents** to the inspection by agents and employees of the Corporation of all records and documents that may be material to an evaluation of his professional qualifications and ability to carry out the clinical privileges he requests, his or her utilization history, professional ethical qualifications for staff status, his physical health and mental health, emotional stability, his current licensure, and his current competence. Such records and documents will include information obtained from physician data banks maintained on a statewide or national basis.

7.5.4 **Releases** from any liability all agents and employees of the Corporation from their acts without malice in connection with evaluating the applicant and his credentials, including evaluation related to temporary privileges; periodic reappraisals undertaken for reappointment or for increases or decreases in clinical privileges; proceedings for reduction or suspension of clinical privileges or revocation of Medical Staff appointment or any other disciplinary sanction; summary suspension; or hearings and appellate reviews.

7.5.5 **Releases** from any liability all individuals, corporations and organizations who provide information, including otherwise privileged or confidential information, to the agents and employees of the Corporation without malice concerning the applicant's ability, training, licensure, experience, background, utilization history, professional ethics, character, physical and mental health, emotional stability and other qualifications for the requested status and clinical privileges.

7.5.6 **Authorizes** and consents to the Corporation’s agents and employees providing other hospitals, professional associations and other organizations concerned with provider performance and the quality and efficiency of patient care, including physician data banks maintained on a statewide or national basis, with any information the Corporation may have concerning him, and releases the Corporation and the Corporation's agents and employees from liability for so doing; provided that such furnishing of information is done without malice.

7.5.7 **Agrees** to be bound by the provisions contemplated by Section 7.4.2 (h), (i) and (j).

7.5.8 **To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to, and releases from liability, the Corporation and its agents and employees and any third party with respect to any and all civil liability which might arise from any acts, communications, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested or received by the Corporation and its agents and employees, to or from, any third party including other appointees to the Medical Staff concerning activities relating to the professional conduct of an appointee to the Medical Staff or of any individual granted privileges to practice at the Hospital or Nursing Home.

7.5.9 **Represents and warrants** that all information provided by him is true, correct and complete in all material respects.
7.6 PROCESSING THE APPLICATION

7.6.1 Applicant's Burden. The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training and ability, professional ethics, physical health status and, upon request mental health status and emotional stability, and of resolving any doubts about these or any of the other basic qualifications specified in these Bylaws. Each application has the duty to update all information contained in the application during the application process if information supplied by the applicant becomes untrue or incomplete during that period. Each applicant has the duty to supplement information contained in the application as requested by the CEO or his designee.

7.6.2 Verification of Information. The applicant shall deliver a completed application to the applicable Medical Director who shall, in a timely fashion, seek to collect or verify the references, licensure and other qualifications evidence submitted, using primary sources whenever feasible. The applicable Medical Director shall promptly notify the applicant of any failure of others to respond to such collection or verification efforts. After such notice, the applicant shall have the obligation of obtaining responses to requests for information. The applicable Medical Director shall also solicit and receive information concerning the applicant from staff members and, if appropriate, other persons holding staff status, who have information concerning the applicant's qualifications. Where possible, verification of the applicant's licensure and professional standing in states other than New York is obtained using national clearinghouses established by recognized national professional organizations such as the American Medical Association's Physician Master File and the Federation of State Medical Board's Physician Disciplinary Data Bank, as well as the Federal National Practitioner Data Bank.

7.6.3 Initial Procedure. When collection and verification is accomplished by receipt of responses from all persons or entities so contacted, the application shall be considered complete. The application and all related materials shall then be transmitted to the Credentials/Peer Review Committee. The Committee shall review the application and related documentation for completeness, and may conduct a personal interview with the applicant. Where appropriate, as part of this process, the Committee may require an impartial physical or mental examination of the applicant and shall require that the results be made available for the Executive Leadership Committee’s consideration. This information taken as a whole, together with other available information relevant to the applicant's qualifications, shall be the professional criteria upon which the Credentials/Peer Review Committee bases their consideration, and such criteria shall be uniformly applied to all applicants.

7.6.4 Credentials/Peer Review Committee Action. The Credentials/Peer Review Committee shall review the application, the related documentation compiled, and such other information available to or obtained by the Committee that may be relevant to consideration of the applicant's qualifications for the staff status and/or clinical privileges requested. The Committee shall have the full resources of the Corporation available to it, as well as the authority to engage outside consultants, if required, to adequately evaluate the applicant's qualifications. The Credentials/Peer Review Committee shall then transmit a written report, usually
via its minutes, and recommendations as to staff status and clinical privileges and any special conditions to be attached to the appointment, to the Executive Leadership Committee. The Committee may also recommend that the Executive Leadership Committee defer action on the application. The reason for each recommendation shall be concisely stated. Any minority views shall also be reduced to writing, supported by concise statements of reasons and transmitted with the majority report.

7.6.5 Executive Leadership Committee Action. After its receipt of the written report from the Credentials/Peer Review Committee, the Executive Leadership Committee shall meet to review the application and all related documentation, relevant information and recommendations regarding staff status and, if appointment is to be granted, clinical privileges to be granted, and any special conditions to be attached to the appointment. The reason for each recommendation shall be concisely stated. Any minority views shall also be reduced to writing, supported by concise statements of reasons, and transmitted with the majority recommendations. The Executive Leadership Committee shall then forward a written report, usually via its minutes, for transmittal to the Board, the application, related documentation, relevant information, and recommendations as to staff status and, if appointment is recommended, as to clinical privileges to be granted and any special conditions to be attached to the appointment. The Sr. VP of Medical Affairs may, at his discretion, call upon members of the Medical Staff to assist in this process.

7.6.6 Effect of Executive Leadership Committee Action.

(a) Deferral: Action by the Executive Leadership Committee to defer the application for further consideration must be followed up within thirty (30) days with a subsequent favorable or adverse recommendation, or not more than one additional deferral.

(b) Favorable Recommendation: When the recommendation of the Executive Leadership Committee is favorable to the applicant, the CEO shall promptly forward it, together with the application and all related documentation, to the Board.

(c) Adverse Recommendation: When the recommendation (including those made after deferral) of the Executive Leadership Committee is adverse to the applicant, the Sr. VP of Medical Affairs shall promptly so inform the applicant by Special Notice, and he shall be entitled to the procedural rights as provided in Article IX. An "adverse recommendation" by the Executive Leadership Committee is defined in Section 9.2.1.

7.6.7 Board Action.

(a) On Favorable Executive Leadership Committee Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Executive Leadership Committee or refer the recommendation back to the Executive Leadership Committee for further consideration, stating the reasons for such referral back and setting a reasonable time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant, the Executive
Director or the appropriate Medical Director shall promptly so inform the applicant by Special Notice, and he shall be entitled to the procedural rights as provided in Article IX.

(b) Without Benefit of Executive Leadership Committee Recommendation: If the Board does not receive an Executive Leadership Committee recommendation within the time period specified in section 7.6.11, it may after five days' notice to the Executive Leadership Committee take action on its own initiative. If such action is favorable, it shall become effective as of the decision of the Board. If such action is adverse to the applicant, the Executive Director or appropriate Medical Director of shall promptly so inform the applicant by Special Notice, and he shall be entitled to the procedural rights as provided in Article IX.

(c) After Procedural Rights: In the case of an adverse Executive Leadership Committee recommendation pursuant to Section 7.6.6. (c) or an adverse Board decision pursuant to Section 7.6.7.(a) or (b), the Board shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article IX if the same are applicable to the applicant. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further consideration. Any such referral back shall set a reasonable time limit within which a subsequent recommendation to the Board shall be made. After receipt of such subsequent recommendation, the Board shall make a final decision.

7.6.8 Denial for Accommodation Reasons. A recommendation by the Executive Leadership Committee, or a decision by the Board, to deny staff status or particular clinical privileges either:

(a) Because the Corporation does not then provide adequate facilities or supportive services for the applicant and his patients, for whatever reason, including but not limited to utilization levels then existing or services not then offered, or

(b) Because of inconsistency with the Corporation’s plans in respect to its development, including the mix of patient care services to be provided,

Shall be considered adverse and shall entitle the applicant to the procedural rights as provided in Article IX; provided, however that in a proceeding under Article IX, a determination made without malice by the Board that the Corporation’s facilities are not adequate or appropriate for the offering or expansion of a service shall not be subject to challenge with regard to the validity or appropriateness of such determination.

7.6.9 Notice of Final Decision.

(a) Notice of the Board’s final decision if favorable to the applicant shall be given to the applicant in the manner determined by the Executive Director. Notice of the Board’s final decision if unfavorable to the applicant shall be given by Special Notice
(b) A decision and notice to appoint shall include:

(i) the staff status to which the applicant is appointed;
(ii) the clinical privileges to which he is granted; and
(iii) any special conditions attached to the privileges or to the appointment.

7.6.10 Reapplication after Adverse Appointment Decision. An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply for a period of two years. Any such reapplication shall be processed as an initial application.

7.6.11 Time Periods for Processing. Action on an individual's application for clinical privileges is withheld until all required information is made available and is verified. Completed applications for staff appointments shall be considered in a timely manner without malice by all individuals and groups required by these Bylaws to act thereon, shall be processed within the time limits specified in any applicable State law, and except for good cause, shall be processed within the time period of 180 days. If all responses required for a complete application are not received at the end of 90 days after being requested, the applicant will be notified about the incomplete responses, and if the required information is not received within 30 days after notification, the application shall be deemed to be rejected due to incompleteness and such action shall be deemed not to be an adverse action against the applicant. The applicable Medical Director shall transmit an application to the Credentials/Peer Review Committee upon completing the information collection and verification tasks. The Credentials/Peer Review Committee shall act on an application within sixty (60) days after receiving it from the applicable Medical Director. The Executive Leadership Committee shall formulate recommendations to the Board within five (5) days following the regular meeting at which the application was considered. The Board shall then take action on the application not later than its next regular meeting following receipt of the Executive Leadership Committee's recommendation.

7.7 REAPPOINTMENT PROCESS

The reappointment process may include information concerning the individual's current licensure, health status, information from the National Practitioner Data Bank, professional performance, peer recommendations, judgment, current clinical and technical skills, as indicated by the results of performance improvement activities and other reasonable indicators of continuing qualifications.

7.7.1 Information Form for Reappointment. The applicable Medical Director shall, at least ninety (90) days prior to the expiration date of the current staff appointment of each person holding the same, provide such person with an interval information form for use in considering reappointment. Failure to return the form within 45 days prior to the expiration date of the current staff appointment shall be deemed a voluntary resignation from staff status and shall result in automatic termination of staff status together with all clinical privileges at the expiration of
such person's current terms, unless the applicable Medical Director grants an extension of time as needed, upon a showing of good cause by the member of such an extension. The reappointment applicant shall have the burden of producing adequate information for an evaluation of his reappointment application, and shall have the duty to supplement information contained in the interval information form as requested by the applicable Administrator or Medical Director.

7.7.2 Content of Interval Information Form. The interval information form shall be a prescribed form and shall require and, when completed, shall contain information necessary to maintain as current the Corporation’s file including, without limitation, information about:

(a) Proof of current licensure or certification.

(b) Continuing training, education, employment or experience that qualifies the reappointment applicant for any new status and/or privileges sought on reappointment.

(c) Information from performance improvement profiles as defined in the Rules and Regulations of the Medical Staff, which includes information from peer recommendations including recommendations from the President of the Medical Staff, the applicable Medical Director, or other special staff officers.

(d) Current physical health, mental health and emotional stability status.

(e) Membership, awards or other recognitions conferred, granted or revoked by any professional healthcare societies, institutions, or organizations voluntarily or involuntarily relinquished by the reappointment applicant.

(f) Sanctions of any kind imposed or pending by any other healthcare institution, professional healthcare organization, government agency, or licensing or drug control authority, or the voluntary relinquishment of any registration or licensure to a licensing or drug control authority.

(g) Current investigations into the professional conduct of the reappointment applicant by any other healthcare organization, professional healthcare society, government agency, licensing organization or drug control authority.

(h) Complete details about malpractice claims experience.

(i) Proof of professional liability insurance coverage consistent with Section 3.1.8.

(j) Such other specific information about the reappointment applicant's professional ethics, qualifications, and ability as the Board or Medical Director may require.

(k) The reappointment applicant's current home and office addresses and telephone numbers.
l) The name and address of any other healthcare organization or practice setting where the reappointment applicant provided clinical services during the preceding appointment period, as well as information about voluntary or involuntary limitation, reduction, or loss of clinical privileges in such other healthcare organization or practice setting.

(m) Any request for modification of staff status or privileges which the reappointment applicant may desire to make.

(n) Current CPR certification is encouraged.

7.7.3 Verification of Information. The applicable Medical Director shall, in timely fashion, seek to collect or verify the information made available on each interval information form and to collect any other materials or information deemed pertinent, including the utilization history of the reappointment applicant and other information regarding conduct in this or any other healthcare facility, using primary sources whenever feasible. When collection and verification is accomplished by receipt of responses from persons or entities so contacted, the application shall be considered complete. The applicable Medical Director shall then transmit the information form and related request for privileges to the Credentials/Peer Review Committee. The provisions of Section 7.7.8. shall apply to applications for reappointment.

7.7.4 Credentials/Peer Review Committee Action. The Credentials/Peer Review Committee shall review each information form and all other pertinent information available to or obtained by the Committee on each professional being considered for reappointment, including continued compliance with staff status qualification, the recommendation of two members of the Medical Staff and all relevant professional performance, utilization, and performance improvement, and medical audit information, and shall transmit to the Executive Leadership Committee its report and recommendation that appointment be either renewed, renewed with modified staff status and/or clinical privileges, renewed with special conditions or terminated. The Committee may also recommend that the Executive Leadership Committee defer action. Each such report shall satisfy the requirements of Section 7.6.4. Any minority views shall also be reduced to writing and transmitted with the majority report.

7.7.5 Executive Leadership Committee Action. After receipt of the written report from the Credentials/Peer Review Committee, the Executive Leadership Committee shall review each information form and all other pertinent information, and shall then transmit to the Board, its report and recommendation that appointment be either reviewed, renewed with modified staff status and/or clinical privileges, renewed with special conditions or terminated.

7.7.6 Final Processing and Board Action. Thereafter the procedure provided in Sections 7.6.7. through 7.6.10 shall be followed. For purposes of reappointment, the term "applicant" and "appointment" as used in those sections shall be read, respectively, as "reappointment applicant" and "reappointment."

7.7.7 Basis for Recommendation. Each recommendation concerning the reappointment of a reappointment applicant and the clinical privileges to be
granted upon reappointment, and the determination made with respect thereto shall be based upon such reappointment applicant's professional ability, demonstrated current competence, clinical and/or technical skills, and clinical judgment in the treatment of his patients; his professional ethics; his satisfaction of the qualifications for staff membership and his discharge of obligations for staff membership; his compliance with the Medical Staff Bylaws, the applicable Rules and Regulations of the Medical Staff and Hospital or Nursing Home and Board policies, including utilization policies, his cooperation with other professionals and with patients; his physical health, mental health and emotional stability; and other matters bearing on his ability and willingness to provide quality patient care, including his ability and willingness to cooperate and work in harmony with the Corporation’s employees.

7.7.8 Time Periods for Processing. Time for the transmittal of the information form for a reappointment applicant and his return of it shall be carried out in accordance with section 7.7.1. Thereafter and, except for good cause, each person, unit and committee required by these Bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning reappointment shall have been transmitted to the Executive Leadership Committee for consideration and action pursuant to Section 7.7.5., and to the Board for its action pursuant to Section 7.7.6., all prior to the expiration date of the appointment of the reappointment applicant. However, the Credentials/Peer Review Committee shall not transmit a reappointment application pursuant to section 7.7.4. until the information referred to in Section 7.7.2. has been collected and verified; and, if responses required for a complete interval information form and responses to any inquiries made pursuant to Section 7.7.3. have not been received within eighty (80) days after being requested, the application may be deemed rejected and such action shall be deemed not be adverse action against applicant.

7.7.9 Requests for Modification of Appointment. A staff member, either in connection with reappointment or at any other time, may request modification of his staff status, or privileges by submitting a written application to the applicable Medical Director on the prescribed form. Such application shall be processed in substantially the same manner as provided in this Section 7.7. for reappointment.

7.7.10 Factors to be Considered. Recommendations for an increase in clinical privileges made to the Board shall be based upon relevant recent training, observation of patient care provided, review of the records of patients treated in this or other healthcare institutions and review of all other records and information from applicable units of the Medical Staff which evaluate the individual's participation in the delivery of clinical care that justify increased privileges. The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such periods of time as are thought necessary.

7.8 EXERCISE OF PRIVILEGES

A Practitioner provides clinical services at the Hospital or Nursing Home by virtue of Medical Staff membership and may exercise only those clinical privileges specifically granted to him by the Board. Regardless of the level of privileges granted, each
Practitioner shall obtain consultation when necessary for the safety of his patients or when required by the rules, regulations, or other policies of the staff. See Section 6.1.

7.9 FAST TRACKING

Under certain circumstances, a member who has applied for reappointment may be "fast tracked." This system involves moving the reappointment applicant through the credentialing process expeditiously, requiring the review and approval of at least one officer of the Credentials/Peer Review Committee, at least one officer of the Executive Leadership Committee and at least one member of the Board in addition to the Executive Director. This method should only be utilized when the Credentials/Peer Review Committee, Executive Leadership Committee or Board is unable to duly convene within the necessary time frame and when the reappointment applicant has submitted all of the appropriate documentation; primary source verification has taken place; there are no licensing or malpractice impediments as outlined in the Credentialing and Privileging Plan; and the committees that have reviewed the application have recommended reappointment.

7.10 TELEPSYCHIATRY

The Executive Leadership Committee must approve the use of telepsychiatry and other telemedicine technology in connection with any services offered by the Hospital. The Executive Leadership Committee shall adopt appropriate standards and requirements for the use of telepsychiatry and other telemedicine technology, which standards address such matters as security of information transmission, maintenance of medical records confidentiality and minimum technological requirements. Members of the Medical Staff who wish to use approved telemedicine technology must apply for privileges specifically authorizing such use, in accordance with Articles VI and VII.
ARTICLE VIII
CORRECTIVE ACTIONS AFFECTING MEDICAL STAFF/ALLIED HEALTH PROFESSIONAL APPOINTEES

8.1 COLLEGIAL INTERVENTION

The Board encourages the use of progressive steps by Medical Staff leaders and management, beginning with collegial and educational efforts, to address questions relating to a Staff member’s clinical practice or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Staff member to resolve questions that have been raised. Collegial intervention is part of the ongoing and focused professional practice evaluation, performance improvement and peer review. Collegial intervention efforts are not mandatory and will be within the discretion of the appropriate Staff leaders and management. If documentation of collegial efforts is included in the member’s Medical Staff file, the member will have an opportunity to review it and respond in writing. The response will be maintained in the member’s file along with the original documentation.

8.2 PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE, PATIENT CARE OR TREATMENT, OR CASE MANAGEMENT

8.2.1 Grounds for Action. Whenever a serious concern or question has been raised or where collegial intervention efforts (if attempted) have not resolved an issue, a Staff member may request corrective action be taken against another Staff member in the following circumstances:

(a) Evidence exists that he is unable to practice with reasonable skill and safety, because of a physical or mental illness, including deterioration through the aging process, or loss of motor skills, or excessive use or abuse of drugs or chemicals, including alcohol.

(b) His clinical competence falls below the generally acceptable level of competence in the community.

(c) His care or treatment of his patient or patients, or management of a case, threatens patient safety or the delivery of quality patient care.

(d) He violates the policies of the Corporation, including but not limited to utilization policies, the Bylaws, or the applicable Rules and Regulations of the Medical Staff.

(e) He fails to adhere to the ethical standards of his profession.

(f) His ability to work harmoniously with others deteriorates to the extent that it affects the orderly operation of the Hospital, Nursing Home or Medical Staff organization.

(g) He ceases to satisfy the qualifications for staff membership or to fulfill the responsibilities of staff members described in these Bylaws.
8.2.2 Requests and Notices. All requests for corrective action shall be in writing, submitted to the applicable Medical Director, and supported by concise reference to the specific activities or conduct which constitute the grounds for the request. The applicable Medical Director shall review the request, with related documentation, and unless the applicable Medical Director finds the request to be baseless, he shall transmit the request to the Medical Staff. In addition, the applicable Medical Director shall promptly notify the President of the Medical Staff and Executive Director in writing of all requests for corrective action received by the Medical Director and shall continue to keep the President of the Medical Staff and Executive Director fully advised and informed concerning action taken in conjunction therewith. In the case in which corrective action is requested concerning a Medical Director, the request is made to the Executive Director.

8.2.3 Medical Staff Procedure. The Credentials/Peer Review Committee shall meet after receiving the request from the applicable Medical Director, or in the case of a Medical Director, the Executive Director, and shall take proper steps to have the matter investigated. An Investigating Sub-Committee of the Credentials/Peer Review Committee shall convene for that purpose. This Investigating Sub-Committee shall be appointed by the Credentials/Peer Review Committee and may consist of persons who do not hold appointments on the Medical Staff. This committee shall not include partners or associates of the affected individual. The Investigating Sub-Committee shall have the full resources of the Corporation to aid in its work, as well as the authority to use outside consultants as required. The Investigating Sub-Committee may also request that the member submit to medical, psychiatric or psychological examination and/or blood, breath or urine testing. A record of the interviews it conducts shall be maintained and included with a final report by the investigating body. The investigation and the report shall be completed within thirty (30) days after the Credentials/Peer Review Committee appoints the members of the Sub-Committee. The report shall then be transmitted to the Credentials/Peer Review Committee for review. The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Investigating Sub-Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in Article IX shall apply.

8.2.4 Credentials/Peer Review Committee Actions. In acting after the investigation of the Investigating Sub Committee, the Chairman of the Credentials/Peer Review Committee may make the following recommendations to the Executive Leadership Committee:

(a) Reject the request for corrective action.
(b) Issue a written warning, admonition or reprimand.
(c) Recommend terms of probation or requirements for consultation or supervision.
(d) Recommend reduction, suspension or revocation of clinical privileges.
(e) Recommend suspension or revocation of staff membership.
The report of the Investigating Sub-Committee, together with all related documentation, and the Credentials/Peer Review Committee Chairman's recommendations, shall then be promptly transmitted to the Executive Leadership Committee.

8.2.5 Board Action.

(a) Recommendation of Executive Leadership Committee:  
The Executive Leadership Committee shall review the information provided and make recommendations to the Board as specified in Section 8.2.4 (a) - (e).

(b) Board Action:  
The Board shall, in whole or in part, adopt or reject the Executive Leadership Committee's recommendation, or refer the recommendation back to the Executive Leadership Committee for further consideration stating the reasonable time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant, he shall be notified by Special Notice, and he shall be entitled to the procedural rights as in Article IX.

8.2.6 Procedural Rights. Any recommendation by the Executive Leadership Committee pursuant to Section 8.2.4. (c), (d), or (e), or any combination of such recommendations, shall entitle the Practitioner or other professional to the rights as provided in Article IX and the matter shall be processed in accordance with the provisions of Article IX. If the Executive Leadership Committee’s recommendation is as provided in Section 8.2.4. (a) or (b), such recommendation, together with all supporting documentation, shall be transmitted to the Board and to the appointee’s Medical Staff file. Thereafter, if the Practitioner wishes, he may submit a letter of explanation or rebuttal, which shall also be transmitted to the Executive Leadership Committee and to the Board and to his Medical Staff file. No other appeal rights are granted, unless the Board takes an action adverse to the Practitioner, as defined in Section 9.2.1. In that event, the procedure to be followed shall be as provided in section 7.6.7.

8.2.7 Other Action. Action taken as a result of any Medical Staff investigation shall be reported to the Board, and, if required, to the appointee's state licensure board and to any additional bodies as required by law. Where required by law, allegations of impropriety will be reported in advance of investigation to the appropriate agency, body or authority.

8.3 PRECAUTIONARY SUSPENSION OR RESTRICTION

8.3.1 Criteria and Initiation. Whenever the conduct of a member of the Staff requires immediate action be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person, the President of the Medical Staff, the applicable Medical Director, or the Executive Director or his designee shall have the authority to (a) suspend or restrict all or any portion of the clinical privileges of such person, or (b) afford the member an opportunity to voluntarily refrain from exercising privileges pending an investigation. Such suspension or restriction shall become effective immediately upon imposition, but shall not imply any final finding of
responsibility for the situation that caused the suspension or restriction. The Executive Director shall promptly give to such person Special Notice of the suspension or restriction.

8.3.2 Medical Staff Consideration; Board Action. As soon as practical after such suspension or restriction, an Investigating Sub-Committee shall be convened to review and consider the action taken. This Sub-Committee may recommend to the Executive Leadership Committee to continue or terminate the precautionary suspension or restriction or modify its terms and continue it. The Executive Leadership Committee shall then promptly meet to review and consider the precautionary suspension or restriction. The Executive Leadership Committee may recommend that the Board continue or terminate the precautionary suspension or restriction or modify its terms and continue it. The matter shall then be promptly referred to the Board, which shall take action to continue or terminate the precautionary suspension or restriction or modify its terms and continue it.

8.3.3 Procedural Rights. Unless the Board terminates the suspension or restriction and ceases all further and related corrective action, the professional shall be entitled to the procedural rights provided in Article IX. The CEO shall give Special Notice of the Board's action to the professional. The terms of a suspension or restriction as imposed by the Board under Section 8.3.2 shall remain in effect until the professional has exhausted or waived his procedural rights as provided in Article IX or until such time as the suspension or restriction is modified or terminated pursuant to Article IX.

8.3.4 Care of Suspended Individual's Patients. Immediately upon the imposition of a precautionary suspension or restriction, the applicable Medical Director or his designee, shall implement the precautionary restriction as appropriate, or assign to another person appointed to the Medical Staff, responsibility for patients or residents of the suspended individual cared for at the Hospital or Nursing Home at the time of such suspension and until such time as the suspension is terminated or the patients are discharged. It shall be the duty of the President of the Medical Staff and the Service Medical Directors to cooperate with the applicable Medical Director in enforcing all suspensions and restrictions.

8.4 AUTOMATIC SUSPENSION

8.4.1 License. A Practitioner whose license, certificate or other legal credential authorizing him to practice his profession in New York State is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital or Nursing Home, from his staff status, and from exercise of privileges. If such license is partially limited or restricted, privileges within the scope of the limitation or restriction shall be automatically suspended.

8.4.2 Drug Enforcement Administration (DEA) Number. A Practitioner whose DEA number is revoked or has expired shall immediately and automatically be suspended from practicing at the Hospital or Nursing Home, from his staff status, and from exercise of privileges but shall be automatically reinstated upon subsequent presentation of a current, valid DEA certificate. If such number or other right to prescribe controlled substances is suspended, partially limited or restricted, or is subject to an order of probation, privileges within the scope of
such suspension, limitation or restriction or probation shall be automatically suspended, limited or restricted.

8.4.3 Failure to Satisfy Special Appearance Requirements. A professional who (a) fails to appear before an Investigating Sub-Committee or (b) fails to make a special appearance as required in Section 11.1.11 when Special Notice has been provided and no excuse has been granted by the applicable Medical Director shall immediately and automatically be suspended from exercising all or a portion of his clinical privileges. Such an appearance must be preceded by three (3) days' notice, excluding periods of approved absences.

8.4.4 Medical Records. An automatic suspension of admitting privileges shall, after not less than three (3) days’ warning of delinquency, be imposed for failure to complete medical records in timely fashion pursuant to and as required by Corporation policies. Such suspension shall take the form of withdrawal of admitting privileges until all records are completed or three (3) days whichever is greater. Should a professional be placed on suspension more than three (3) times during any calendar year, or should a professional's suspension under this Subsection 8.4.4 last for a continuous period of over three (3) months, his Medical Staff privileges shall be automatically terminated. In the event of privileges termination under this Subsection 8.4.4, the professional shall be ineligible for re-application for a period of one (1) year.

8.4.5 Professional Liability Insurance. A professional who fails to satisfy the requirements of Section 3.1.8 shall immediately and automatically be suspended from practicing in the Hospital or Nursing Home, from his staff status and from exercise of privileges.

8.4.6 Refusal to Submit to Physical or Mental Examination. A professional who refuses or fails to undergo any examination within twenty-four (24) hours of a request in accordance with Sections 3.1.7. or 8.2.3 or who impedes the provision of examination results as provided in the Rules and Regulations of the Medical Staff shall automatically be suspended from practicing in the Hospital or Nursing Home, from his staff status and from exercise of privileges.

8.4.7 Exclusion from Participation in Federal Healthcare Programs. A Practitioner who is excluded from participating in Medicare, Medicaid or any other federal healthcare program shall immediately and automatically be suspended from practicing in the Hospital or Nursing Home, from his staff status and from exercise of privileges.

8.4.8 Conviction of a Crime Related to Professional Practice or Patient Care. A Practitioner who is convicted of a crime related to his professional practice or the treatment of his patients shall immediately and automatically be suspended from practicing in the Hospital or Nursing Home, from his staff status and from exercise of privileges.

8.4.9 Procedural Rights. A person under automatic suspension by operation of this Section 8.4 shall not be entitled to the procedural rights provided in Article IX. Such suspension is not the result of any adverse action or recommendation of the Board, the Staff, or any committee or unit.
8.4.10 Reinstatement, New Application.

(a) Any Practitioner or other professional automatically suspended under Sections 8.4.1., 8.4.6, 8.4.7. or 8.4.8 shall not, by the passage of time or the curing of the event which gave rise to automatic suspension, be automatically reinstated to his staff status and/or clinical privileges. Instead, in order to regain staff status and/or clinical privileges such persons shall be required to file an initial application for staff status and clinical privileges, which application shall be processed as provided in Article VII.

(b) Any professional automatically suspended pursuant to Sections 8.4.2, 8.4.3., 8.4.4., or 8.4.5., may be reinstated, at the discretion of the Credentials/Peer Review Committee upon curing, in whatever manner the Medical Staff deems appropriate, the failure. In the event a professional who has been automatically suspended is not reinstated within thirty (30) days after such curing, then such professional shall be entitled to the procedural rights provided in Article IX.

8.5 PROCEDURE FOR LEAVE OF ABSENCE AND RESIGNATION

Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence for an explicitly stated period of time. Requests for leaves of absence shall be made to the applicable Medical Director, and shall state the beginning and ending dates of the requested leave. The applicable Medical Director shall review such requests and shall approve, reject or modify such requests. Any action by the applicable Medical Director to reject or modify a leave of absence request shall be deemed not to be an adverse action against the member and shall not entitle the member to the procedural rights provided in Article IX.

A member of the Medical Staff may resign his appointment to the Medical Staff and all privileges at any time upon not less than ninety (90) days notice to the applicable Medical Director. If a member resigns his appointment, the member may not reapply for appointment to the Medical Staff for a period of one year, unless permission to apply sooner is granted by the Executive Leadership Committee.

8.6 IMPAIRED MEDICAL STAFF MEMBER

Persons appointed to the Medical Staff who may be prevented (by reasons of illness or other health related problems) from performing their duties at the expected level of skill and competency, need to be identified and assisted.

To this end the Medical Staff has implemented a process to identify and manage matters relative to the individual clinician’s health, which is separate from the medical staff disciplinary function. This process is outlined in Hospital-Wide Directives, Policy No. MS-015.
ARTICLE IX

INTERVIEWS, HEARINGS AND APPEAL PROCEDURES

9.1 INTERVIEWS

When the Executive Leadership Committee or the Board receives or is considering initiating an adverse recommendation or action concerning a Practitioner, the Practitioner may, at the discretion of the Executive Leadership Committee or the Board, be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature and need not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the circumstances and may present information and documents relevant thereto. A concise record of such interview shall be made.

9.2 ADVERSE RECOMMENDATIONS OF ACTIONS

9.2.1 Hearing Entitlement. A Practitioner shall be entitled to a hearing pursuant to the provisions of these Bylaws only after an adverse recommendation or adverse action involving:

(a) Denial of initial appointment to staff status.
(b) Denial of reappointment.
(c) Non-reinstatement of staff status or clinical privileges after a leave of absence or resignation.
(d) Non-reinstatement within thirty (30) days after curing an event of default which gave rise to automatic suspension under Sections 8.4.2, 8.4.3., 8.4.4. or 8.4.5.
(e) Suspension or restriction of staff status or clinical privileges.
(f) Denial of requested clinical privileges.
(g) Reduction or revocation of clinical privileges.
(h) Probation and its terms.
(i) Requirements of consultation, supervision or monitoring imposed at times other than during a provisional period.
(j) Termination of staff status or privileges during or at the end of a probationary period.

9.2.2 The actions listed in Section 9.2.1. constitute "adverse recommendations" or "adverse actions" as such terms are used herein, except that none of the following shall be deemed to be adverse:

(a) Probation and its terms or requirements of consultation, supervision or monitoring which are imposed on Practitioners holding membership status or clinical privileges for a provisional period.
(b) Automatic suspension except where the Medical Credentials/Peer Review Committee has failed to reinstate a Practitioner suspended pursuant to Sections 8.4.2, 8.4.3., 8.4.4. or 8.4.5. within thirty (30) days after such
Practitioner has cured the event which gave rise to the automatic suspension.

(c) Actions by the Medical Staff or any of its committees pursuant to Section 8.2.4(b).

(d) Denial, termination or reduction of temporary privileges (whether or not the stated term thereof has expired).

(e) Termination of on-call staff status because of completion of post-graduate training.

(f) Denial of an initial appointment to staff status because responses required for a complete application have not been received in a timely manner; denial of reappointment because responses required for a complete interval information form have not been received in a timely manner; including denial of appointment or reappointment due to applicant's failure to supplement his application or interval information form as requested by the applicable Medical Director or Administrator.

(g) Termination of staff status or privileges for failure to complete continuing educational requirements as provided in Section 7.4.2 (m).

(h) The actual or deemed voluntary resignation of appointment or privileges pursuant to these Bylaws.

9.3 WHEN A HEARING MAY BE REQUESTED

A Practitioner shall be entitled to a hearing only upon request and only after:

9.3.1 An adverse recommendation by the Executive Leadership Committee, other than an adverse recommendation pursuant to Section 8.3.2;

9.3.2 An adverse action by the Board contrary to a favorable recommendation by the Executive Leadership Committee; or

9.3.3 An adverse action by the Board in the absence of a recommendation by the Executive Leadership Committee, including an adverse action by the Board pursuant to Section 8.3.2.

9.4 HEARING PROCEDURE FOLLOWING AN ADVERSE RECOMMENDATION

The hearing procedure following an adverse recommendation by the Executive Leadership Committee shall consist of a hearing before a hearing committee appointed pursuant to Section 9.11 and an appellate review of an adverse recommendation by the hearing committee as such appellate review is provided for herein.

9.5 HEARING PROCEDURE FOLLOWING AN ADVERSE ACTION

The hearing procedure following an adverse action of the Board shall consist of a hearing before a hearing committee appointed pursuant to Section 9.12,appellate review of an adverse recommendation by the hearing committee as such appellate review is provided for herein.\n
9.6  NOTICE OF ADVERSE RECOMMENDATION OR ACTION

When an adverse recommendation or adverse action has been taken which entitles a Practitioner to a hearing as provided in Section 9.3., the Executive Director shall within thirty (30) days thereafter provide Special Notice to such Practitioner of such action, of such Practitioner's right to request a hearing, and of the time limit within which he must request such hearing. This notice shall contain a statement of reasons and summary of rights described in Section 9.10., and shall note that failure to request a hearing within the required time frame constitutes a waiver of the right to a hearing. If pertinent, records or information supporting the recommendation shall be identified. This statement may be amended or added to at any time, even during the hearing so long as the material is relevant to the continued appointment or clinical privileges of the person requesting the hearing, who shall have sufficient time to study this additional information and rebut it. Notwithstanding the foregoing, Special Notice of an adverse action by the Board pursuant to Section 8.3.2. shall be provided to the Practitioner within three days thereafter by the Executive Director.

9.7  REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his receipt of a notice pursuant to Section 9.6. to file a written request for a hearing. Such request shall be delivered to the Executive Director by Special Notice.

9.8  WAIVER BY FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 9.7. waives any right to such hearing and to any appellate review to which he might otherwise have been entitled. Such waiver in connection with:

9.8.1  An adverse action by the Board shall constitute acceptance of that action which shall thereupon become effective as of the final decision of the Board.

9.8.2  An adverse recommendation by the Executive Leadership Committee shall constitute acceptance of the recommendation which shall thereupon become and remain effective pending the final decision of the Board. A Practitioner who has not previously requested a hearing is not entitled to a hearing on a Board action based on an adverse recommendation of the Executive Leadership Committee, having been afforded an opportunity to request a hearing on such adverse recommendation prior to such Board action.

9.9  TIME, PLACE AND NOTICE OF HEARING

Upon receipt of a timely request for hearing, the Executive Director shall promptly schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the Executive Director shall send the Practitioner notice of the time, place, and date so scheduled. This notice shall also contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Executive Leadership Committee or the Board. Notwithstanding the foregoing, a hearing for a Practitioner who is under a precautionary suspension or restriction which is then in effect shall be held if the Practitioner so desires and requests, as soon as the arrangements may reasonably be made.
9.10 STATEMENT OF REASONS AND SUMMARY OF RIGHTS

The notice of adverse recommendation or action required by Section 9.6 shall contain a statement of reasons for the adverse recommendation or action. The notice shall also contain a summary of the Practitioner's rights in the hearing process.

9.11 HEARING BODY WHEN HEARING OCCASIONED BY RECOMMENDATION OF THE EXECUTIVE LEADERSHIP COMMITTEE

A hearing occasioned by an adverse recommendation of the Executive Leadership Committee pursuant to Section 9.3.1. shall be conducted before a hearing committee appointed by the Executive Director (with the concurrence of the Medical Director) composed of not less than three nor more than seven persons, some of whom shall be Members of the Medical Staff and one or more of whom shall not be Members of the Medical Staff. The Executive Director shall fix the number of members, shall designate one member as moderator, shall appoint substitute members in the event previously appointed members are unable or unwilling to serve, and shall provide to the Practitioner a list of the members of the hearing committee. The Practitioner may object to the qualifications of any hearing committee member to participate in the hearing for reasons other than those specified in Section 9.13. Such objection shall be made in writing and shall be promptly provided by Special Notice to the Executive Director, who after consultation with the applicable Medical Director shall then take appropriate action to address such objection.

9.12 HEARING BODY WHEN HEARING OCCASIONED BY ACTION OF THE BOARD

A hearing occasioned by an adverse action of the Board pursuant to Section 9.3.2. or 9.3.3. shall be conducted before a hearing committee appointed by the Chairperson of the Board and composed of not less than three or more than seven persons. At least one Medical Staff member shall be included on this committee when feasible and the remaining members of the committee may be members of the Board, the Medical Staff, or any other persons; provided, however, that at least one member of the committee shall not be a member of the Medical Staff. The Chairperson of the Board shall fix the number of members, shall designate one member as moderator, shall appoint substitute members in the event previously appointed members are unable or unwilling to serve, and shall provide to the Practitioner a list of the members of the hearing committee. The Practitioner may object to the qualification of any hearing committee member to participate in the hearing for reasons other than those specified in Section 9.13. Such objection shall be made in writing and shall be promptly provided by Special Notice to the Chairperson of the Board, who then shall take appropriate action to address such objection.

9.13 PRIOR INVOLVEMENT OF HEARING COMMITTEE MEMBERS

Prior involvement of a hearing committee member in formulation of the adverse recommendation or action which occasioned the hearing shall not bar participation as a hearing committee member. To the extent practicable, a hearing committee shall have no members who have actively participated in formulating the adverse recommendation or action that occasioned the hearing, or in initiating or investigating the underlying matter at issue at any earlier stage of the proceedings. When it is not practical for the hearing committee to exclude such persons, the Executive Director or Chairperson of
the Board, as the case may be, shall make such determination and shall file a statement with the moderator of the hearing committee stating the reasons therefore. A copy of such statement shall be provided promptly to the Practitioner. Any such determination made without malice shall be final and binding on all parties.

9.14 PERSONAL PRESENCE OF PRACTITIONER AT HEARING

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause shown, as determined by the hearing committee, to appear and proceed at such hearing waives his right to a hearing, with the same consequence as provided in Section 9.8.

9.15 MODERATOR

9.15.1 The moderator of the hearing committee shall be the presiding officer. The moderator 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 shall be entitled to determine the order of proceeding during the hearing, to promulgate rules of procedure not inconsistent with these Bylaws, to exclude or remove any person who is disruptive to an orderly and professional hearing, and to refuse to admit evidence which is not relevant to the subject matter of the hearing. Service as a moderator shall not in any way prevent the moderator from full participation in the deliberations and actions of the hearing committee.

9.15.2 The moderator shall require the Practitioner who requested the hearing or his representative (who may be legal counsel) and a representative of the Executive Leadership Staff or the Board (who may be legal counsel) to participate in a pre-hearing conference. At the pre-hearing conference, the moderator will seek to resolve all outstanding procedural questions, including any objections to exhibits or witnesses. The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is required.

9.16 REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or by any other person of the Practitioner's choice. The Medical Staff or the Board may appoint an attorney to represent its position at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Counsel to the Corporation or the Practitioner shall have the right, upon the request of his client, to be present as an overseer at any hearing, even if such counsel's client has elected not to be represented by counsel at the hearing.

9.17 RIGHTS OF PARTICIPANTS

During a hearing, the participants and/or their representatives shall have the right to:

9.17.1 Call and examine witnesses who voluntarily agree to appear on behalf of the participant calling such witnesses. Notice is hereby given to the participants that neither the Medical Staff nor the Corporation has the legal power of subpoena.
9.17.2 Introduce exhibits and documents relevant to the issues.

9.17.3 Cross-examine any witness on any matter relevant to the issues.

9.17.4 Rebut any evidence.

9.17.5 Subject to the provisions of Section 9.21., request that the record of the hearing be made by use of a court reporter or, if the material recorded is to be reduced to writing promptly after the hearing, an electronic recording unit.

9.17.6 Present evidence determined to be relevant by the moderator of the hearing, regardless of its admissibility in a court of law.

If the Practitioner who requested the hearing does not testify on his own behalf, he may be called and examined as if under cross-examination.

9.18 PROCEDURE AND EVIDENCE

The hearing shall be de novo. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, or at the close of the hearing, be entitled to submit written statements concerning any issue of law or fact and such written statements shall become a part of the hearing record. The moderator 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 and entitled to notarize documents in the state where the hearing is held.

9.19 OFFICIAL NOTICE

In reaching a decision, the hearing committee may take official notice either before or after submission of the matter for decision, of any generally accepted technical, scientific, professional or ethical matter relating to the issues under consideration and of any facts of the type customarily noticed by courts or by administrative agencies. Parties present at the hearing shall be informed of matters to be noticed, and those matters shall be noted in the hearing record. Any party shall be given an opportunity, on request made not later than the close of taking testimony at the hearing, to request that a matter be officially noticed by written or oral presentation of authority or, at any time prior to a decision, to refute the officially noticed matters of evidence. The manner of such refutation shall be determined by the hearing committee.

9.20 OBLIGATIONS TO PRESENT EVIDENCE

In hearings on adverse recommendations or actions of the type identified in Section 9.2.1. (b), (d), (e), (g), (h), or (i), the body whose adverse recommendation or action occasioned the hearing shall have the obligation of showing by the evidence that the adverse recommendation or action was not arbitrary, irrational or capricious and to present evidence in support of its recommendation or action. In hearings on adverse recommendations or actions of the type identified in Sections 9.2.1. (a), (c), (f), or (j), the body whose recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its recommendation or action; and the
Practitioner shall thereafter be responsible for supporting by evidence his or her challenge to the recommendation or action and shall prevail only if he establishes by clear and convincing evidence that the recommendation or action was arbitrary, irrational or capricious. In such hearings relating to Section 9.2.1. (a), (c), (f), or (j), the evidence presented by the Board or Executive Leadership Committee in support of its initial obligation described above may relate to omissions (such as incompleteness or erroneous statements) or to negative judgments of such body regarding information contained in the Practitioner's application or request and related references and documentation to the effect that such materials, for reasons explained by such body, fail to establish an acceptable basis for granting the application or request.

9.21 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to permit the making of an informed and valid judgment by any body that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee shall select the method to be used, such as Court Reporter, electronic recording unit, detailed transcription, or minutes of the proceedings, for making the record. A Practitioner electing the method specified under Section 9.17.5. shall bear the cost thereof unless such method has also been selected by the hearing committee. The Practitioner shall be entitled to obtain copies of the record of the hearing upon payment of any reasonable charge associated with the preparation of such copies.

9.22 POSTPONEMENT

Requests for postponement of a hearing shall be granted by the hearing committee only upon showing of good cause.

9.23 RECESSES AND DELIBERATIONS

The hearing committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence. Upon conclusion of the presentation of evidence and such argument or summation as the hearing committee deems appropriate, the hearing shall be closed. The hearing committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

9.24 HEARING REPORT

Within fourteen (14) days after the hearing record is made available to it, the hearing committee shall make a written report of its findings and recommendation in the matter and shall forward the same together with the hearing record and all other documentation considered by it as described in Section 9.26 and to the body whose adverse recommendation or action occasioned the hearing. The hearing report shall concisely state the reasons for the findings and recommendation made in the report. The hearing report shall specifically affirm, reverse, or modify the adverse recommendation or adverse action which was reviewed. In its discretion the hearing committee shall have the right to request the parties to submit proposed findings and recommendations, and the reasons thereafter. No party shall be required to submit proposed findings and recommendations. If the hearing committee requests the parties to submit proposed findings and recommendations, the hearing committee shall have the right to extend the
time for issuance of the hearing report for not more than twenty-one (21) days. The Practitioner shall have the right to obtain a copy of the hearing report.

9.25 ACTION ON HEARING COMMITTEE REPORT AFTER ADVERSE HEARING COMMITTEE REPORT

If, after a hearing on an adverse recommendation or action, the recommendation of the hearing committee is also adverse, the CEO shall provide Special Notice of the recommendation of the hearing committee to the Practitioner. This notice shall include a copy of the hearing report and shall inform the Practitioner of the right to appellate review as provided herein. A hearing committee modification of an adverse recommendation or action shall be deemed to be adverse if it would result in one of the types of action identified as being adverse under Section 9.2.1.

9.26 ACTION ON HEARING COMMITTEE REPORT AFTER FAVORABLE HEARING COMMITTEE REPORT

9.26.1 If, after a hearing on an adverse recommendation or action, the finding of the hearing committee is that the adverse recommendation or action be reversed, the report of the hearing committee shall be transmitted to the Board, together with the hearing record, for Board action. The hearing committee report and hearing record shall also be transmitted to the Executive Leadership Committee in instances where the hearing was occasioned by its adverse recommendations pursuant to Section 9.3.1. Within thirty (30) days after receipt of the report of the hearing committee, the Board or a committee thereof shall render its decision in the matter unless the Executive Leadership Committee requests appellate review pursuant to Section 9.27. The Executive Director shall inform the Practitioner by Special Notice of the Board's decision, including a statement of the basis for the decision. The Board or its committee shall be entitled to consider the entire hearing record, including any documentary evidence introduced at the hearing, in making its decision.

9.26.2 If the Board's action after a favorable hearing committee report is an adverse action, the Executive Director shall provide Special Notice of the action to the Practitioner. This notice shall inform the Practitioner of his right to a further review in accord with the provisions of these Bylaws relating to appellate review, except that the Practitioner shall have no right to appellate review if the Board's decision was made after appellate review requested by the Executive Leadership Committee pursuant to Section 9.27.

9.27 REQUEST FOR APPELLATE REVIEW

A Practitioner shall have thirty (30) days following his receipt of a notice pursuant to Sections 9.25 and 9.26.2 to file a written request for an appellate review, unless there has been appellate review of the matter upon request of the Executive Leadership Committee. Such request shall be delivered to the Executive Director by Special Notice and may include a request for a copy of the record of the hearing committee and all other material that was considered in making the adverse determination against him. In the event the hearing committee report on an adverse recommendation by the Executive Leadership Committee (a) is favorable to the Practitioner or (b) if the Board's action after an adverse report is favorable to the Practitioner and the Practitioner did not request and receive appellate review prior to Board action, the Executive Leadership Committee shall
be entitled to appellate review upon written request to the CEO made within thirty (30) days after such report or such action. Special notice of such request shall promptly be given to the Practitioner. Such requests may include a request for a copy of the report and record of the hearing committee and all other material considered in making the report.

9.28 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

Failure to request an appellate review within the time and in the manner specified in Section 9.27 constitutes a waiver of any right to such review on the part of the Practitioner or the Executive Leadership Committee failing to request appellate review. Waiver by the Practitioner shall have the same force and effect as that provided in Section 9.8. The Practitioner shall not be entitled to a hearing or appellate review of any adverse action taken by the Board on the basis of an adverse recommendation followed by an adverse Hearing Committee report after a failure to request appellate review in the manner provided herein.

9.29 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the CEO or his designee shall deliver such request to the Board. The Board shall schedule and arrange for an appellate review within ninety (90) days. At least forty-five (45) days prior to the date scheduled for the appellate review, the CEO or his designee shall send the Practitioner and the Executive Leadership Committee, Special Notice of the time set for the review. The time for the appellate review may be extended by the appellate review body for good cause.

9.30 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 not more than three members of the Board appointed by the Chairperson of the Board. If a committee is appointed, one of the members shall be designated as chairperson. Prior involvement of a Board member or an appellate review committee member (except as a hearing committee member) in formulation of the adverse recommendation or action or hearing committee report which occasioned the appellate review shall not bar participation in the appellate review.

9.31 NATURE OF APPELLATE REVIEW PROCEEDINGS

The proceeding by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee’s report, and all subsequent actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 9.32. and such other materials as may be presented and accepted under Section 9.34. The appellate review body shall meet and deliberate out of the presence of the parties, and no party shall have the right to make oral argument.

9.32 WRITTEN STATEMENTS

The party seeking the appellate review shall submit a written statement detailing the findings, conclusions and recommendations, and procedural matters with which he
disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the Executive Director or his designee at least fifteen (15) days prior to the scheduled date for the appellate review. A similar written statement in reply may be submitted by the other party, and, if submitted, the Executive Director or his designee shall provide a copy thereof to the party requesting review at least five (5) days prior to the scheduled date of the appellate review. Failure of the requesting party to file such written statement in a timely manner shall constitute a waiver of the right to appellate review.

9.33 PRESIDING OFFICER

The chairperson of the appellate review body shall be the presiding officer and shall determine the order of procedure of the review.

9.34 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, nor otherwise reflected in the record, shall be introduced during the appellate review process only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

9.35 RECESSES

The appellate review body shall determine the hearing committee's compliance with these Bylaws. 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.

9.36 ACTION TAKEN

The appellate review body may recommend that the Board adopt, modify or reject the Hearing Committee report or that the Board affirm, modify or reverse the adverse action previously taken by the Board, or, in its discretion, may refer the matter back to the Hearing Committee for further proceedings within a specified number of days and in accordance with its instructions. Except where the appellate review body consists of the entire Board, the appellate review body will transmit its written recommendation to the Board, or notify the Board of such a referral to the hearing committee, within ten (10) days after the review proceedings are adjourned. Within ten (10) days after receipt of a recommendation from the hearing committee after referral, the appellate review body shall make its recommendation to the Board (or, if the appellate review body consists of the entire Board, its final decision) as provided in Section 9.37.

9.37 FINAL DECISION OF THE BOARD

If the appellate review body is a committee of Board members, then within fourteen (14) days after the receipt of the recommendation of the appellate review body, the Board shall render a final decision and the matter shall be finally closed. If the appellate review body consists of the entire Board, then its action under Section 9.36. shall be (after any referral) the final action of the Board. Special Notice of final action shall be given within five (5) business days to the Practitioner. This notice shall include a statement of the basis of the Board's decision.
9.38 **WAIVER**

If at any time after receipt of Special Notice of an adverse recommendation or adverse action, a Practitioner fails to comply with this Article IX, he shall be deemed to have consented to such adverse recommendations or action and have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

9.39 **RELEASE**

By requesting a hearing or appellate review under these Bylaws, a Practitioner agrees to be bound by the provisions of Article XIV of the Medical Staff Bylaws in all matters relating thereto.

9.40 **REMOVAL FROM POSITION OF SPECIAL STAFF OFFICER**

Removal from office or position of a special staff officer may be accomplished in accordance with the usual personnel policies of the Corporation or the terms of such employment or engagement agreement, if any.

9.41 **REMOVAL FROM POSITION OF ON-CALL STAFF MEMBERS**

Removal from office or position of an on-call staff member may be accomplished in accordance with the usual personnel policies of the Corporation or the terms of such employment or engagement agreement, if any.
ARTICLE X

OFFICERS AND ORGANIZATION OF THE MEDICAL STAFF

10.1 GENERAL OFFICERS OF THE MEDICAL STAFF

10.1.1 Identification. The general officers of the Medical Staff are:

(a) President
(b) President-Elect
(c) Immediate Past President

10.1.2 Qualifications. Each officer must be a physician and member of the active Medical Staff at the time of nomination and election, must remain a member in good standing continuously during his term of office, and must be willing and able to faithfully discharge the duties of the office held.

10.2 TERM OF OFFICE

The term of office of general officers is two Medical Staff years. Officers assume office on the first day of the Medical Staff year following their election or appointment except that an officer elected to fill a vacancy assumes office immediately upon election. Each officer serves until the end of his term and until a successor is elected, unless he sooner resigns or is removed from office.

10.3 ATTAINMENT OF OFFICE

10.3.1 Nominations.

(a) Makeup of Nominating Committee: The nominating committee shall consist of the Medical Directors (co-Chair), President, the President-Elect, and one active member of the Medical Staff. In the case of one or more of these members not being available, the Medical Director shall appoint substitute members from the active Medical Staff members.

(b) By Nominating Committee: The nominating committee shall submit to the Medical Staff one or more qualified nominees for the office of the President-Elect of the Medical Staff at least thirty (30) days prior to the annual meeting.

(c) By Petition: Nominations may also be made by petition signed by at least 25% of the members of the active staff.

(d) By Other Means: If, before the election, any one or more of the Individuals nominated for pursuant to section 10.3.1.(b) shall decline, be disqualified from or otherwise be unable to accept nomination, then the nomination, then the nominating committee shall submit one or more substitute nominees at the annual meeting, and nominations shall be accepted from the floor.

10.3.2 Election. The President-Elect shall be elected at the annual meeting of the staff every two years. Only staff members accorded the prerogative to vote for staff
officers under Article IV shall be eligible to vote. Voting shall be by secret written ballot, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held at the annual meeting between the two candidates receiving the highest number of votes. Sections 10.3.1. and 10.3.2. shall not apply to the offices of President and Immediate Past President. The President of the Medical Staff shall attain office by virtue of his advancement, after two years, from the office of President-Elect. The Immediate Past President shall attain office by virtue of his service as President during the previous year.

10.4 VACANCIES

10.4.1 In the Office of the President. A vacancy in the office of President is filled by succession of the President-Elect.

10.4.2 In the Office of the President-Elect. A vacancy in the office of the President-Elect shall be filled by the Nominating Committee submitting to the Medical Staff one or more qualified names for the office of President-Elect at least thirty (30) days prior to the next Medical Staff meeting. Nominations can also be made in accordance with Section 10.3.1. (c) and (d).

10.4.3 In the Office of Immediate Past President. A vacancy in the office of Immediate Past President shall not be filled until the term of office of the President expires and the President succeeds to the position.

10.5 RESIGNATION AND REMOVAL FROM OFFICE

10.5.1 Resignation. Any staff officer may resign at any time by giving written notice to the Medical Staff. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified on it.

10.5.2 Removal. Removal of a general officer of the Medical Staff may be effected by a two-thirds vote by secret ballot of the members of the staff eligible and qualified to vote for the staff officer, such vote being taken at a special meeting called for the purpose. Permissible bases of removal of a general staff officer include, without limitation:

(a) Failure to perform the duties of the position held in a timely and appropriate manner.
(b) Failure to continuously satisfy the qualifications for that position.

10.6 DUTIES OF THE OFFICERS

10.6.1 President. The president is the administrative officer of the staff and the staff's representative in its relationships with the Corporation. His specific functions and tasks are to:

(a) Serve as a member of the Medical Staff.
(b) Promote the quality and efficiency of medical services and professional performance within the Hospital and Nursing Home, and the effectiveness of the patient care audit and other performance improvement functions delegated to the Staff.

(c) Assist the Medical Directors in the development and implementation of continuing medical education programs, utilization management, concurrent monitoring of practice and retrospective patient care audits.

(d) Communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board and the CEO.

(e) Perform the duties required of the President of the Medical Staff by these Bylaws.

(f) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff.

10.6.2 President-Elect. The President-Elect shall be a member of the Medical Staff. In the absence of the President, he shall assume all the duties and authority of the President. He shall perform such additional duties as may be assigned by the President or the Medical Staff.

10.6.3 Immediate Past President. The Immediate Past President shall perform such additional duties as may be assigned to him by the President or the Medical Staff.

10.7 SPECIAL STAFF OFFICERS

10.7.1 Medical Directors. The Hospital Medical Director and Nursing Home Medical Director are special staff officers and shall be voting members of the Credentials/Peer Review Committee, the Bylaws Committee, and the Executive Leadership Committee. The Hospital Medical Director shall be an ex-officio member of all other Hospital committees and committees of the Medical Staff made up of members who admit/attend patients of the Hospital. The Nursing Home Medical Director shall be an ex-officio member of all other Nursing Home committees and committees of the Medical Staff made up of members who admit/attend residents of the Nursing Home.

(a) Qualifications: The Hospital Medical Director shall be qualified to practice psychiatry in the State of New York and shall meet the requirements for membership on the active Medical Staff of the Hospital.

(b) Qualifications: The Nursing Home Medical Director shall be qualified to practice medicine in the State of New York and shall meet the requirements for membership on the active Medical Staff of the Nursing Home.

(c) Selection: The Hospital Medical Director and Nursing Home Medical Director shall be appointed by the Board, upon recommendation of the Executive Director, with the consultation of the other members of the Medical Staff.
10.7.2 **Duties of the Hospital Medical Director.** The Hospital Medical Director shall be the Chief Medical Officer of the Hospital and shall:

(a) Direct and coordinate all medical and psychiatric services of the Hospital.

(b) Be accountable to the Board, as representative of the Hospital Medical Staff, for the quality and efficiency of medical services and professional performance within the Hospital and for the effectiveness of the patient care audit and other performance improvement functions delegated to the Staff.

(c) Develop and implement, with assistance of Hospital Medical Staff, Service Medical Directors, V.P. of Behavioral Health, continuing medical education programs, utilization management, concurrent monitoring of practice and retrospective patient care audits.

(d) Assist the Service Medical Directors and the Hospital Medical Staff in establishing standards of psychiatric care, and supervise the services of the Hospital Medical Staff in accordance with those standards.

(e) In conjunction with the Service Medical Directors and the Hospital Medical Staff, investigate new developments in psychiatric practices and techniques, adapting them to specific needs of the Hospital.

(f) Act as a consultant in unusual and difficult psychiatric cases.

(g) Initiate and direct staff conferences for instructional purposes.

(h) Review and approve all clinically relevant policy and procedure manuals as a representative of the Medical Staff.

(i) Make medical decisions or institute medical treatment on any patient in the Hospital under urgent conditions when the attending physician cannot be immediately contacted.

(j) Screen the admission of any person, and require the discharge of any patient, whose needs cannot be adequately met at the Hospital.

(k) Provide leadership and act as a resource to the Hospital and Hospital Medical Staff in such functions as performance improvement, medical records, peer review, etc.

(l) Participate in the planning and implementation of inservice training for staff.

(m) Make recommendations regarding the hiring of personnel involved in direct patient care.

(n) Review medical service contracts between the Hospital and providers of medical care as a representative of the Hospital Medical Staff.
Have the authority to recommend to the Executive Director suspension and termination of employees.

Review medical reports released under the name of the Hospital.

Facilitate the development of Hospital Medical Staff professional relationships.

Assist in the development and implementation of Hospital policies.

Ensure that the Hospital medical programs meet appropriate licensure and accreditation standards.

Make recommendations to the Medical Credentials/Peer Review Committee/Medical Staff regarding the approval of applicants to join the Hospital Medical Staff by interviewing all applicants requesting to join the Hospital Medical Staff and making written recommendations regarding appointment and privileges.

Represent the Hospital at hearings and other legal proceedings relative to patient care as requested.

10.7.3 Duties of the Nursing Home Medical Director. The Nursing Home Medical Director shall be the Chief Medical Officer of the Nursing Home and shall:

(a) Develop and implement Nursing Home policies governing resident medical care.

(b) Coordinate and supervise physician services and medical care in the Nursing Home.

(c) Coordinate the review, in accordance with Public Health Section 2805-j, of any physician, dentist, or podiatrist prior to granting or renewing professional privileges or association with the Nursing Home.

(d) Assure that each resident’s responsible physician attends to the resident’s medical needs, participates in care planning, follows the schedule of visits, and complies with Nursing Home policies.

(e) Advise the Nursing Home Administrator regarding medical and medically-related problems.

(f) Establish procedures for emergency physician coverage, records and consultants.

(g) Establish professional relationships with other institutions and agencies such as general hospitals, rehabilitation centers, home health agencies, hospital outpatient departments, clinics, and laboratories.

(h) Ensure that a licensed physician is available for consultation at all times, either through on-call coverage or by arranging alternate coverage with members of the Medical Staff.
(i) Act as a consultant in unusual and/or difficult clinical cases.

(j) Make medical decisions or institute medical treatment on any resident under urgent conditions when the attending physician is not available.

(k) Assist the Nursing Home Administrator in the direction and supervision of the Nursing Home’s performance improvement program in accordance with Nursing Home policies and the policies of accrediting organizations.

10.7.4. **Division Director.** The Division Director is a special staff officer. He shall belong to the Hospital Medical Staff and is appointed to one or more one-year terms. He shall coordinate patient care provided by the unit’s members with nursing and patient care services and with administrative support services.

(a) **Qualifications:** Division Directors shall be licensed to practice medicine in the State of New York and shall meet the requirements for membership on the Medical Staff.

(b) The Service Medical Directors shall be appointed by the Medical Director in consultation with the VP of Behavioral Health Services and Executive Director

10.7.5 **Duties of the Service Medical Director.**

(a) The Division Director shall account to the Hospital and to the Hospital Medical Director for all professional and clinical activities within his unit. He shall participate in quality improvement functions.

(b) The Division Director shall confer with unit staff about the operation of the program and the overall therapeutic milieu.

(c) The Division Director shall conduct or attend staff conferences as needed and patient treatment planning conferences as needed.

(d) The Division Director shall give guidance on the overall clinical policies of the Hospital and shall make specific recommendations and suggestions regarding the unit in order to assure quality patient care.

(e) The Division Director shall be responsible for implementing within the unit actions taken by the Medical Staff.

(f) The Division Director shall assist in teaching, education, and research programs on the unit (if applicable).

(g) The Division Director shall be responsible for informing the Hospital Medical Director of any deficiencies in professional support services on the unit.

(h) The Division Director shall inform the Hospital Medical Director of any planned absences from the Hospital in order that approved arrangements can be made for appropriate delegation of his responsibilities.
(i) The Division Director shall assist the Hospital Medical Director in developing new programs.

(j) The Division Director shall be responsible for, in conjunction with the Hospital Medical Director, implementing suggestions and recommendations from The Joint Commission and other inspecting organizations.
ARTICLE XI

MEDICAL STAFF MEETINGS, COMMITTEES AND FUNCTIONS

11.1 MEETINGS OF THE MEDICAL STAFF

11.1.1 Annual Meetings. There shall be an Annual Meeting of the joint Medical Staff. At this meeting, any retiring officers and committees shall make such reports as may be desirable and, every two (2) years a new President-Elect of the Medical Staff will be elected.

11.1.2 Regular Meetings. The Hospital Medical Staff and Nursing Home Medical Staff shall meet regularly as a group, separate from each other. These meetings shall be used for the purpose of reviewing and evaluating staff and committee reports, including performance improvement activities, and to act on any other matters placed on the agenda by the applicable Medical Director or President of the Medical Staff. The applicable Medical Director shall designate the time and place for all regular Medical Staff meetings. Notice shall be given of any change. Staff members will also be notified.

11.1.3 Special Staff Meetings. Special meetings of the joint Medical Staff may be called at any time by the Board, the Executive Director, the Medical Director, or a petition signed by not less than one-fourth of the active staff. In the event that it is necessary for the staff to act on a question without being able to meet, the active staff may be presented with the question by mail, and their votes returned to the Executive Director by voting email. Such a vote shall be binding so long as the question is voted on by a majority of the staff eligible to vote. Special meetings of the Hospital Medical Staff may be called at any time by the Hospital Administrator or Hospital Medical Director. Special meetings of the Nursing Home Medical Staff may be called at any time by the Nursing Home Administrator or Nursing Home Medical Director.

11.1.4 Notice of Special Meeting. A written notice stating the place, day, hour and purpose of any special meeting of the Medical Staff shall be e-mailed to each appointee eligible to vote, not less than seven (7) days before the date of such a meeting. No business shall be transacted at any special meeting except as stated in the notice calling the meeting.

11.1.5 Quorum. The presence of a majority of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any action to be taken. Notwithstanding anything herein to the contrary, a quorum once having been found, the business of the meeting may continue and all actions taken shall be binding, even though less than a quorum exists at a later time in the meeting. However, any member eligible to vote may call for a quorum at any time. If a quorum is not then present, no further action may be taken.

11.1.6 Agenda. The agenda at regular Medical Staff Meetings shall be at the discretion of the applicable Medical Director but shall normally include:

(a) Call to order.
(b) Acceptance of the minutes of the last regular and of all intervening special meetings.
(c) Report from the applicable Administrator to include Board activities.
(d) Report from the Medical Director.
(e) Committee reports, as required.
(f) Old business.
(g) New business.
(h) Adjournment.

11.1.7 Minutes. Minutes of each meeting shall be prepared and shall include a report of the attendance of members, and of the votes taken on each matter. The minutes will reflect resultant conclusions, recommendations, and actions taken. A summary of the Medical Staff meetings shall be presented to the Executive Leadership Committee at each of its meetings.

11.1.8 Voting. Any individual, who by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

11.1.9 Rules of Order. Wherever they do not conflict with these Bylaws, the currently revised Robert’s Rules of Order shall govern at meetings.

11.1.10 Absence from Meetings. Any member who is compelled to be absent from any staff or committee meeting shall promptly provide, to the regular presiding officer thereof, the reason for such absence. Unless excused for good cause shown, failure to meet the attendance requirements in Section 4.2. may be grounds for any of the corrective actions specified in Section 8.2.4. Reinstatement of a staff member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

11.1.11 Special Appearance. A Practitioner whose patient's clinical course of treatment is scheduled for discussion at a unit or committee meeting shall be so notified. The chairperson of the meeting shall give the Practitioner at least three days advance notice of the time and place of the meeting. Whenever apparent or suspected deviation from sound clinical practice is involved, Special Notice shall be given by the chairperson of the meeting and shall include a statement of the issue involved and that the Practitioner’s appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he was given such Special Notice shall, unless excused by the applicable Medical Director upon a showing of good cause, result in an automatic suspension of all or such portion of his clinical privileges as the applicable Medical Director may direct. Such automatic suspension shall remain in effect until the matter is resolved pursuant to these Bylaws.
11.2 EXECUTIVE LEADERSHIP COMMITTEE FUNCTION

The Executive Leadership Committee shall serve as the Executive Committee of the Medical Staff. The Executive Leadership Committee shall consist of the President of the Medical Staff (Chair), the Past President of the Medical Staff, the Hospital Medical Director, the Nursing Home Medical Director, the Executive Director, the V.P. of Behavioral Health Services and the V.P. of Senior Services. Members shall be removed once they no longer serve in the designated role. Other staff may be invited to participate in meetings of the Executive Leadership Committee at the discretion of the President of the Medical Staff or Executive Director. Minutes of Executive Leadership Committee meetings shall be maintained; such minutes shall report conclusions, recommendation and actions taken and indicate whether the Executive Leadership’s duties are performed. The Executive Leadership Committee shall meet as needed. Any member of the Executive Leadership Committee may submit agenda items to be added to the report to the Board, and may be requested to attend meetings of the Board, and participate in relevant discussions/presentations to the Board.

11.2.1 Duties. The duties of the Executive Leadership Committee in fulfilling this function shall be to:

(a) Coordinate the activities and general policies of the Medical Staff as they relate to clinical activities; receive and act upon reports and recommendations from the committees of the Medical Staff.

(b) Receive, review and act upon reports and recommendations from committees and the President of the Medical Staff concerning performance improvement activities and the discharge of their delegated administrative responsibilities, maintain a record of such review that includes resulting conclusions, recommendations, and actions taken. Make recommendations to the Board concerning performance improvement activities and mechanisms.

(c) Form and implement policies and procedures related to the Medical Staff.

(d) Recommend action to the Executive Director on matters of a medico-administrative nature.

(e) Be responsible for reviewing policies and procedures regarding the protection and care of patients and residents and others at the time of internal and external disaster.

(f) Fulfill its accountability to the Board for the medical care rendered to patients in the Hospital and residents of the Nursing Home.

(g) Be responsible for satisfaction and maintenance of The Joint Commission accreditation.

(h) Review the credentials of all applicants and make recommendations to the Board for staff membership, assignments to services and delineation of clinical privileges.
(i) Recommend to the Board all procedural matters relating to appointments, staff status, clinical privileges, credentialing mechanisms, corrective action and membership termination, staff structure, hearing procedures, and performance improvement activities.

(j) Review periodically all information available regarding the performance and clinical competence of Practitioners and as a result of such reviews make recommendations for reappointments and renewal of or changes to clinical privileges.

(k) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

(l) Assume responsibility for recommending programs for the Medical Staff in order to increase the quality of patient/resident care, and to enrich the professional growth of Medical Staff Members.

(m) Function as a Bylaws Committee and assume responsibility for making recommendations relating to revisions to and updating of the Bylaws, rules and regulations.

(n) Represent and act on behalf of the Medical Staff in the interim between Medical Staff meetings, and propose and approve, on behalf of the Medical Staff, the adoption or amendment of Rules and Regulations and policies of the Medical Staff.

11.2.2 Meetings, Reports and Recommendations. The Executive Leadership Committee shall meet as often as necessary to transact pending business. Minutes of the meetings of the Executive Leadership Committee shall be transmitted to the Board at each meeting of the Board.

11.2.3 Designation of Committees by Medical Staff. The Medical Staff, as may from time to time be necessary and desirable to perform staff functions, shall form standing or special committees of the staff to perform specified functions. Those functions requiring participation of, rather than direct oversight by the staff may be discharged by Medical Staff representation on such Corporation management committees as are established to perform such functions. The Medical Staff shall be represented and may participate in administrative deliberations affecting the discharge of Medical Staff responsibilities.

11.3 STAFF FUNCTIONS

11.3.1 General Functions of the Hospital Medical Staff. Provision shall be made, either through assignment to Medical Staff committees or to Hospital management committees, for the performance of the staff functions specified in this section and described in Section 11.4., of all other staff functions required by these Bylaws of the Hospital Medical Staff, and of such other staff functions as the Medical Staff or the Board shall require. The following are functions of the Hospital Medical Staff:
(a) Conduct and review patient care audit and monitoring activities.
(b) Conduct and review utilization management activities.
(c) Review credential investigations and recommendations regarding staff status and clinical privileges.
(d) Monitor and evaluate care provided in and develop medical policy for: special care areas; patient care support services; and emergency, outpatient, home care, and other ambulatory care services. Review policy/procedure manuals for clinical services.
(e) Provide medical education, responsive to the needs of patient care and Hospital staff in cooperation with Hospital administration.
(f) Require that patient medical and related records are completed in a timely manner and are clinically pertinent.
(g) Develop and maintain surveillance over special treatment procedures and drug utilization policies and practices.
(h) Coordinate the care provided by Practitioners and other professionals with the care provided by the nursing service and other Hospital patient care and administrative services.
(i) Monitor programs for control of Hospital-acquired infections and their prevention.
(j) Develop and implement staff programs and activities necessary to maintain Hospital accreditation.
(k) Plan for professional response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.
(l) Develop and monitor programs to manage risk related to clinical aspects of patient care and safety.
(m) Develop and monitor a program for performance improvement of the Medical Staff.
(n) Periodically review and revise the Bylaws, Rules and Regulations and policies of the Hospital Medical Staff.
(o) Develop and review a therapeutic environment and safety program.

11.3.2 General Functions of the Nursing Home Medical Staff. Provision shall be made, either through assignment to Medical Staff committees or to Nursing Home management committees, for the performance of the staff functions specified in this section and described in Sections 11.4.1, 11.4.3, 11.4.4, 11.4.5, 11.4.7, 11.4.8, 11.4.9 and 11.4.11, of all other staff functions required by these Bylaws for the Nursing Home Medical Staff, and of such other staff functions as the
Medical Staff or the Board shall require. The following are functions of the Nursing Home Medical Staff:

(a) Conduct and review resident care audit and monitoring activities.

(b) Review credential investigations and recommendations regarding staff status and clinical privileges.

(c) Provide medical education, responsive to the needs of resident care and Nursing Home staff in cooperation with Nursing Home administration.

(d) Require that resident medical and related records are completed in a timely manner and are clinically pertinent.

(e) Coordinate the care provided by Practitioners and other professionals with the care provided by the nursing service and other Nursing Home resident care and administrative services.

(f) Monitor programs for control of Nursing Home-acquired infections and their prevention.

(g) Develop and implement staff programs and activities necessary to maintain Nursing Home accreditation.

(h) Plan for professional response to fire and other disasters, for Nursing Home growth and development, and for the provision of services required to meet the needs of the community.

(i) Develop and monitor a program for performance improvement of the medical staff.

(j) Periodically review and revise the Bylaws, Rules and Regulations and policies of the Nursing Home Medical Staff.

11.4 DESCRIPTION OF FUNCTIONS

11.4.1 Patient Care Audit and Monitoring Function. The duties involved in conducting and reviewing departmental and staff patient care audit and monitoring programs are to:

(a) Adopt, subject to the approval of the Medical Staff and the Board, specific programs and procedures for reviewing, evaluating and maintaining the quality, uniformity, and efficiency of patient/resident care within the Hospital and Nursing Home, and for reviewing and evaluating the clinical performance of all professionals with clinical privileges, including procedures for: (1) establishing active criteria which reflect current knowledge and clinical expertise; (2) routinely collecting information about important aspects of patient care and about members’ clinical performance to measure actual practice against the criteria; (3) analyzing practice variations from criteria by peers; (4) taking appropriate action to correct identified problems; (5) following up on action taken; and (6)
documenting and reporting the findings and results of the audit activity to the Medical Staff, the CEO and the Board.

(b) Review and act upon factors affecting the quality, uniformity, and efficiency of patient/resident care provided in the Hospital and Nursing Home.

(c) Coordinate the findings and results of medical committees; staff audit procedures; utilization review activities; medical record completeness, timeliness and clinical pertinence; and other staff activities designed to monitor patient care practices.

(d) Identify opportunities to improve patient care and identify important problems in patient care. When such opportunities or problems are identified, the effectiveness of the actions taken are evaluated, and the actions taken are documented and reported to the Medical Staff.

(e) Ensure that all Practitioners provide services within the scope of individual clinical privileges granted.

11.4.2 Utilization Management Function. The duties involved in conducting and overseeing the utilization management function are to:

(a) Participate in the development of a utilization management plan based on patient needs appropriate to the Hospital and that meets the requirements of law. Such a plan shall include provision for: (1) review of admissions and of continued Hospital stay; (2) discharge planning; and (3) data collection and reporting.

(b) Require that the utilization management plan be in effect, known to the staff members and functioning.

(c) Conduct such studies, take such actions, submit such reports and make such recommendations as are required by the utilization plan.

11.4.3 Credentials/Peer Review Function. The duties involved in coordinating and reviewing credential/peer review investigations and recommendations are to:

(a) Review and evaluate the qualifications of each applicant for initial appointment to staff status, reappointment or modification of appointment and/or clinical privileges, and in connection therewith to obtain and consider the recommendations of the Service Medical Directors as appropriate.

(b) Submit a report, as required by these Bylaws, to the Executive Leadership Committee on the qualifications of each applicant for staff status or clinical privileges. Such report shall include recommendations with respect to appointment, staff status, unit affiliation, clinical privileges, and special conditions attached thereto.

(c) Investigate, review, and report on matters, including the clinical or ethical conduct of any professional assigned or referred to it by:
(1) the President of the Medical Staff
(2) the Medical Directors, or
(3) those responsible, respectively, for functions described in Sections 11.4.1. and 11.4.2.

(d) The Credentialing/Peer Review Committee shall be comprised of the Hospital Medical Director (Chair), the Nursing Home Medical Director, a member of the Hospital Medical Staff, and a member of the Nursing Home Medical Staff. The Nursing Home Administrator and Hospital Administrator shall be ex-officio members of the Committee.

11.4.4 Continuing Medical Education Function. The duties involved in organizing continuing medical education programs are to:

(a) Develop and plan programs of continuing medical education which are designed to keep the Medical Staff and other staff informed of significant new developments and new skills in the field of clinical care which are responsive to evaluation and relevant to the type of patient care delivered in the Hospital or Nursing Home, as well as to performance improvement findings and members’ educational needs.

(b) Act upon continuing medical education recommendations from the Medical Staff, the medical services or other committees responsible for patient care audit and other performance improvement and monitoring functions.

11.4.5 Medical Records Function. The duties involved in maintaining patient and resident medical records that are complete, timely and clinically pertinent are to:

(a) Review patient and resident treatment plans to ensure that a treatment plan is developed promptly for each patient/resident, is reappraised as appropriate, and is considered, followed, and reviewed by members of the appropriate treatment team.

(b) Review and evaluate medical records to determine that they (1) adequately describe the diagnosis, condition and progress of the patient/resident, the therapy provided, results thereof, and results of diagnostic tests, discharge condition, and the identification of responsibility for all actions taken; (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient/resident care services in the Hospital or Nursing Home; and (3) are adequate in form and content to permit patient/resident care audit and other performance improvement activities to be performed.

(c) Review staff and administrative policies, rules and regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage and availability, and recommend methods of enforcement and changes. Review summary information regarding the timely completion of medical records.
(d) Act upon recommendations from the Medical Staff or other committees responsible for patient/resident care audit and other performance improvement monitoring functions.

(e) Provide liaison with facility administration and medical records personnel on matters relating to medical records practices.

(f) Maintain a record of conclusions, recommendations, all actions taken, and results of actions, and submit periodic reports and recommendations to the Medical Staff concerning medical records practices in the Hospital or Nursing Home.

11.4.6 Special Treatment Procedures and Pharmacy and Therapeutic Function. The duties involved in developing and maintaining surveillance over special treatment procedures and drug utilization policies and practices are to:

(a) Assist in the formulation of policies and conduct reviews, with respect to special treatment procedures, including restraint and seclusion.

(b) Assist in the formulation of policies regarding evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the Hospital. This function includes policies regarding drugs which have abuse potential or significant side effects.

(c) Advise the Hospital Medical Staff and the Hospital's pharmaceutical department on matters pertaining to the choice of available drugs.

(d) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(e) Develop and review periodically a formulary or drug list for use in the Hospital.

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(g) Maintain a record of activities relating to the pharmacy and special treatment procedures function and submit periodic reports to the medical staff concerning drug utilization and special treatment procedures policies and practices in the Hospital, including findings, conclusions, recommendations, actions taken, and results of actions taken.

(h) Review and evaluate all significant untoward drug reactions.

(i) Establish standards concerning the use and control of any investigational drugs and of research in the use of recognized drugs.

(j) Perform such other duties as are assigned by the Hospital Medical Director or the Medical Staff.
11.4.7 **Infection Control Function.** The duties involved in preventing, investigating and controlling Hospital-acquired or Nursing Home-acquired infections are to:

(a) Maintain surveillance of Hospital or Nursing Home infection potentials.

(b) Identify and analyze the incidence and cause of infections to the extent practical.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards.

(d) Act upon recommendations related to infection control received from the Medical Directors, the Medical Staff, and other staff and administrative committees.

(e) Review infection control in all phases of the facilities’ activities including, if applicable, isolation procedures; testing of personnel for carrier status; disposal of infectious material; and other situations as requested by the Medical Staff.

11.4.8 **Disaster Planning Function.** The duties involved in planning to provide appropriate professional response to, and the protection and care of Hospital patients, Nursing Home residents and others at the time of internal and external disasters are to:

(a) Develop and periodically review, in cooperation with the facility administration, a written plan designed to safeguard patients and residents at the time of an internal disaster and require that all key personnel rehearse fire and other types of disaster drills.

(b) Develop and periodically review, in cooperation with the facility administration, a written plan for the care, reception and evacuation of mass casualties, and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital and Nursing Home, that adequately relates to other available resources in the community and coordinates the facilities’ role with other agencies in the event of disasters in the Hospital or Nursing Home.

11.4.9 **Bylaws Review and Revision Function.** The duties involved in maintaining appropriate Bylaws, rules and regulations and other organizational documents pertaining to staff, in order to establish a structure for self-governance of staff activities and accountability to the Board are to:

(a) Conduct a review of the Bylaws and the rules, regulations, procedures and forms promulgated in connection therewith, as needed.

(b) Submit recommendations to the Medical Staff, the Executive Leadership Committee and to the Board for changes in these documents when necessary.
(c) Act upon all matters concerning the Bylaws as may be referred by the Board, Medical Staff, the Medical Directors, the Executive director and committees of the staff.

11.4.10 **Therapeutic Environment and Safety Function.** The duties involved in planning to provide an appropriate therapeutic environment and adequate safety are to review, in cooperation with the Hospital administration, procedures and facilities for maintaining an environment which enhances the self image of patients and preserves their human dignity and maintaining functional safety and security for patients, employees, and visitors.

11.4.11 **Medical Staff Performance Improvement Function.** The duties involved in the performance improvement function are to:

(a) Participate in developing mechanisms to assure a uniform quality of patient and resident care and the accountability of the Medical Staff for the care provided, which mechanisms shall be described in the Corporation's performance improvement plan.

(b) To perform the Medical Staff function of the Corporation's performance improvement program, including annual reappraisal of the performance improvement program, problem identification, problem assessment, problem correction, and problem correction monitoring.

11.4.12 **Risk Management Function.** The duties involved in participating in risk management activities related to clinical aspects of patient care and safety are to:

(a) Identify general areas of potential risk in the clinical aspects of patient care and safety.

(b) Develop criteria for identifying specific areas with potential risk in the clinical aspects of patient care and safety, and evaluate these cases.

(c) Correct problems in the clinical aspects of patient care and safety identified by risk management activities.

(d) Design programs to reduce risk in the clinical aspects of patient care and safety.

11.5 **COMMITTEES OF THE STAFF**

11.5.1 **Composition and Appointment.** Unless otherwise expressly provided, a staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of members of the active staffs and may include, in the discretion of the Medical Directors with the concurrence of the Executive Director representation from administration, nursing service, medical records service, pharmaceutical service, social work and other such Corporation services as are appropriate to the function to be discharged.

11.5.2 **Vacancies.** Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.
11.5.3 **Meetings.** A Staff Committee established to perform one or more of the staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties.

11.5.4 **Removal.** Any committee members may be removed by the individual or entity which elected or appointed the committee member.
ARTICLE XII

GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES, REGULATIONS AND POLICIES

Rules, regulations, and policies as may be necessary to implement more specifically the general principles found within these Bylaws or to regulate the proper conduct of Medical Staff organizational activities and the clinical practices that are required of each Practitioner may be adopted by the Executive Leadership Committee or proposed by the Medical Staff, subject to the approval of the Board, in accordance with the following procedures:

(a) Except as provided in paragraph (b) of this Section 12.1, any proposed rule or regulation, or amendment thereto, being considered by the Executive Leadership Committee shall be communicated to the Members of the Medical Staff before the proposed rule or regulation is adopted by the Executive Leadership Committee and sent to the Board for approval. The Executive Leadership Committee, in its discretion, may permit the Members of the Medical Staff to attend any meeting of the Executive Leadership Committee for the purpose of commenting upon any proposed rule or regulation or amendment thereto.

(b) In the event there is a documented need for an urgent amendment to rules and regulations of the Medical Staff, or the adoption of a new rule or regulation of the Medical Staff, necessary to comply with law or governmental regulation, the Executive Leadership Committee may provisionally adopt, and the Board may provisionally approve, an urgent amendment to the rules and regulations of the Medical Staff without prior communication to the Medical Staff. In such event the provisional amendment shall be promptly communicated to the Medical Staff, and Members of the Medical Staff may submit to the Executive Leadership Committee any comments regarding the amendment. Upon petition signed by at least fifty-one percent (51%) of the Members of the Medical Staff, the provisional amendment may be submitted to the conflict management process described in Section 12.2 of this Article. The results of the conflict management process shall be communicated to the Executive Leadership Committee, the Medical Staff and the Board. Any repeal or revision of a provisional amendment shall be subject to approval by the Board.

(c) Any policy adopted by the Executive Leadership Committee and approved by the Board shall be promptly communicated to the Medical Staff.

(d) Any communication to the Medical Staff required under this Article may take any one or more of the following forms: regular mailing, bulletin board posting, announcement during departmental meetings, announcement during meetings of the Medical Staff or email. The manner of giving such communications shall be determined in the sole discretion of the Executive Leadership Committee, and the failure of any Members of the Medical Staff to receive such communication or actual notice of any action by the Executive Leadership Committee or the Board
shall not invalidate any rule, regulation or policy, or amendment thereto, approved by the Executive Leadership Committee and the Board.

(e) Rules, regulations and policies, and amendments thereto, may also be proposed to the Board by the Medical Staff, by majority vote of the Members of the active staff entitled to vote, present at any regular or special meeting of the Medical Staff. Any such proposal may be brought before the Medical Staff by petition signed by at least fifty-one percent (51%) of the Members of the active staff, and the proposal must be submitted to the Executive Leadership Committee for review and comment before such proposed rule, regulation, or policy, or amendment thereto, is voted on at a Medical Staff meeting. Any rule, regulation, or policy, or amendment thereto, approved by the Medical Staff shall be presented to the Board along with any comments from the Executive Leadership Committee.

(f) All rules, regulations or policies of the Medical Staff shall become effective only after approval by the Board.

12.2 CONFLICT MANAGEMENT

The following conflict management process shall be followed in the event of conflict between the Executive Leadership Committee and the Medical Staff regarding a proposed or adopted medical staff By-law, medical staff Rule and Regulation, or associated medical staff policy, or other significant matter under the purview of the Medical Board. A written petition to trigger the conflict management process signed by at least seven (7) members of the Medical Staff shall be submitted to the President of the Medical Staff. The petition shall include (a) a clear statement of the reason for the conflict and the terms of any alternative By-law, Rule and Regulation or associated policy, and (b) the designation of 3 members of the Medical Staff as selected by the petitioners to serve as the petitioners’ representatives.

Within one week after receipt of the petition, the President of the Medical Staff shall convene a meeting between the 3 petitioners’ representatives and 3 non-petitioner members of Executive Leadership. The 3 non-petitioner members shall be members of the Medical Staff whenever possible.

These representatives shall exchange information relevant to the conflict and shall work in good faith to resolve differences within thirty (30) days of their first meeting, in a manner that respects the positions of the Medical Staff, the leadership responsibilities and the safety and quality of patient care at the Hospital. Resolution of the matter shall require a majority vote of the 3 representatives of the non-petitioners and a majority vote of the 3 petitioners’ representatives. If such a resolution proposes a medical staff By-law, medical staff Rule and Regulation, or associated medical staff policy that has not been previously submitted to the Medical Staff, such resolution shall follow the process outlined in Article XIII.

If the parties’ representatives are unable to reach a resolution, they may, by mutual agreement, utilize the System Chief Medical Officer and/or other persons skilled in conflict management to assist in resolving their conflict. Differences that remain unresolved after the expiration of the above thirty-day period shall be submitted to the Board of Trustees for its consideration in making a final decision with respect to the proposed medical staff By-law, medical staff Rule and Regulation, or associated medical staff policy, or other matter. The Board of Trustees shall determine the method by which unresolved conflicts are submitted to the Board.
At all times the participants in the conflict management process shall observe the following principles:

- Resolution of all conflicts shall be undertaken in a manner that promotes productive, collaborative, and effective teamwork, and in an atmosphere of mutual respect and understanding.

- Resolution of the conflict shall be consistent with the organization’s mission, values, strategic objectives, policies and organizational ethics; shall protect patient safety and quality of care; and shall best serve the interests of the patient.

- All discussions regarding the issues that are the subject of the conflict shall be confined to internal communications, and the highest level of confidentiality shall be maintained with respect to such discussions and issues. Communication to the public with respect to the issues is not appropriate.

12.3 **EXCLUSIVE MEANS**

These Bylaws provide the sole and exclusive means for the delivery of patient services by professionals at the Hospital and Nursing Home. Except as otherwise specifically provided by these Bylaws no professional shall deliver any such services at the Hospital or Nursing Home unless such professional has been granted privileges hereunder to deliver such services at the Hospital or Nursing Home.
ARTICLE XIII

AMENDMENT OF BYLAWS

13.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the responsibility and authority to formulate, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally professionally recognized level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community. These Bylaws may be amended in the manner set forth in Section 13.2 of this Article. No amendments to these Bylaws shall be effective until approved by the Board in the manner set forth in Section 13.2.3 of this Article.

13.2 METHOD

Medical Staff Bylaws may be amended in the following manner:

13.2.1 Amendments Initiated by the Executive Leadership Committee. All proposed Bylaws amendments approved by the Executive Leadership Committee shall be submitted to the Medical Staff for approval. Bylaws amendments shall be subject to the approval by a majority of the Members of the active staff voting on the proposed amendment. Proposed amendments may be voted on at any regular or special meeting of the Medical Staff or submitted to the Members of the active staff by written or electronic ballot according to such procedures as are approved by the Executive Leadership Committee.

13.2.2 Amendments Initiated by Vote of the Medical Staff. These Bylaws may be amended after notice given at any regularly scheduled or special meeting of the Medical Staff, assuming the required quorum is present. Voting on the proposed amendments shall take place at a regular or special Medical Staff meeting following the meeting at which notice was given, provided the proposed amendment must be submitted to the Executive Leadership Committee for review and comment before it is submitted to the Medical Staff for a vote.

13.2.3 Approval by the Board. Bylaws amendments approved by the Medical Staff shall be forwarded, together with any comments of the Executive Leadership Committee, to the Board, which shall approve, disapprove or approve with modifications. If the Board modifies any amendment approved by the Medical Staff, such amendment, as modified, shall be returned to the Executive Leadership Committee, which may accept or reject the modifications adopted by the Board. If the Executive Leadership Committee accepts the modifications, the amendment shall be submitted to the Medical Staff for approval or disapproval in accordance with Section 13.2.2 of this Article. If the Executive Leadership Committee rejects the modifications, the amendment shall again be submitted to the Board, which may either approve or disapprove
the amendment as approved by the Medical Staff.

13.3 REVIEW

The Bylaws of the Medical Staff shall be reviewed as needed and amended as is appropriate at any time.

13.4 COMMUNICATION

A copy of the Bylaws shall be provided to all Medical Staff members upon initial appointment. Copies which include any revisions made during the course of any year shall be made available to all Medical Staff members.
ARTICLE XIV
CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

14.1.1 INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, letters, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5.2.

14.1.2 MALICE means the purposeful dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

14.1.3 PRACTITIONER means a staff member or applicant.

14.1.4 REPRESENTATIVE means the Board, any member or committee thereof; the CEO; the Administrators; the Medical Staff organization and any member, officer, unit, service or committee thereof; and any individual authorized by any of the foregoing or these Bylaws to perform information gathering, disseminating, communicating or evaluating functions.

14.1.5 THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATIONS AND CONDITIONS

By applying or reapplying for, or requesting or exercising staff status or clinical privileges pursuant to these Bylaws a Practitioner:

14.2.1 Authorizes representatives and the Corporation to solicit, provide, receive, review, evaluate, verify and act upon information bearing on his professional ability, current clinical competence, qualifications, utilization history, training, background, ethics, physical and mental health, emotional stability, and any other matter relevant to his application, reapplication or exercise of privileges.

14.2.2 Agrees to be bound by the provisions of this Article and to waive forever all legal and equitable claims and actions (whether known or unknown to the Practitioner) against the Corporation, any representative or third party who acts in accordance with the provisions of this Article.

14.2.3 Acknowledges that the provisions of this Article are express conditions to his application or reapplication for or acceptance of staff status and/or clinical privileges, or his exercise of clinical privileges at the Hospital or Nursing Home.
14.3 **CONFIDENTIALITY OF INFORMATION**

Information with respect to any Practitioner submitted, collected or prepared by any representative for the purpose of performing functions under these Bylaws, achieving and maintaining quality patient care, reducing morbidity and mortality, reviewing or evaluating Practitioner performance, or contributing to medical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's files or of the general Corporation records. Breach of confidentiality by response to legal process apparently valid on its face or exercise of legal rights by or on behalf of or in respect of a patient shall not nullify or void any other provision of this Article.

14.4 **IMMUNITY FROM LIABILITY**

14.4.1. **For Action Taken.** Neither the Corporation nor any representative shall be liable for damages or other relief for action taken or statement or recommendations made within the express or implied or reasonably inferable scope of its or his duties, if such acts are taken or made without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the acts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts as the same are believed to exist by the Corporation or such representative or by reasonable inferences made from such facts as the same are believed to exist by the Corporation or such representative. Regardless of the provisions of State law and without limiting other defenses (including defense based on this section 14.4.), truth shall be an absolute defense in all circumstances.

14.4.2 **For Providing Information.** Neither the Corporation, any representative nor any third party shall be liable for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to the Corporation or a representative or to any other hospital, state or other licensing or similar agency or board, physician data bank maintained on a state-wide or national basis, organization of health professionals or other health-related organization concerning a Practitioner who is or has been an applicant or reappointment applicant or member or holder of staff status or who did or does exercise clinical privileges at the Hospital or Nursing Home, provided that the Corporation, such representative or third party acts without malice.

14.5 **ACTIVITIES AND INFORMATION COVERED**

14.5.1 **Activities.** The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, letters, or disclosures performed or made and all meetings held in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment, staff status or clinical privileges.
(b) Periodic reappraisal for reappointment, renewal of staff status or clinical privileges.
(c) Corrective action.
(d) Hearings and appellate reviews.
(e) Patient care audits.
(f) Utilization management activities.
(g) Other facility, staff, or committee activities relating to monitoring and evaluating quality patient care and appropriate professional conduct.
(h) Other staff functions provided by these Bylaws.

14.5.2 Information. The information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, training, background, experience, character, utilization history, physical and mental health, emotional stability, professional ethics, and current clinical competence, or any other matter that might directly or indirectly affect patient care.

14.6 RELEASES

Each Practitioner shall, at any time and from time to time upon request of the Corporation, execute general and specific releases in accordance with the tenor and import of this Article, subject to the requirements and conditions of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article.

14.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality or information, and immunities from liability shall be in addition to other protection provided by law and not in limitation thereof.
THE LONG ISLAND HOME

REVIEW OF MEDICAL STAFF BYLAWS

SIGNATURE PAGE

Reviewed by the Medical Staff

Kiran Kamdar, MD; President

Date: 12.21.15

Reviewed by the Hospital Medical Director

Tina Walch, MD

Date: 12/18/15

Reviewed by the Nursing Home Medical Director

Hena Siddiqui, MD

Date: ______________

Reviewed by the Executive Director

Patricia A. Porter

Date: 12-18-15

Reviewed by the Board of Trustees

Robert F. Rose

Date: 12/16/15
1. **Availability**

Each member of the Medical Staff who is not within one hour travel time from the Hospital for a continuous period of twelve hours or more or who is not able to care for his patients must arrange for coverage. In case of failure in this regard, the Medical Director or the Administrator of the Hospital shall have authority to call any member of the staff to provide coverage.

Each member of the Medical Staff must respond to a telephone call from the Hospital within the following time:

- Message includes 222.................. - Immediately
- Message with #1 following............ - 20 minutes
- Message with #2 following or no number - 2 hours

If there is no response, the Service Division Director, the Medical Director or the Administrator of the Hospital shall have the authority to call any member of the staff should he consider it necessary to assure the temporary direction of professional care for any patient of the Medical Staff member failing to respond.

2. **Absence of Physician/NP**

When any physician/NP is unable to attend to his/her patient in the Hospital, he/she shall leave with Medical Records the name of the covering prescriber, to be called in the case of an emergency, who will fully function during the absence of the attending physician/NP. A covering prescriber shall have appropriate privileges as an active, courtesy, or temporary member of the staff.

3. **Sentinel event**

A Sentinel event that occurs at the hospital, will be referred to a Root Cause Committee (RCA). The RCA Committee shall be comprised of the Medical Director, the Director of Quality management, appropriate Medical leadership as designated by the Medical Director, the attending physician and such other individuals as are appointed by the Executive Director. The function of the RCA will be to investigate the events leading up to the death. The Committee shall carefully review the medical record. The Committee will also review the findings of the autopsy, if performed. Based upon the Committee findings a report and, if necessary, recommendations will be forwarded to the Medical Staff and the appropriate committees.
4. Autopsy

Every member of the Medical Staff is expected to encourage families to consent for an autopsy in the event of an unexplained death. The attending physician shall be involved in this process. No autopsy shall be performed without proper written consent.

5. Attending Practitioner

Admission to the inpatient or partial hospitalization program requires an order from a physician or nurse practitioner/Physician assistant under the direction of a physician credentialed to admit such patients. Attending practitioners will provide care in accordance with state laws and criteria for standards of medical care established by the Medical Staff.

6. Standing Orders

There shall be no general standing orders. All orders must be specified for each patient.

7. Orders

a. Admitting orders shall be given before or at the time of admission.

b. All orders for treatment and medications must be, dated and timed by the prescriber. All orders for treatment dictated over the telephone shall be received/entered by the Registered Nurse or other legally authorized professional to whom dictated and entered in the computer with a ‘read back’ prior to finalization. They must be electronically signed by the authorized prescriber within 24 hours of the verbal order.

c. Orders may be written by a Nurse Practitioner or Physician Assistant as allowed by New York State Law.

d. Written orders for other consultations, and diagnostic procedures including but not limited to radiology, EEG and psychological testing shall contain rationale for the request.

8. Expiration of Medication Orders

All medication expirations are to be handled in accordance with the Directive Manual of Long Island Home/South Oaks Hospital.

9. Automatic Drug Stop Orders
Groups of drugs as specified in the Policy and Procedure Manual of the Pharmacy shall have automatic stop dates and shall be discontinued in the prescribed time frames unless:

a. The prescriber’s order indicated an exact period of time the medication is to be administered, not to exceed the maximum period; or

b. The prescriber reorders the medication.

10. Admitting Diagnosis

Each patient admitted to the inpatient psychiatric program or psychiatric partial hospitalization program must have an appropriate diagnosis by the admitting prescriber recorded in the medical record.

11. Admission Workup

Each patient admitted for inpatient care or to the psychiatric partial hospitalization program shall be assessed no more than 24 hours prior to admission to the Hospital.

a. Inpatient Admission Workup -- Physical

Each patient admitted to the Hospital shall have an appropriate medical history, routine physical examination and appropriate laboratory work. The medical history and initial physical examination shall be completed within 24 hours after admission.

An additional physical examination should be ordered when clinically appropriate as determined by the medical needs of the patient. The initial examination need not be repeated if the patient is readmitted within 30 days of discharge; however, an interim/update note will be required.

Laboratory work should be completed as is clinically indicated.

b. Admission Workup -- Psychiatric

Each patient admitted to the inpatient psychiatric hospital programs and psychiatric partial hospitalization program has a psychiatric history, mental status examination and admitting diagnosis within 24 hours of admission. This information is recorded in the medical record. The attending prescriber then reviews this material, completes the first hospital day note and the psychiatric section of the Treatment Plan within 72 hours, adjusts the diagnosis if needed, and then records subsequent changes in the patient's condition in the progress notes. For patients under 18 years of age, the developmental history is included.

Intra System Transfer
APPENDIX I

Any time a patient needs to be moved from one unit or service of care to another, an order must be written prior to the transfer taking place.

12. **Prescriber Visits and Progress Notes**

   a. Patient’s are evaluated on a regular basis by the clinical staff. The number of visits shall be determined by the standard of care and any applicable billing requirements. Visits may be conducted by a psychiatrist, a Physician Assistant or a nurse practitioner. Progress notes shall be written by all staff members having significant participation in the program of treatment or care.

   b. For the detox program, the patient is evaluated at least once per shift by the nursing staff for the first five days and once per day thereafter. The number of prescriber visits shall be determined by the standard of care and any applicable billing requirements. Prescriber visits may be conducted by a psychiatrist, Physician assistant, or nurse practitioner, according to the appropriate standard of care. Progress notes shall be written for each visit by the clinical staff member providing the service. If more frequent services are required, clinical staff members shall document the provision of care and services in the patient’s medical record.

   c. For alcoholism/chemical dependency rehabilitation program patients, the patient is seen at least once per week by a prescriber. The number of visits shall be determined by the standard of care and any applicable billing requirements. Visits may be conducted by a psychiatrist, PA, or nurse practitioner, according to the appropriate standard of care. Progress notes shall be written by the responsible clinical staff member no less often than once per week.

   d. For the partial hospitalization program patients, a progress note shall be written for each visit or contact with the patient by the responsible clinical staff member.

   e. For the outpatient programs, progress notes must be written, signed and dated by the clinical staff member providing the services. In the outpatient mental health program, progress notes must be written for each visit.

13. **Consultations**

   It is the duty of the Medical Staff to see that consultants are utilized as needed. The consultant shall be qualified to give an opinion and be privileged in the field in which his opinion is sought. All consultations shall have a written order. A satisfactory consultation includes examination of the patient and a written opinion signed by the consultant, which is made a part of the medical record. In circumstances of grave urgency, or where consultation is required by the Rules and Regulations of the Hospital, the Medical Director shall have the right to call a consultant or consultants.

14. **Treatment Plans**
APPENDIX I

The attending physician's/NP's/PA's portion of the treatment plan must be completed within 72 hours of admission and updated to reflect current patient condition. Attending practitioners shall attend treatment team meetings to discuss treatment needs and discharge plans. Updates to the treatment plan and finalizing signatures must be completed according to OMH/OASAS guidelines...

15. Restraint and Seclusion Orders

Restraint or seclusion will be employed only as a final alternative when other methods of control are deemed inadequate to prevent the patient from harming himself or others. Only physicians may order restraints, the rationale and authorization for the use of seclusion or restraint shall be clearly set forth in the patient's record by the attending physician or authorizing practitioner. Use of restraint or seclusion shall comply with the procedure specified in the Hospital Directive Manual.

16. Restrictions

The attending prescriber may impose restrictions on visitation, telephone calls, or other communication or activities only to the extent that the restriction is necessary to the individual's welfare or to protect another person. The prescriber shall document the reasons for the restriction and the duration of the restriction in the medical record. Any such restrictions shall not limit the patient's right to communicate with legal counsel, the courts, the Commission on Quality of Care or Mental Hygiene Legal Service.

17. Patient Use of Own Medications

The use of patient's own medication is allowed only as specified in Pharmacy Policy and Procedure. The medication must be physically identified by the pharmacist or their designee, approved by the treating prescriber, and administered by the nursing staff, unless unit policy allows self-administration under defined circumstances.

18. Patient Discharge

Patients shall be discharged only on written order of the attending prescriber or his/her designee. Unless medically indicated, the attending prescriber is not required to see the patient prior to discharge. The responsible clinical staff member or multi-disciplinary team shall develop a discharge plan and discharge instructions, which shall be co-signed by the attending prescriber, and a copy given to the patient and/or family. When it is not possible to do so, the reason must be indicated in the record. In addition to any other information transmitted, the patient and/or family member is asked to bring the discharge plan to the first visit, when referral is made to an outside provider for aftercare.
19. **Administrative Discharges**

Administrative discharges may occur when it is determined that inpatient treatment is no longer appropriate. A recommendation for administrative discharge may originate from the Medical Director, or Service Medical Director. In the event administrative discharge is recommended contrary to the wishes of the attending physician, the Medical Director shall write the order for discharge, allowing up to 72 hours for disposition being prearranged.

20. **Discharge Summary**

The discharge summary shall be completed within 3 days discharge.

21. **Medical Records**

All records are the property of the Hospital. Inpatient and psychiatric partial hospitalization records shall not leave the Medical Records Department, except to the nursing unit in case of a readmission, to committee meetings of the Medical Staff, and under court order. In case of readmission of a patient, all previous records shall be available for the use of the attending physician/NP/PA. This shall apply whether the patient is attended by the same physician/NP/PA or by another.

a. **Medical Records - Inpatient Psychiatric and Psychiatric Partial Hospitalization**

A. The medical record standards will reflect the requirements in the current Joint Commission and Medicare guidelines.

b. **Medical Records - Inpatient Rehab, Outpatients and Alcoholism Partial Hospital**

Records of inpatient rehab, outpatients and alcoholism partial hospitalization patients shall be kept in accordance with the policy and procedure of those programs.

c. **Medical Records - Progress Notes.**

Progress notes may be entered into the medical record by all members of the clinical treatment team involved in the assessment, treatment and aftercare planning of the patient and family.

22. **Confidentiality of Medical Records**

All members of the Medical Staff shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the Hospital, or by business associates of the Hospital, in accordance with any and all health information privacy policies adopted by the Hospital to comply with current Federal, State and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Protected health information shall not be
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requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the Hospital. Inappropriate accessing of PHI may result in disciplinary action, in accordance with health system policies, up to and including termination.

23. Health Information Consents and Privacy Authorizations

Members of the Medical Staff shall cooperate with Hospital personnel in obtaining and documenting or maintaining in the medical record any and all patient consents and patient authorizations required under any and all health information privacy policies adopted by the Hospital to comply with current Federal, State and local laws and regulations, including, but not limited to, HIPAA.

24. Symbols and Abbreviations

The hospital maintains a list of unapproved abbreviations and symbols that may not be utilized in the official medical record.

25. Utilization Review

The Hospital Utilization Review (UR) plan which describes the UR function and includes specific procedures, is available to the Medical Staff and is in accordance with North Shore LIJ policy.

26. Performance Improvement Profile

There will be an ongoing Performance Improvement Profile kept on each Medical Staff member; the prescriber group shall participate in the selection of the ongoing performance measures.

27. Involvement in Professional Liability Action

Members of the Medical Staff must inform the Medical Director of any investigation or proceeding that may affect the member's license or ability to participate in a federal healthcare program or any professional liability action within one month of initiation of such action. Medical Staff members shall disclose as much information with respect to such action as is requested by the Medical Director. Final verdicts, judgments, agency actions or settlements involving the individual must be reported to the Medical Director immediately.

28. Psychoactive Medication and Minors

A psychoactive medication (including anti-psychotic or neuroleptic, antidepressants, agents for the control of mania or depression, anti-anxiety agents, sedatives, hypnotic, or other sleep promoting drugs, and psychomotor stimulants) cannot be prescribed without first obtaining an informed consent by the patient or legal guardians except as follows (1) the patient is in an emergency situation (2) The patient is a minor or does not have the capacity to consent and the patient's representative authorized by law to
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consent on behalf of the patient has consented to the administration; or (3) administration of the medication regardless of the patient's refusal is authorized by a judicial order.

29. Employee Assistance

South Oaks hospital follows the procedures outlined in the Employee assistance programs when any member of the medical staff is suspected of impairment.

30. Medical Staff ID

All members of the Medical Staff are required to wear a hospital issued photo ID badge at all times when in the hospital, before the provision of treatment and/or care to patients/residents.

31. Review of Rules & Regulations

The Medical Staff Rules and Regulations will be reviewed as needed and amended as is appropriate at any time.

Revised 11/24/15
BROADLAWN MANOR NURSING & REHAB CENTER
MEDICAL STAFF RULES & REGULATIONS

The following rules and regulations for Attending Physicians are in conformance with State, Federal and Joint Commission requirements, and are formulated in the interest of good resident/patient care.

1. ADMISSION
   Initial evaluation and plan of care for resident/patient is made by the physician within 48 hours of admission to the nursing facility and documented in the medical record.
   a. The evaluation shall include:
      b. History and Physical - including Diagnosis and Level of Care
      c. Rehabilitation Potential
      d. Medical Orders For . . .
         i. Diet
         ii. Medication
         iii. Restorative Services
         iv. Special Procedures for Safety
         v. Clinical Work-up as deemed necessary

2. FOLLOW UP VISITS - MEDICATION AND TREATMENT
   a. The nursing facility resident shall be visited no less often than once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner employed by the physician or his group and who has been credentialed and privileged to see residents by the Nursing Home. Residents of the Sub-acute Unit will be visited no less than once each week.
   b. All orders and plans for the resident's/patient's care are to be reviewed with the licensed nurse every thirty days in the nursing facility.
   c. Documentation in the resident's/patient's record of the medical supervision shall be evidenced by signed written orders and progress notes.
   d. Medication shall be ordered generically whenever possible.

3. ORDERS
   a. Admitting orders shall be given before or at the time of admission.
   b. All orders for treatment and medications must be in writing and signed, dated and timed by the physician. All orders for treatment dictated over the telephone shall be received, dated, timed and signed by the Registered Nurse or Licensed Practical Nurse (for those orders which can be administered by a Licensed Practice Nurse) or other legally authorized professional to whom dictated and countersigned, dated and timed by the authorized physician within 24 hours of the telephone order.
   c. Orders may be written by a Nurse Practitioner or Physician Assistant as allowed by New York State Law.
   d. Written orders for other consultations, and diagnostic procedures including but not limited to radiology, EEG and psychological testing shall contain a concrete statement of the reason for the request.
4. **CHANGE OF PHYSICIAN**
New physician will complete an evaluation of the patient/resident and review all orders for care and treatment.

5. **DISCHARGE PLAN**
A discharge plan must be developed within thirty days to include restorative and discharge potential. Appropriate staff members with the guidance of the attending physician develop the plan. The attending physician shall acknowledge his approval by signing the discharge plan.

6. **NEW ADMISSION**
All new admissions shall have a P.P.D. (Mantoux Tuberculin Skin Test) performed if not known to have had a positive P.P.D. by history. If resident has had a positive P.P.D. by history a P.P.D. shall not be performed. (See P.P.D. policy.)

7. **ANNUAL PHYSICAL REQUIREMENTS**
A comprehensive examination of the resident shall be performed annually during the day shift to allow the physician to review the resident’s care plan with the charge nurse. Appropriate laboratory studies will be ordered as deemed necessary by physician.

8. **VERBAL ORDERS**
Verbal orders may be accepted when necessary by a licensed nurse or pharmacist. Verbal orders are written into the appropriate clinical record by the nurse receiving them. Verbal orders must be countersigned by the attending physician within a 48-hour period. In the event a verbal order is not signed by the prescriber or another authorized practitioner within 48 hours, the order shall be terminated and the Medical Director shall evaluate the resident’s medication needs.

9. **CONSULTATIONS**
Consultations, when necessary, must be ordered by the attending physician. Consultant's recommendations for treatment or medication require approval by the attending physician before implementation.

10. **EMERGENCY CARE**
All attending physicians are required to make arrangements with a facility credentialed physician for the medical care of their residents/patients in their absence. In cases of impending extended absence, we ask that the facility be notified in advance.

In case of emergency, the licensed nurse contacts the attending physician or the covering physician. If neither is available, the physician on emergency call and/or the Medical Director or Associate Medical Director will be contacted.

11. **DISCHARGES**
Discharges are to be ordered and signed by the attending physician. A discharge summary shall be documented in the resident’s medical record.

12. **Medical Records**
Attending physicians and their respective employees and agents shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the facility, or by business associates of the facility, in accordance with any and all health information privacy policies adopted by the facility to comply with current
Federal, State and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Protected health information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the facility.

13. Health Information Consents and Privacy Authorizations
Attending physicians and their respective employees and agents shall cooperate with facility personnel in obtaining and documenting or maintaining in the medical record any and all patient consents and patient authorizations required under any and all health information privacy policies adopted by the facility to comply with current Federal, State and local laws and regulations, including, but not limited to, HIPAA.


Approved 07/19/01
Revised 01/24/02
06/10/09
1. **AUTHORITY**

   In accordance with the Medical Staff Bylaws, and The Long Island Home’s ("the Corporation") Performance Improvement Program, this Credentialing and Privileging Plan is established to institute the mechanism by which qualifications are defined and reviewed, and privileges granted for the provision of clinical services at South Oaks Hospital ("the Hospital") and Broadlawn Manor Nursing and Rehabilitation Center ("the Nursing Home").

2. **GOAL**

   The goal of the Credentialing and Privileging Plan is the assurance of competence of the Medical Staff providing direct services to patients of the Hospital and residents of the Nursing Home.

3. **MEDICAL STAFF DEFINED**

   Each member of the Medical Staff is credentialed and privileged by the Board of Directors following review and recommendations by the Credentials/Peer Review Committee and the Executive Leadership Committee.

   The Medical Staff is defined as those practicing physicians, nurse practitioners, dentists, and podiatrists and ancillary staff licensed in the State of New York who have been credentialed and privileged to provide direct treatment services to patients at the Hospital or residents of the Nursing Home.

4. **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

   The Board of Directors of the Corporation has delegated the authority and responsibility for the provision of appropriate patient care to the Medical Staff. The Board requires that the Medical Staff conduct and be accountable for activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Hospital and Nursing Home.
5. **PROCESS**

All medical staff members who are permitted by the law and by the Corporation to provide independent patient care services under their own licenses or certificates have delineated clinical privileges. Allied Health Professionals employed by the Hospital or Nursing Home to provide patient care will have a job description or contract rather than delineated clinical privileges, filed in the department office. AHPs are not required to be employed by the Hospital or Nursing Home to exercise privileges or the Hospital or Nursing Home. The Hospital Medical Director or Nursing Home Medical Director may interview applicants for medical staff appointment, as applicable and/or prior to receipt of an appointment application. It is the applicant's responsibility to complete the application legibly. The completed application packet shall contain a completed application form, the information required by Section 7.4.2 of the Medical Staff Bylaws, current health statement and consents, and a C.V. or resume. The completed application packet should be delivered to the applicable Medical Director or Medical Staff Coordinator.

A. **Record of Application**

The Medical Staff Coordinator shall maintain a separate record for each applicant for appointment to the Medical Staff. Upon receipt of a complete application form with the appropriate documentation as outlined in the Medical Staff Bylaws, Article VII, the Medical Staff Coordinator shall seek, in a timely fashion, to collect and/or verify the following information:

1) Licensure - this includes verification with the New York State Licensure Board assuring applicant's license is in force and information on whether the license has ever been suspended or revoked, and information on any ongoing disciplinary action.

2) Specific training and experience, verified in writing by the university, and/or medical school/nursing school and residency and/or internship director

3) Letters of professional reference (at least two)- one reference shall be someone in the same professional discipline who has firsthand knowledge of the applicant's relevant training, experience, health status, and current clinical competence.

4) Current or previous Hospital affiliations (if applicable) or information on whether the applicant has had voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges

5) A written report from the applicant's malpractice insurance company on the applicant's involvement in any professional liability actions with final judgments and settlements and other reasonable indicators of continuing qualifications

6) New York State Office of Professional Medical Conduct query

7) National Practitioner Data Bank report

8) Health statement completed by a licensed physician
9) Infection control certificates

Affiliations with other institutions will be verified by mail with recommendations/references requested in writing. Professional references will be contacted by mail with recommendations/references requested in writing. The applicable Medical Director or Medical Staff Coordinator shall promptly notify the applicant of any failure of others to respond to requests for information. After such notice, the applicant shall have the obligation of obtaining responses to such requests or submitting another name as a reference/recommendation. Within 120 days of receipt of a completed application all responses to requests for information should have been received. The information will be transmitted to the Credentials/Peer Review Committee upon completion of the information collection and certification tasks. However, if all responses required for a complete application are not received at the end of 90 days after being requested, the applicant will be notified about the incomplete responses. If the required information is not received within 30 days after such notification, the application shall be deemed to be rejected due to incompleteness. Such action shall be deemed not to be an adverse action against the applicant.

B. Reappointment Process

At least ninety 90 days prior to the expiration date of the current staff appointment of each member of the Medical Staff, the Medical Staff Coordinator shall provide each member with an interval information form for use in considering reappointment. In addition to the information required by Section 7.7.2 of the Medical Staff By-Laws, the information form shall indicate whether the Medical Staff Coordinator knows of any reason why the member may not meet the qualifications for active staff, courtesy staff or consulting staff, as appropriate. These qualifications are outlined in the Medical Staff By-Laws, Article IV, Sections 4.2, 4.3 and 4.4.

Failure to return the interval information form within 45 days prior to the expiration date of the current staff appointment shall be deemed a voluntary resignation from staff status and shall result in automatic termination of staff status together with all clinical privileges at the expiration of the member’s current term, unless the applicable Medical Director grants an extension of time as needed, upon a showing of good cause by the member for such an extension.

Upon receipt of a completed information form, the Medical Staff Coordinator shall seek, in a timely fashion, to collect or verify the information made available on each interval information for and to collect any other materials or information deemed pertinent, including the utilization history of the reappointment applicant and other information regarding conduct in this or any other healthcare facility, using primary sources whenever feasible. When collection and verification is accomplished by receipt of responses from person or entities so contacted, the application shall be considered complete.
C. **Credentials/Peer Review Committee**

The Credentials/Peer Review Committee is a standing committee comprised of the, Hospital Medical Director, the Nursing Home Medical Director, a member of the Hospital Medical Staff and a member of the Nursing Home Medical Staff. The members of the committee from the Medical Staff shall be appointed by the applicable Administrator and Medical Director. After the Medical Staff Coordinator informs the applicable Medical Director that all relevant information regarding an application has been obtained, the Medical Director will transmit the application to the Credentials/Peer Review Committee. The Credentials/Peer Review Committee then reviews, in depth, the completed application and supporting documentation and information available that may be relevant to consideration of the applicant's qualifications for requested privileges and Staff membership. For reappointment applications, the Committee shall consider continued compliance with staff status qualification, the recommendation of two members of the Medical Staff and all relevant professional performance, utilization, and performance improvement and medical audit information. The Committee makes its recommendations regarding staff membership and clinical privileges to be granted and any special conditions insofar as the applicant is concerned. The report of the Credentials/Peer Review Committee with recommendations is then transmitted to the Executive Leadership Committee within sixty (60) days after the Committee receives the completed application. If deemed appropriate, the Credentials/Peer Review Committee may recommend that the Executive Leadership Committee defer processing an application for stated reasons, until further information and/or clarification is obtained.

D. **Executive Leadership Committee**

After receipt of the application with recommendation from the Credentials/Peer Review Committee, the Executive Leadership Committee shall then meet to review the application and all related documentation. The Executive Leadership Committee may also defer action on the application pursuant to section 7.6.6. The reason for each recommendation shall be concisely stated. Any minority views shall also be reduced to writing, supported by statements of reasons, and transmitted with the majority recommendations. The Executive Leadership Committee shall formulate recommendations to the Board within five (5) days following the regular meeting at which the application was considered.

E. **Board of Directors**

When an application is forwarded to the Board of Directors, the Board shall take action on it within 5 (five) days following its next regular meeting. Following action by the Board, the Medical Staff Coordinator will then inform the applicant in writing of the Board's decision. Notice of a decision to appoint the applicant will include:

1) Staff Status
2) Medical or Service privileges he may have or exercise.
3) Any special conditions attached to the appointments or to privileges granted.
4) A current copy of the Medical Staff Bylaws.
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When the recommendation of the Executive Leadership Committee has been adverse to the applicant, the applicant shall be so informed by the CEO or Medical Director in accordance with Article VII of the Medical Staff Bylaws.

6. MEDICAL STAFF STATUS

The Medical Staff as a whole shall be divided into two groups: the Hospital Medical Staff and the Nursing Home Medical Staff. Each group shall also be divided into four categories as delineated and described in the Medical Staff Bylaws, Article IV (Sections 4.2 - 4.5).

7. HOSPITAL CLINICAL PRIVILEGES

Categories of Psychiatric Privileges:

A. Category I Privileges

Psychiatrists who are recent graduates of a psychiatric residency, and who are not board certified are granted Category I privileges. These psychiatrists, during their first year at South Oaks, are expected to seek consultation on all complicated cases.

Psychiatrists with Category I privileges, during their first year of staff membership, will be judged on general clinical competence including diagnostic and treatment skills. They will be evaluated using the hospital wide FPPE and OPPE standards.

B. Category II Privileges

Psychiatrists with Category II privileges are experienced general psychiatrists who are either Board certified or Board eligible with at least five years experience. These psychiatrists may treat and render second opinions on complicated cases. These psychiatrists will be judged on their general clinical competence using hospital wide FPPE and OPPE standards and reappointed every two years.

C. Category III Privileges

Psychiatrists with Category III privileges are those who have special certification or fellowship training in subspecialty areas such as child psychiatry, gerontology, and forensics and addiction psychiatry. These psychiatrists are appropriate to render consultations in their specialty area in cases that are considered high risk or complicated. These psychiatrists will be judged on their general clinical competence and reappointed every two years.

D. Privileges for Special Procedures

1) Psychiatric Consultation
2) Telepsychiatry

Privileges for these procedures will be based on training, experience and licensure as required by New York State Law.
E. Privileges for Nurse Practitioners

Qualified licensed certified nurse practitioners may be privileged in accordance with Standards of Nursing Practice and in collaboration with a physician.

These privileges will be based upon training, experience and licensure as required by New York State Law.

8. NURSING HOME CLINICAL PRIVILEGES

The prerogatives of members of the Nursing Home Medical Staff are described in Article IV of the Medical Staff Bylaws. There shall be no further delineation of privileges for the members of the Nursing Home Medical Staff.

9. PRIVILEGES: NON-PSYCHIATRIC PHYSICIANS

All non-psychiatric physicians may be privileged as members of the Nursing Home Medical Staff or as consultants in the specialty areas in which they are Board certified or eligible to consult without supervision or proctoring.

10. CLINICAL PRIVILEGES: DENTISTS

Qualified licensed dentists may be privileged as consultants to perform dental procedures for which they are licensed under New York State Law.

11. CLINICAL PRIVILEGES: PODIATRISTS

Qualified licensed podiatrists may be privileged as consultants to perform podiatric procedures for which they are licensed under New York State Law.

12. DELINEATION OF PRIVILEGES

General Medical Staff privileges:

A. Psychiatrists
   1) Admission and Discharge
   2) Pharmacotherapy
   3) Individual therapy
   4) Ongoing patient care and management including laboratory/ diagnostic testing and management/coordination

B. Non-Psychiatric Physicians - Hospital
   1) Provide consultation in applicable medical specialties
   2) Medical Care

C. Non-Psychiatric Physicians – Nursing Home
   1) Admission and Discharge
   2) Medical care as attending physician
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D. Nurse Practitioners
   1) Admission (Psychiatric NP)
   2) Physical Examinations
   3) Ongoing psychiatric care and management including laboratory /diagnostic testing and management/coordination (Psychiatric NP)
   4) Pharmacotherapy
   5) Ongoing Medical Care and management (Adult/Family Health NP)

E. Dentists
   1) Dental care and treatment

F. Podiatrists
   1) Podiatric care and treatment

G. Physician Assistants- under direction of a physician
   1) Physical examination
   2) Laboratory and diagnostic management
   3) Pharmacotherapy
   4) Ongoing patient care and management
   5) Discharge

Specific privileges:

A. For Psychiatrists/Psychiatric Nurse practitioners:
   Adult Services
      1) Adolescent Services
      2) Child Services
      3) Geriatric Services
      4) Addiction Services
      5) Family Psychotherapy

B. For Non-Psychiatric Physicians: (Nursing Home Medical Staff and Medical Consultants)
   1) Physical Examinations
   2) Pharmacology
   3) Internal Medicine
   4) Neurology
   5) Other Medical/Surgical Specialties

13. RESPONSIBILITIES OF PHYSICIAN MEMBERS OF THE CLINICAL STAFF IN RELATION TO NON-PHYSICIAN CLINICAL STAFF

Patients may be diagnosed and treated within a collaborative model involving physician and non-physician clinical staff. Psychiatrist members of the Medical Staff shall have the ultimate responsibility for patients at the Hospital. Those members of the Nursing Home Medical Staff designated as attending physicians shall have the ultimate responsibility for residents of the Nursing Home. In accordance with the individualized treatment plan, which is developed through interdisciplinary consultation, a non-physician clinical staff member may be delegated responsibility for one or more therapeutic procedures within the scope of such non-physician's clinical privileges and as provided in the applicable Medical Staff Rules and Regulations. All members of the treatment team who have specific treatment
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responsibilities shall have appropriate education, experience and knowledge for such responsibilities or shall be supervised by Medical Staff members who are qualified by education, experience and knowledge. Only physicians and NPs/PAs under the direction of Active or Courtesy Staff may admit and discharge patients from the Acute care Hospital or Nursing Home. Detox and Rehabilitation patients may be discharged by nursing staff under the direction of a NP/PA or MD.

The prescribing of medications should be carried out by physicians and other health professionals with appropriate qualifications, licenses and clinical privileges as allowed by New York State law.

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