MEDICAL STAFF BYLAWS OF UNIVERSITY HOSPITALS CLEVELAND MEDICAL CENTER: FEBRUARY 27, 2025

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MEDICAL STAFF BYLAWS OF UNIVERSITY HOSPITALS CLEVELAND MEDICAL CENTER: FEBRUARY 27, 2025

PREAMBLE

University Hospitals Cleveland Medical Center ("UHCMC"), a wholly-owned subsidiary of University Hospitals Health System, Inc. ("UH"), is a nonprofit corporation organized under the laws of the State of Ohio with a single Medical Staff.

The Board of Directors has adopted the following structure of the Hospital's Mission, Vision and Values, which the Medical Staff has embraced as its own:

Our Mission – To heal, to teach, to discover;

Our Vision – University Hospitals Cleveland Medical Center will be the regional leader in providing high quality, compassionate, cost-effective health care, including the full spectrum of prevention, diagnosis and treatment – while enhancing our status as a nationally recognized academic health center in partnership with Case Western Reserve University;

Our Values – At University Hospitals Cleveland Medical Center we value patient-centered care, caring, excellence, value, innovation, scholarship, cooperation, and integrity;

The Medical Staff is a component of the Hospital corporation and must work with and is subject to the ultimate authority of the Board of Directors of University Hospitals Cleveland Medical Center. The cooperative efforts of the Medical Staff, Administration and the Board of Directors are necessary to fulfill the objective of providing quality patient care.

University Hospitals Health System, Inc. is an Ohio nonprofit corporation and a public benefit corporation. Its role and purpose is to (1) maintain, manage, oversee and set policy for a multi-entity health care delivery system (the "System") that includes hospital, out-patient, home care, research, educational and related facilities, (2) provide administrative and management expertise and services to the health care delivery entities within the System, (3) encourage, promote and support the functions, operations and purposes of the health care delivery entities within the System, and (4) to encourage, promote and support the carrying out of research, study and education, including medical and nursing education.

Therefore, all members of the Medical Staff practicing at University Hospitals Cleveland Medical Center shall carry out the functions delegated to the Medical Staff by the Board of Directors in conformity with these Medical Staff Bylaws.

1.0 DEFINITIONS: The following definitions apply to the provisions of these Bylaws of the Medical Staff.

1.1 **ADMINISTRATION** refers to the President, Chief Officers, and Vice Presidents within General Administration of University Hospitals Cleveland Medical Center.

1.2 **ALLIED HEALTH PROFESSIONALS** refers to certified nurse anesthetists, anesthesia assistants, physician assistants, licensed independent social workers and others as approved by the Board of Directors, authorized to provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or supervised by an active member, in good standing, of the Medical Staff who is in the same specialty.

1.3 **BOARD OF DIRECTORS (BOARD)** refers to the Board of Directors of University Hospitals Cleveland Medical Center, which is the governing body of UHCMC.

1.4 **BYLAWS** refer to the Medical Staff Bylaws of University Hospitals Cleveland Medical Center. The Bylaws are not a contract, and do not establish any contractual rights or relationships, either express or implied.

1.5 **CHIEF MEDICAL OFFICER (CMO)** refers to the Chief Medical Officer and fulfills the function of a Chief of Staff.

1.6 **CLINICAL COUNCIL** fulfills the function of a Medical Staff Executive Committee.

1.7 **HOSPITAL or UHCMC** refers to University Hospitals Cleveland Medical Center.

1.8 **HOSPITAL REPRESENTATIVE** includes the Board of Directors, its members and committees, the Administration, and the following individuals as designated by Administration: agents and employees, all Medical Staff members, departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

1.9 **LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONER (LIAP)** refers to clinical nurse specialists, nurse practitioners, and others as approved by the Board of Directors, authorized to independently practice or provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or in collaboration with an active member, in good standing, of the Medical Staff who is in the same specialty.

1.10 **LICENSED INDEPENDENT PRACTITIONER (LIP)** refers to any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

1.11 **MEDICAL STAFF** refers to duly licensed physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, nurse midwives, and other licensed independent practitioners as defined by Clinical Council and Board of Directors, including members of the Active, Honorary, Courtesy, Fellow, and Associate categories of the Medical Staff of University Hospitals Cleveland Medical Center and who (except for Honorary Staff) participate in the care of patients, teaching and/or research at University Hospitals Cleveland Medical Center.

1.12 **NOTICE** means written notification sent by certified mail, return receipt requested or by hand-delivery service.

1.13 **POLICIES AND PROCEDURES** refer to the Policies and Procedures of University Hospitals Cleveland Medical Center, its clinical departments, its Medical Staff, and University Hospitals Health System.

1.14 **RULES AND REGULATIONS** refers to the Rules and Regulations of the Medical Staff of University Hospitals Cleveland Medical Center.

1.15 **SCHOOL OF MEDICINE** refers to Case Western Reserve University School of Medicine.

1.16 **SCHOOL OF DENTISTRY** refers to Case Western Reserve University School of Dental Medicine.

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1.17 **UH** refers to University Hospitals Health System.

1.18 **UHCD** refers to the UH Medical Staff Services and Credentialing Department

1.19 **UHMG** refers to University Hospitals Medical Group.

1.20 **UHMP** refers to University Hospitals Medical Practices.

1.21 **UH INSTITUTE** refers to an institute established by University Hospitals Health System, as well as MacDonald Women's Hospital, Rainbow Babies and Children's Hospital, and Seidman Cancer Center.

1.22 **UNIVERSITY** refers to Case Western Reserve University.

2.0 NAME: The name of this organization shall be the Medical Staff of University Hospitals Cleveland Medical Center.

3.0 PURPOSES AND RESPONSIBILITIES

3.1 <u>Purposes.</u>

3.1.1 The purposes of the Medical Staff shall be to:

3.1.1.1 To provide a formal organizational structure through which the Medical Staff shall carry out their responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board.

3.1.1.2 Facilitate the provision of quality medical care to Hospital patients regardless of race, color, religion, creed, gender, sexual orientation, national origin, marital or family status, presence of any disability, age, ancestry, veteran's status or financial resources.

3.1.1.3 Ensure the same level of quality of patient care by all individuals with delineated clinical privileges, within Medical Staff departments and across departments.

3.1.1.4 Achieve and maintain a high level of professional performance by all members of the Medical Staff and other individuals with delineated clinical privileges through the credentialing process and the delineation of clinical privileges.

3.1.1.5 Provide quality medical care consistent with available resources to all patients admitted to or treated in any of the facilities of the Hospital.

3.1.1.6 Provide education and conduct research within the approved policies and procedures established by the Medical Staff, Clinical Council and the Board of Directors.

3.1.1.7 Develop and adopt bylaws and rules and regulations to establish a framework for the self-governance of the Medical Staff through the recorded action of Clinical Council.

3.1.1.8 Provide a means by which issues concerning the Medical Staff, other individuals with delineated clinical privileges and the Hospital may be discussed and resolved with the Board of Directors and Administration.

3.1.1.9 Provide the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained

by individual practitioners and through which the obligations of Medical Staff membership may be fulfilled.

3.1.1.10 Serve as the primary means for accountability to the Board of Directors for the appropriateness of the professional performance, and ethical conduct of its members and other individuals with delineated clinical privileges, and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

3.2 Responsibilities.

3.2.1 The responsibilities of the Medical Staff, to be fulfilled through the recorded actions of its Clinical Council, clinical departments and committees, shall be to:

3.2.1.1 Account for the quality and appropriateness of patient care to the Board of Directors, provide oversight of care, treatment, and services rendered by all members of the Medical Staff and other individuals with delineated clinical privileges authorized to practice in the Hospital, and provide for a uniform quality of patient care, treatment, and services through the following measures:

3.2.1.1.1 making recommendations to the Board of Directors for appointment, reappointment, granting and revoking of clinical privileges, including recommendations regarding departmental policies and procedures governing the credentialing process, and granting of or revoking admitting and clinical privileges based on verified credentials, quality-of-care criteria and current demonstrated competence of the Medical Staff member or applicant for Medical Staff membership and/or clinical privileges;

3.2.1.1.2 a continuing education program, fashioned at least in part on the needs demonstrated through the Hospital's Performance Improvement Plan;

3.2.1.1.3 an organizational structure that provides for continuous monitoring of patient care practices, and measuring the performance of patient care processes;

3.2.1.1.4 designing, monitoring, assessing, measuring, and improving the effectiveness, efficacy, availability, timeliness, appropriateness, accessibility, continuity, efficiency, and safety of patient care and respect for patients through active involvement in the Hospital's Performance Improvement Plan.

3.2.1.2 Account for compliance with Hospital requirements regarding completion and documentation of medical histories and physical examinations (H&P) detailed in UH policy available on the UH Intranet:

3.2.1.2.1 Completion of H&P

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3.2.1.2.1.1 Within 24 hours of and/or prior to surgery, invasive or non-routine procedure, administration of anesthesia or moderate/deep sedation.

3.2.1.2.1.2 Performed no more than 30 days before the procedure. If more than 30 days, H&P repeated.

3.2.1.2.1.3 H&P may be completed by any of the following: physicians, oral and maxillofacial surgeons, advanced practice nurses, physician's assistants, and house staff.

3.2.1.2.2 Documentation of H&P

3.2.1.2.2.1 Copy of H&P shall be in patient's medical record.

3.2.1.2.2.2 H&P update shall be documented for H&P performed prior to admission; within 24 hours of admission; prior to a major diagnostic or therapeutic intervention; if no changes to the initial H&P.

3.2.1.2.3 H&P consists of

3.2.1.2.3.1 Medical history including chief complaint, details of present illness, co-morbidities and relevant social and family histories

3.2.1.2.3.2 Physical exam including inventory by body system; assessment of physical, psychological, and social needs.

3.2.1.2.3.3 Conclusions or impressions drawn from H&P

3.2.1.2.3.4 Diagnosis

3.2.1.2.4 Emergency situations: relevant parts of H&P must be documented prior to an emergency procedure, unless delay may compromise patient care.

3.2.2 Account to the Board of Directors for the quality and efficiency of patient care through regular reports and recommendations concerning performance improvement activities.

3.2.3 Initiate and pursue corrective action with respect to practitioners when warranted.

3.2.4 Develop, administer, and seek compliance with these Bylaws, the Rules and Regulations, the Privileging Policy for Licensed Independent Affiliate Health Care Practitioner (LIAP) and Allied Health Professionals (AHP), University Hospitals Health System Corporate Compliance, and all professional and patient care-related policies of the Hospital and University Hospitals Health System.

3.2.5 Assist in identifying community health needs, setting appropriate institutional goals and implementing programs to benefit the community.

3.2.6 Exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

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4.0 MEMBERSHIP

4.1 Membership Privileges. Membership on the Medical Staff of the Hospital is a privilege extended by the Hospital and is not a right of any physician, practitioner or other person. Membership shall be extended only to those individuals who continually meet the qualifications, standards and requirements set forth in these Bylaws. Membership may be with or without admitting and/or clinical privileges. Appointment to the Medical Staff shall be limited to the needs of the patient population served by the Hospital as determined by the Board of Directors after recommendation by the appropriate Chairman and Clinical Council. No person shall be automatically entitled to Medical Staff membership or to the exercise of clinical privileges simply by virtue of the fact that she or he is licensed to practice within her or his healthcare profession, is a member of a professional organization, is certified by any board or has or in the past had medical staff membership or clinical privileges at any other hospital or health care organization.

4.2 Eligibility.

4.2.1 Only physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, optometrists, nurse midwives, and other licensed or registered practitioners (as defined by Clinical Council) shall be considered for membership on the Medical Staff. No applicant shall be entitled to membership on the Medical Staff solely by virtue of the fact that he/she holds an academic appointment at the University, or that he/she is licensed/registered/certified to practice in the State of Ohio or in any other state, or because he/she is or is not a participating provider in any managed care organization or network, or because he/she is a member of any professional organization, is certified by any clinical board, or presently holds or formerly held Medical Staff membership or clinical privileges at the Hospital or with another health care organization. Membership will neither be granted nor denied on the basis of race, color, religion, creed, gender, sexual orientation, national origin, marital or family status, presence of any disability, age, ancestry, veteran's status or financial resources.

4.2.2 Applicants for membership on the Medical Staff shall demonstrate, with sufficient adequacy, to the Medical Staff and the Board of Directors that they will provide care to patients at least at the generally-recognized professional level of quality, in an economically-efficient manner, taking into account patients' needs, the available Hospital facilities and resources, and the utilization standards in effect at the Hospital.

4.2.3 Requirements for Membership on the Medical Staff shall include the following:

4.2.3.1 Current licensure/registration/certification in good standing in the State of Ohio in the discipline for which clinical privileges are requested (except for members of the Honorary Staff) with the same legal name as set forth on the member's application for membership on the Medical Staff;

4.2.3.2 Current ability to participate in Medicare, Medicaid and all other applicable federal or state healthcare programs, without any limitations, restrictions, sanctions, or exclusions;

4.2.3.3 Membership on the faculty of the Case Western Reserve University School of Medicine or School of Dental Medicine in an academic department corresponding to the hospital clinical department as defined by the applicable departmental site-specific privilege delineation form is a general expectation of Applicants.

4.2.3.3.1 Variances from this expectation require written approval of the President, who will consult with the Chairman of the clinical department in which the appointment is sought in advance of such approval.

4.2.3.4 Current employment by or affiliation with UHMG and/or UHMP or membership in good standing in a UH Institute;

4.2.3.5 Successful completion of an accredited residency training requirement, if any, as defined by the individual clinical departments on the applicable departmental privilege delineation form, and as approved by Clinical Council and the Board of Directors;

4.2.3.6 Board certification in accordance with the following:

4.2.3.6.1 For new graduates and physicians following their last year of residency/fellowship education, within five (5) years;

4.2.3.6.2 For all other applicants, must be board certified in their respective specialty upon appointment and throughout the duration of their Medical Staff membership;

4.2.3.6.3 Failure to maintain continuous certification, including any Maintenance of Certification requirement, will result in the voluntary relinquishment of Medical Staff privileges, which would not be subject to the appeal process under Section 11; notwithstanding the foregoing, Clinical Council may, upon the recommendation of the appropriate chairman, delay such voluntary relinquishment for up to one year to permit the member to re-establish board certification.

4.2.3.6.4 The Board may, in its discretion and after consultation with Clinical Council, the CMO, and the appropriate chairman, grant exceptions to this requirement.

4.2.3.7 Current experience and demonstrated competence in the area of clinical privileges requested;

4.2.3.8 Ability to perform any of the physical or mental health functions related to the specific clinical privileges requested as a member of the Medical Staff, with or without accommodation;

4.2.3.9 Documented proof (in the form of peer recommendations) of strict adherence to professional ethics, the ability to work cooperatively and collaboratively with others and of willingness to participate in the discharge of Medical Staff responsibilities;

4.2.3.10 Evidence of current professional liability insurance as defined by Section 2 of the Medical Staff Rules & Regulations;

4.2.3.11 Evidence of current, unrestricted Drug Enforcement Agency (DEA) registration, valid in the State of Ohio, (unless such registration is not required for the member’s discipline, scope of practice, or requested privileges);

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4.2.3.12 Maintains proof of legal permanent residency or the proper visa for the clinical privileges exercised at the Hospital, if not a United States citizen;

4.2.3.13 Compliance with the UH Communicable Diseases Policy;

4.2.3.14 Compliance with the Hospital policy prohibiting members of the Medical Staff from having a material financial relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System;

4.2.3.15 Compliance with University Hospitals Health System Corporate Compliance Program and Guidelines;

4.2.3.16 Except for members of the Honorary Staff, maintain and regularly monitor a UH-issued electronic mail (e-mail) address, which shall be the only email account used for sending or receiving protected health information of UH patients, privileged information, or information on other Hospital-related matters;

4.2.3.17 Compliance with these Bylaws and the Rules and Regulations; and

4.2.3.18 For applicants with or seeking admitting privileges, demonstrated proficiency, to the satisfaction of the department chairman, in the use of electronic medical records and/or similar technology.

4.2.4 By accepting membership on the Medical Staff, the member agrees to:

4.2.4.1 Provide his/her patients with care at least at the generally-recognized professional level of quality and efficiency;

4.2.4.2 Abide by the Medical Staff Bylaws and Rules and Regulations, and by all other established standards, policies and rules of the Hospital or University Hospitals Health System;

4.2.4.3 Discharge such Medical Staff, Department, Division, Committee, Hospital or University Hospitals Health System functions for which he/she is responsible by appointment, election or otherwise;

4.2.4.4 Prepare and complete, in a timely and legible manner, the medical and other required records for all patients whom he/she admits or for whom he/she provides care in any way in the Hospital;

4.2.4.5 Abide by the University Hospitals Health Systems Corporate Compliance Program and Guidelines and by the ethical principles of his/her profession, including, but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing for continuous care of his/her patients; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a Medical Staff member or privileged practitioner who is not qualified to undertake this responsibility, and who is not adequately supervised; and seeking consultation whenever necessary;

4.2.4.6 Maintain employment by or affiliation with UHMG and/or UHMP, or membership in good standing in a UH Institute;

4.2.4.7 Promptly notify the Chief Medical Officer and UHCD of the following; failure to notify may result in corrective action:

4.2.4.7.1 the revocation, suspension, or limitation of his/her professional license or DEA registration or any DEA schedules;
4.2.4.7.2 the imposition of terms of probation or limitation of practice by any State;
4.2.4.7.3 imposition of any limitations, sanctions, restrictions or exclusion from participation in the Medicare, Medicaid or other applicable federal or state healthcare programs;
4.2.4.7.4 a material change in practice or his/her loss of staff membership or loss or restriction of privileges at any hospital or other health care organization;
4.2.4.7.5 removal from the provider panel of any managed care organization or third party payor;
4.2.4.7.6 the commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or by any State or governmental authority;
4.2.4.7.7 the filing of a claim against the Medical Staff member alleging professional liability;
4.2.4.7.8 entering into a material financial relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System;
4.2.4.7.9 termination of, or change in status of, employment by or affiliation with UHMG and/or UHMP and/or a UH Institute;
4.2.4.7.10 the cancellation, lapse, or restriction of the practitioner's professional liability insurance; or
4.2.4.7.11 any termination or change to any LIAP/AHP supervisory or collaboration agreement.

4.2.4.8 Provide services to all patients regardless of their ability to pay;
4.2.4.9 Participate in teaching and/or research programs conducted by the Hospital;
4.2.4.10 Participate actively in performance and quality improvement initiatives of the Hospital; and
4.2.4.11 Participate in the Hospital's safety program;
4.2.4.12 Participate in educational or instructional programs deemed mandatory by the Chief Medical Officer, Chairmen, Division Chiefs and/or the President; and
4.2.4.13 Participate in all applicable on-call coverage requirements as determined by Chairmen or Division Chiefs or their designees in accordance with applicable laws and regulations.

4.2.5 Exception. The requirements of Sections 4.2.3.4 and 4.2.4.6 shall not apply to a member if any of the following apply:

4.2.5.1 As of December 31, 2008, the individual was a Medical Staff member and was not affiliated with either UHMG or UHMP;
4.2.5.2 The individual is applying for an Honorary or Fellow Staff appointment, or applying solely for privileges at a provider-based location;
4.2.5.3 The individual is requesting privileges in the specialties of Dental Medicine or Oral and Maxillofacial Surgery;
4.2.5.4 The individual is a locum tenens provider; or

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4.2.5.5 Such requirements have been expressly waived by the President and Chief Medical Officer of the Hospital, upon the request of the appropriate Department Chairman.

4.3 Conditions and Duration of Appointment.

4.3.1 All Medical Staff members are assigned to at least one clinical department with corresponding clinical privileges and may be granted privileges in other clinical departments, (except members of the Honorary staff and Courtesy/Refer-and-Follow providers, who are granted no admitting or clinical privileges).

4.3.2 Appointment to the Medical Staff shall be made by the Board of Directors after receiving recommendations from the Clinical Council and Chairman. Medical Staff appointments shall be for a period of no longer than two (2) years. Members of the Active, Courtesy, Fellow and Associate Staffs are required to reapply for continued appointment and/or clinical privileges at least every two (2) years, except for Fellows whose appointments are for less than two years.

4.3.3 After recommendation by the Chairman and the Chief Medical Officer, the President (or in the absence of the President, when necessary, his/her designee) may grant an interim appointment to the Medical Staff member meeting approved criteria for a period not to exceed 120 days in order to complete the approval process. UHCD will notify applicants of the approval of his/her interim appointment and clinical privileges no later than 10 days after approval.

4.3.4 Each appointment or reappointment shall be valid only for the period stated on the appointment or reappointment document, unless otherwise curtailed or restricted as provided herein. Any change in appointment status or clinical privileges shall apply only to the remainder of the then current appointment period.

4.4 Relinquishment of Clinical Privileges Due to Inadequate Utilization of the Hospital.

4.4.1. If a Medical Staff member's Medical Staff appointment and/or clinical privileges are voluntarily relinquished due to failure to provide sufficient patient contact for a satisfactory evaluation, the Medical Staff member shall be given written notice before a report of the voluntary relinquishment is made to the Clinical Council.

4.4.2. The Medical Staff member shall have ten (10) days following his/her receipt of a notice to request a meeting with the Department Chairman and the Chief Medical Officer. Such request shall be deemed to have been made when delivered to the Chief Medical Officer in person or when sent by certified mail to the Chief Medical Officer properly addressed and postage prepaid.

4.4.3. At this meeting, which is in lieu of a hearing, the Medical Staff member shall have an opportunity to explain or discuss extenuating circumstances involving his or her failure to provide sufficient patient contacts for a satisfactory evaluation.

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4.4.4. At the conclusion of the meeting, the Chief Medical Officer shall make a written recommendation to the Clinical Council and the Board of Directors. The decision of the Board of Directors shall be final.

4.4.5. In lieu of voluntary resignation under this section, the Medical Staff member may elect to have his/her privileges modified to Courtesy Staff with Refer-and-Follow privileges, as delineated by Clinical Council. Such modification shall be deemed voluntary, shall not give rise to due process rights under Section 11, and shall not be a reportable event to the State Medical Board or the National Practitioner Data Bank.

4.5 Categories of the Medical Staff.

4.5.1 Active Staff. The Active Staff shall consist of physicians, dentists, oral and maxillofacial surgeons, podiatrists and psychologists who are full or part time, with or without admitting privileges to the Hospital. Psychologists and podiatrists do not have inpatient admitting privileges. Members of the Active Staff may consult on and/or may treat both inpatients and outpatients, as determined by clinical privileges granted. Clinical privileges for psychologists are delineated through the clinical department where they hold their Medical Staff appointment.

4.5.2 Courtesy Staff. The Courtesy Staff shall consist of physicians, dentists or oral and maxillofacial surgeons, podiatrists and psychologists who are part time without admitting privileges at the Hospital. These members, in most cases, have their primary appointments at another hospital. Courtesy Staff members are permitted to supervise the treatment of patients in the ambulatory clinics, but are only permitted to act as consultants for inpatients. Clinical privileges are delineated accordingly.

4.5.3 Associate Staff. The Associate Staff shall consist of independently licensed or State registered practitioners who hold clinical privileges. The Associate Staff includes optometrists, nurse midwives, genetic counselors, or other professionals that Clinical Council may designate. Clinical privileges are delineated through the department where they hold their Medical Staff appointments.

4.5.3.1 Optometrists treat inpatients and patients in the ambulatory setting. Clinical privileges are delineated through the Department of Ophthalmology, where they hold their Medical Staff appointments. Optometrists do not have admitting privileges.

4.5.3.2 Nurse midwives treat inpatients and patients in the ambulatory setting. Clinical privileges are delineated through the Department of Obstetrics and Gynecology, where they hold their Medical Staff appointments.

4.5.3.3 Genetic counselors in the Department of Genetics do not have admitting privileges.

4.5.4 Fellow Staff. The Fellow Staff shall consist of physicians, dentists or oral and maxillofacial surgeons, who are participating in training programs not supported by the Graduate Medical Education Department. Fellows on the Medical Staff may or may not have admitting privileges, but all have delineated clinical privileges.

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4.5.5 Honorary Staff. The Honorary Staff shall consist of physicians, dentists, oral and maxillofacial surgeons, podiatrists, nurse midwives, optometrists, Ph.D.-prepared licensed independent social workers and psychologists who have voluntarily retired from practice but desire to maintain their affiliation with the Hospital and are recommended by their Chairman for this status. They may or may not be appointed to the Emeritus Faculty at the University. No admitting or clinical privileges are granted.

4.6. Contractual Relationships. The appointment and/or clinical privileges of any Medical Staff member or other practitioner who has a contractual relationship with the Hospital, or is either an employee, partner, or principal of, or in, an entity which has a contractual relationship with the Hospital relating to providing services to patients at the Hospital are defined through Medical Staff mechanisms. These privileges shall terminate automatically and immediately, unless the contract specifies otherwise, upon:

4.6.1 the expiration or other termination of the contractual relationship with the Hospital; or
4.6.2 the expiration or other termination of the relationship of the Medical Staff member or other practitioner with the entity that has a contractual relationship with the Hospital.

For members of the Medical Staff, such termination shall be considered a voluntary resignation.

In the event of such termination of Medical Staff appointment and/or clinical privileges or other contractual relationship with the Hospital, there shall be no rights to a hearing or appellate review as provided in Section 11.0 of these Bylaws.

5.0 PROCEDURES FOR APPOINTMENT TO THE ACTIVE, COURTESY, ASSOCIATE, AND FELLOW STAFF

5.1 General Requirements.

5.1.1 No final action shall be taken on applications for a Medical Staff appointment to the Active, Associate, or Courtesy Staff until UHCD has received verification of the applicant's Case Western Reserve University faculty appointment, when required by the individual clinical departments on the applicable departmental site-specific privilege delineation form, and as approved by Clinical Council and the Board of Directors.

5.1.2 No final action shall be taken on applications for a Medical Staff appointment to the Active, Associate, Fellow, or Courtesy staff until UHCD has received verification of the applicant's employment or affiliation with UHMG or UHMP, subject to Section 4.2.5.

5.1.3 The Hospital may utilize a credentialing verification organization ("CVO") in addition to or in lieu of performing its own verification. The applicant's consent for this Hospital to credential the applicant to its Medical Staff shall be deemed authorization to process the applicant's information through such an organization pursuant to an agreement between the Hospital and that organization.

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5.2 Conditions of Application. By applying for appointment and clinical privileges to the Medical Staff, the applicant:

5.2.1 Agrees to appear for interviews in regard to his/her application;

5.2.2 Agrees to produce sufficient information and/or appear for verification of personal identity;

5.2.3 Authorizes Hospital representatives to consult with others who have been associated with him/her, and who may have information bearing on his/her competence and qualifications;

5.2.4 Consents to the inspection by Hospital representatives of all records and documents pertinent to his/her licensure, specific training, experience, current competence and ability to carry out the clinical privileges he/she requests, relationships with peers and patients, as well as of his/her ethical qualifications for Medical Staff membership;

5.2.5 Consents to the release of any information pertaining to his/her professional competence or professional conduct to any UH wholly-owned entity where he/she is privileged, both during the application process and throughout the duration of his/her appointment;

5.2.6 Releases from any liability the Hospital, its Board, and each of their respective affiliates, agents, employees and representatives for their acts performed and statements made in good faith and without malice in connection with evaluating the applicant and his/her credentials;

5.2.7 Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, ability to perform any of the physical or mental health functions related to the specific clinical privileges requested of a member of the Medical Staff, with or without accommodation and other qualifications for Medical Staff appointment and clinical privileges;

5.2.8 Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, Federal or State, in the state in which the defendant resides or is located;

5.2.9 Agrees to submit any reasonable evidence of current health status that may be requested by Clinical Council or its designee;

5.2.10 Is required to submit a completed Request for Application as a prerequisite to any processing of an application for initial appointment; and

5.2.11 Is required to submit a complete appointment application.

5.3 Initiation of the Application Process. Applicants shall initiate a request for appointment and clinical privileges to the Chairman of that department to which he/she wishes to apply for Medical Staff membership. The Chairman shall then notify UHCD to begin the application process.

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5.3.1 Condition. If not received by UHCD in advance, all applicants will receive a Request for Application Processing form with the application packet sent by UHCD in which the applicant will be required to describe in detail all financial relationships, if any, that the applicant has with a health system(s) (or its controlled entity) not affiliated with University Hospitals Health System. Applicants who are determined to have a material financial relationship as defined in Section 8.2 of the University Hospitals Cleveland Medical Center Medical Staff Rules and Regulations, are not considered eligible for Medical Staff membership, and their application will not be processed by UHCD unless the applicant indicates in the information request that he/she is planning to terminate the material financial relationship upon or before appointment to the Medical Staff. In the event that an applicant has a material financial relationship and indicates an intent to terminate such relationship, the application for appointment will be processed contingent upon such termination.

UHCD will not process an application for appointment to the Medical Staff until the Request for Application Processing has been completed by the applicant, received by UHCD, and processed according to Hospital policy.

In the event that an applicant is considered ineligible for Medical Staff membership after processing of his/her Request for Application Processing form, the applicant shall be notified by UHCD. There shall be no rights to a hearing or appellate review as provided in Section 11.0 of these Bylaws.

5.4 Application. A complete application for membership to the Medical Staff shall be submitted to UHCD and shall contain the following:

5.4.1 completed Request for Application Processing form

5.4.2 completed application form consisting of the credentialing application form prescribed by the Ohio Department of Insurance and the University Hospitals Health System Application for Initial Credentialing;

5.4.3 current demographic information, including a personal, confidential electronic mail (e-mail) address (except for members of the Honorary Staff) to monitor critical communications from UH or Administration;

5.4.4 description of education, training, professional experience, current and all former licensure, and other qualifications;

5.4.5 written explanation of all gaps in work history of more than six (6) months;

5.4.6 information regarding any former or current malpractice actions, including but not limited to litigation, arbitration or mediation, regardless of status, method or outcome;

5.4.7 information regarding whether the applicant's professional license or controlled substance registration (federal DEA), in any jurisdiction, has ever been the subject of or is the subject of a disciplinary action, restriction, revocation, suspension or limitation of any kind, and whether voluntary or involuntary relinquishment or limitation of such licensure or registration has occurred;

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5.4.8 any voluntary or involuntary

5.4.8.1 termination or denial of Medical Staff membership, or

5.4.8.2 limitation, reduction, or loss of clinical privileges or employment at another health care organization;

5.4.9 information regarding any physical or mental condition which could affect the ability of an applicant to exercise the clinical privileges requested or would require an accommodation in order to exercise the privileges requested safely and competently;

5.4.10 any history of state or federal criminal charges or convictions;

5.4.11 signed Condition of Application/Release and Immunity Statement;

5.4.12 documentation of all current and prior State license(s) to practice;

5.4.13 evidence of a current, unrestricted DEA registration valid in the State of Ohio (if required for the applicant's discipline, scope of practice, or requested privileges);

5.4.14 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

5.4.15 professional liability history and current proof of insurance coverage showing effective and expiration dates, individual coverage limits and named insured;

5.4.16 confirmation of board specialty certification from a primary source (if applicable), as indicated on the privilege delineation form, as established by department policy;

5.4.17 copy of current curriculum vitae;

5.4.18 Educational Commission for Foreign Medical Graduates (ECFMG) certificate (if applicable);

5.4.19 completed privilege delineation form corresponding to specific site where clinical privileges are requested and to staff category as defined by these Bylaws;

5.4.20 any documentation needed to support the request for clinical privileges that require special training or experience (as indicated on the privilege delineation forms or as established by department policy);

5.4.21 signed Physician Acknowledgement Statement wherein the applicant acknowledges the following: *Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws;* provided, however, that by maintaining Medical Staff membership, the applicant acknowledges having received this statement;

5.4.22 proof of compliance with the Hospital Communicable Diseases Policy;

5.4.23 signed University Hospitals Health System Corporate Compliance Certification;

5.4.24 payment of the appointment application fee prior to the appointment date; and

5.4.25 any other necessary documentation requested by the Credentialing Committee, or its designees, to adequately evaluate the application.

5.4.25.1 If the applicant is a locum tenens provider, the Credentialing Committee may use the credentialing materials from a Locums Agency, provided that Locums Agency is Joint Commission-accredited.

5.5 Processing Application.

5.5.1 Request for Application. With the application packet sent by UHCD, all applicants will receive a Request for Application Processing form. Upon receipt of the completed Request for Application Processing form, UHCD shall process the appointment application of applicants with no material financial relationship with a Health System (or its controlled entity) not affiliated with UH.

5.5.2 Assessment. Following submission of a completed application, UHCD shall review the file for thoroughness and receipt of all required documentation. UHCD has the right to request additional information or clarification of information presented by the applicant. The applicant is advised of the status of his/her application within 21 days of receipt of the credentialing application form prescribed by the Ohio Department of Insurance.

5.5.3 Burden of Proof. An application is considered incomplete until all required documentation and information have been submitted, and neither the Board, the Hospital nor any committee of the Hospital shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant has the following responsibilities:

5.5.3.1 to produce accurate, complete, up-to-date information and/or appear for verification of personal identity;

5.5.3.2 to produce accurate, complete, up-to-date information for a proper evaluation of his/her training, experience, current competence, prior healthcare organization affiliations, liability history, and health status;

5.5.3.3 to resolve any questions about these or any of the qualifications for a Medical Staff appointment and clinical privileges; and

5.5.3.4 to satisfy any requests by the Hospital for additional information or clarification of any information presented.

5.5.4 Verification of Information. UHCD verifies the following from the primary source, according to approved sources for primary source verification, when feasible:

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5.5.4.1 professional education or ECFMG certification, residency, fellowship training and post-residency training;
5.5.4.2 current and former licensure;
5.5.4.3 National Provider Identifier (NPI)
5.5.4.4 board specialty certification(s);
5.5.4.5 previous professional experience and work history;
5.5.4.6 current employment by or affiliation with UHMG and/or UHMP or membership in good standing in a UH Institute, subject to Section 4.2.5;
5.5.4.7 AMA Physician Profile or AOA Osteopathic Physician Profile Report may be used for primary source verification;
5.5.4.8 if attempts to contact primary sources are not successful, approved equivalent sources or other reliable secondary sources may be used to verify licensure, training, experience, and current competence;
5.5.4.9 UHCD verifies the clinical competence of an applicant by obtaining peer evaluations from all hospitals or other health care entities where he/she has trained, held Medical Staff appointments, or clinical assignments within the past five (5) years. If the applicant's experience is limited, personal peer references will be obtained to meet a minimum of three (3) current clinical competence evaluations. Peer is defined as appropriate practitioner in the same professional discipline as the applicant who has firsthand knowledge of the applicant;
5.5.4.10 unsuccessful attempts to reach primary sources are documented in the credentials file and reported to the Credentialing Committee.

5.5.5 Queries for Information. At a minimum, UHCD queries the following entities:

5.5.5.1 Federation of State Medical Boards (if applicable);
5.5.5.2 National Practitioner Data Bank;
5.5.5.3 the applicable State of Ohio licensure board(s) and other state licensure boards, if applicable;
5.5.5.4 source for professional background check.

5.5.6 Incomplete Application. UHCD promptly informs the applicant of any missing information or problems in obtaining verification of information. The applicant is ultimately responsible for ensuring the receipt of all required information and shall be responsible for ensuring that any required information is provided to the UHCD. Action on an individual's application for initial appointment and clinical privileges shall be withheld until the above information is available and verified.

5.5.7 Time Periods for Processing. All individuals and groups required to act on a complete application for Medical Staff appointment and clinical privileges must do so in a timely and good faith manner. Except for obtaining required information, or for other good cause, each application should be processed within 180 days, beginning with receipt of a complete application including all applicable components noted in 5.4.1 through 5.4.25 above, submission to the Credentialing Committee of the Medical Staff within 90 days of application receipt, and ending with Clinical Council and the Board of Directors for approval.

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5.5.8 Each applicant, and the clinical department to which the Medical Staff appointment and/or privileges are being processed, may be informed of the status of his/her application, upon request.

5.5.9 Termination of Applications. Applications for Medical Staff appointment and clinical privileges that are incomplete shall remain active for 90 days. Applications shall be terminated upon written notice to applicant in the event that an application remains incomplete at the end of a 90-day period. Applicants who desire to pursue a Medical Staff appointment and clinical privileges at a later date must contact the appropriate Chairman to reapply.

5.6 Credentialing Committee and Chairman Review. UHCD screens all new appointment applications to determine whether any applications are deemed to be with issue. UHCD submits all applications, except those with issue, to the Credentialing Committee for review.

5.6.1 Any application determined to be with issue shall be submitted directly to the Chairman, who, after reviewing the application, shall forward it to the Credentialing Committee with a preliminary recommendation. For purposes of this section, an application is determined to be with issue if it deviates from one or more baseline criteria pre-established by UHCD.

5.6.2 Upon receipt, the Credentialing Committee shall review the application and evaluate the appointment and clinical privileges based on the available documentation, including any preliminary recommendation from the Chairman.

5.6.2.1 The Credentialing Committee shall make a recommendation for appointment and/or clinical privileges to the Chairman.

5.6.2.2 If the Credentialing Committee is unable to make a recommendation for appointment or clinical privileges without further evidence of training, experience, competence, relationship with peers and patients, and/or ethics, UHCD may be requested to obtain additional information from the applicant.

5.6.3 Recommendations to Clinical Council for appointment and/or clinical privileges rest solely with the Chairman. Following review of Credentialing Committee recommendations, the Chairman then submits his/her recommendation to the Clinical Council.

5.7 If the recommendations of the Credentialing Committee and Chairman for appointment and/or clinical privileges conflict, Clinical Council shall be informed of this fact.

5.8 Interim Appointment and Clinical Privileges.

5.8.1 After review and favorable recommendation by the Credentialing Committee and upon recommendation of the Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant an interim appointment and clinical privileges to a Medical Staff member meeting the following criteria for a period not to exceed 120 days in order to complete the approval process. UHCD will

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notify applicants of the approval of his/her interim appointment and clinical privileges no later than 10 days after Credentialing Committee approval.

5.8.1.1 Eligibility Criteria for Interim Appointment to the Medical Staff

5.8.1.1.1 After review and favorable recommendation by the Credentialing Committee and upon recommendation of the Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant an interim appointment and clinical privileges to a Medical Staff member meeting approved criteria for a period not to exceed 120 days in order to complete the approval process.

5.8.1.1.2 The following criteria shall be met prior to granting of an interim appointment.

5.8.1.1.2.1 Verification of:

5.8.1.1.2.1.1 Current licensure;

5.8.1.1.2.1.2 Current DEA registration (unless such registration is not required for the member's discipline, scope of practice, or requested privileges);

5.8.1.1.2.1.3 Relevant training or experience;

5.8.1.1.2.1.4 Current competence;

5.8.1.1.2.1.5 Ability to perform the privileges requested;

5.8.1.1.2.1.6 Current employment by or affiliation with UHMG and/or UHMP or membership in good standing in a UH Institute, subject to Section 4.2.5;

5.8.1.1.2.1.7 Other criteria required by the Medical Staff Bylaws.

5.8.1.1.2.2 Results of National Practitioner Data Bank query have been obtained and evaluated.

5.8.1.1.2.3 Applicant has:

5.8.1.1.2.3.1 A complete application

5.8.1.1.2.3.2 No current or previously successful challenge to licensure or registration

5.8.1.1.2.3.3 Not been subject to involuntary termination of Medical Staff membership at another organization

5.8.1.1.2.3.4 Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

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5.8.1.1.3 If any interim appointment eligibility criterion is not met by the applicant, the applicant shall not be granted interim appointment and clinical privileges, and appointment and clinical privileges shall be granted only after approval by the full Board of Directors.

5.8.2 If any adverse information regarding the applicant's credentials, training, experience, clinical competence, ethics, or other pertinent facts become known to the Hospital during this time period, such information shall be reported simultaneously to the Chairman and the Chief Medical Officer. The Chairman shall make a recommendation regarding the appointee's continued interim appointment and clinical privileges to Clinical Council and the Board of Directors. If necessary, the appointee's privileges may be summarily suspended in the manner outlined in Section 10.2 of the Bylaws.

5.8.3 If there is a recommendation from Clinical Council to terminate an interim appointee's appointment and/or clinical privileges, the appointee shall have due process as outlined in Section 11.0 of these Bylaws.

5.9 Clinical Council. Clinical Council (or its Executive Committee) shall review all recommendations from the Chairman and transmit the recommendations to the next meeting of the Board of Directors or to the Board of Directors' authorized committee. If the Clinical Council's recommendation is to deny appointment or clinical privileges, the Chief Medical Officer shall send notice to the appointee of his/her right to a hearing pursuant to Section 11.0.

5.10 Board of Directors. The Board of Directors shall review all recommendations transmitted to it from Clinical Council; the Board of Directors has the final decision on all applications. The Board of Directors may elect to delegate the authority to render initial appointment and clinical privileges or modification of clinical privileges decisions for those practitioners meeting the eligibility criteria to a committee of the Board of Directors, containing three or more members of the Board of Directors.

5.11 If the Board of Directors denies a favorable recommendation of Clinical Council, the Chief Medical Officer shall send notice to the appointee of his/her right to a hearing pursuant to Section 11.0.

5.12 Notification of Appointment. UHCD shall notify appointee of the Board of Directors' approval of their requests for appointment and/or clinical privileges.

6.0 PROCEDURES FOR REAPPOINTMENT TO THE ACTIVE, COURTESY, FELLOW AND ASSOCIATE STAFF

6.1 General Requirements. Reappointment and/or renewal or revision of clinical privileges is based on a reappraisal of the Medical Staff member at the time of reappointment and/or renewal or revision of clinical privileges. Reappointment to the Medical Staff is required for all Active, Courtesy, Fellow and Associate Staff members at least every two (2) years on a staggered schedule by clinical department. In order to be eligible for reappointment, members of the Medical Staff must maintain a University faculty appointment in the academic department corresponding to the Hospital clinical department as defined by the individual

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clinical departments on the applicable departmental site-specific privilege delineation form and as approved by Clinical Council and the Board of Directors and, subject to Section 4.2.5, maintain employment by or affiliation with UHMG and/or UHMP, or membership in good standing at a UH Institute.

6.2 Conditions of Application. By applying for reappointment to the Medical Staff and clinical privileges, the applicant:

6.2.1 Agrees to appear for interviews in regard to his/her application;

6.2.2 Authorizes Hospital representatives to consult with others who have been associated with him/her and who may have information bearing on his/her competence and qualifications;

6.2.3 Consents to the inspection by Hospital representatives of all records and documents pertinent to his/her licensure, specific training, experience, and current competency and ability to carry out the clinical privileges he/she requests, relationships with peers and patients as well as of his/her ethical qualifications for Medical Staff membership;

6.2.4 Consents to the release of any information pertaining to his/her professional competence or professional conduct to any UH wholly-owned entity where he/she is privileged, both during the application process and throughout the duration of his/her appointment.

6.2.5 Releases from any liability the Hospital, its Board and each of their respective committees, affiliates, agents, employees and representatives for their acts performed and statements made in good faith and without malice in connection with evaluating the applicant and his/her credentials;

6.2.6 Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges;

6.2.7 Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located;

6.2.8 Is required to submit any reasonable evidence of current health status that may be requested by Clinical Council or its designee; and

6.2.9 Is required to submit a complete, accurate, up-to-date reappointment application.

6.3 Initiation of Reappointment/Reappraisal Process. UHCD will initiate the reappointment process with all current members of the Medical Staff in the clinical departments in accordance with the staggered reappointment schedule.

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6.3.1 Condition. Medical Staff members who are determined to have a material financial relationship as defined in Section 8.2 of the University Hospitals Cleveland Medical Center Medical Staff Rules and Regulations, are not considered eligible for reappointment to the Medical Staff, and their application will not be processed by UHCD unless the applicant indicates in the information request that he/she is planning to terminate the material financial relationship upon or before reappointment to the Medical Staff. In the event that a Medical Staff member has a material financial relationship and indicates an intent to terminate such relationship, the application for reappointment will be processed contingent upon such termination. In the event that the Medical Staff member is not considered eligible for reappointment, the Medical Staff member's Medical Staff appointment and clinical privileges will expire at the end of the Medical Staff member's current appointment period. This shall be considered a voluntary resignation.

There shall be no rights to a hearing or appellate review as provided in Section 11.0 of these Bylaws.

6.4 Application. A complete application for reappointment to the Medical Staff shall contain complete, accurate and up-to-date information and shall be submitted to UHCD and shall contain the following:

6.4.1 completed application form consisting of the credentialing application form prescribed by the Ohio Department of Insurance and the University Hospitals Health System Application for Recredentialing;

6.4.2 current demographic information, including a personal, confidential electronic mail (e-mail) address (except for members of the Honorary Staff) to monitor critical communications from UH or Administration;

6.4.3 description of education, training, professional experience (if new);

6.4.4 information regarding any former or current professional liability or malpractice actions, including but not limited to litigation, arbitration or mediation, regardless of status, method or outcome;

6.4.5 information regarding whether the applicant's professional license or controlled substance registration (federal DEA), in any jurisdiction, has ever been the subject of or is the subject of a disciplinary action, restriction, revocation, suspension or limitation of any kind and whether voluntary or involuntary relinquishment or limitation of such licensure or registration has occurred;

6.4.6 any voluntary or involuntary

6.4.6.1 termination or denial of Medical Staff membership, or
6.4.6.2 limitation, reduction, or loss of clinical privileges or employment at any other health care organization;

6.4.7 information regarding any physical or mental condition which could affect the ability of an applicant to exercise the clinical privileges requested or would require an accommodation in order to exercise the privileges requested safely and competently;

6.4.8 any history of state or federal criminal charges or convictions;

6.4.9 signed Condition of Application/Release and Immunity Statement;

6.4.10 documentation of current State license(s) to practice;

6.4.11 documentation of a current, unrestricted DEA registration valid in the State of Ohio (unless such registration is not required for the member's discipline, scope of practice, or requested privileges);

6.4.12 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

6.4.13 proof of board certification (if applicable), as indicated on the privilege delineation form, as established by department policy;

6.4.14 copy of current curriculum vitae;

6.4.15 evidence of professional continuing education;

6.4.16 completed privilege delineation form corresponding to specific site where clinical privileges are requested and to staff category as defined by these Bylaws;

6.4.17 any documentation needed to support the request for clinical privileges that require special training or experience (as indicated on privilege delineation form or as established by department policy);

6.4.18 proof of compliance with the Hospital Communicable Diseases Policy;

6.4.19 reappointment activity profile which outlines inpatient and practice activities at the Hospital;

6.4.20 signed University Hospitals Health System Corporate Compliance Certification; and

6.4.21 any other necessary documentation requested by the Credentialing Committee, or its designees, to adequately evaluate the application.

6.5 Processing Application.

6.5.1 Application. UHCD shall process the reappointment application of applicants with no material financial relationship with a Health System (or its controlled entity) not affiliated with UH.

6.5.2 Assessment. Following submission of a completed application, UHCD shall review the file for thoroughness and receipt of all required documentation. UHCD has the right to request additional information or clarification of information presented by the applicant.

6.5.3 Burden of Proof. A reappointment application is considered incomplete until all required documents and information have been submitted. The applicant has the following responsibilities:

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6.5.3.1 to produce sufficient information for a proper evaluation of his/her training, experience, current competence, prior health care organization affiliations, liability history, and health status;
6.5.3.2 to resolve any questions about these or any of the qualifications for Medical Staff reappointment and clinical privileges; and
6.5.3.3 to satisfy any requests by the Hospital or Hospital representatives for additional information or clarification of information presented.

6.5.4 <u>Verification of Information.</u> UHCD verifies the following from the primary source, according to listing of approved sources for primary source verification, when feasible:

6.5.4.1 any new training during the previous two (2) years;
6.5.4.2 any new board specialty certifications or recertifications during the previous two (2) years;
6.5.4.3 AMA Physician Profile or AOA Osteopathic Physician Profile Report may be used for primary source verification;
6.5.4.4 if attempts to contact primary sources are not successful, approved equivalent sources or other reliable secondary sources may be used to verify licensure, training, experience, and current competence;
6.5.4.5 the clinical competence of the applicant by obtaining a peer evaluation from the primary facility where he/she is affiliated. Peer is defined as appropriate practitioner in the same professional discipline as the applicant who has firsthand knowledge of the applicant;
6.5.4.6 employment by or affiliation with UHMG and/or UHMP, or membership in good standing in a UH Institute, subject to Section 4.2.5;
6.5.4.7 unsuccessful attempts to reach primary sources are documented in the credentials file and reported to the Credentialing Committee.

6.5.5 <u>Queries for Information.</u> At a minimum, UHCD queries the following entities:

6.5.5.1 the National Practitioner Data Bank;
6.5.5.2 the applicable State of Ohio licensure board(s);
6.5.5.3 source for professional background check, if not previously documented.

6.5.6 Each applicant, and the clinical department to which the Medical Staff reappointment and/or clinical privileges are being processed, may be informed of the status of his/her application, upon request.

6.5.7 <u>Termination for Not Completing the Application Process.</u>

6.5.7.1 <u>Application.</u> The applicant is ultimately responsible for ensuring the receipt by UHCD of the completed Application by the deadline. Non-receipt of the completed Application by the deadline will result in the automatic termination of the applicant's Medical Staff appointment and clinical privileges at the end of the applicant's current appointment period. This shall be considered a voluntary resignation.

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6.5.7.2 Incomplete Application. UHCD promptly informs the applicant of any missing information or problems in obtaining verifications of information. The applicant is ultimately responsible for ensuring the receipt of this information. An incomplete reappointment application will result in the automatic termination of the applicant's Medical Staff appointment and clinical privileges at the end of the applicant's current appointment period.

6.6 Time Periods for Processing. All individuals and groups required to act on a complete application for Medical Staff reappointment and clinical privileges must do so in a timely and good faith manner. Except for good cause, each complete application should be submitted to the Credentialing Committee for review and recommendation within 180 days of receipt of a complete reappointment application including all applicable components noted in Section 6.4.1 through 6.4.22 above and ending with submission to the Clinical Council and the Board of Directors for approval.

6.6.1 Deadline for return of completed application. Deadline for return of the completed application, privilege delineation form and all related documentation is no less than sixty (60) days prior to the date of appointment expiration. After notification of the Chairman by the UHCD of the failure of an applicant to file by the deadline, automatic termination from the Medical Staff shall result at the expiration of the current appointment period and shall be considered a voluntary resignation.

6.7 Credentialing Committee and Chairman Review. UHCD screens all reappointment applications to determine whether any applications are deemed to be with issue. UHCD submits all applications, except those with issue, to the Credentialing Committee for review.

6.7.1 Any application determined to be with issue shall be submitted directly to the Chairman, who, after reviewing the application, shall forward it to the Credentialing Committee with a preliminary recommendation. For purposes of this section, an application is determined to be with issue if it deviates from one or more baseline criteria pre-established by UHCD.

6.7.2 Upon receipt, the Credentialing Committee shall review the application and evaluate the reappointment and clinical privileges requested based on the available documentation, including any preliminary recommendation from the Chairman.

6.7.1.1 The Credentialing Committee shall make a recommendation for reappointment and/or clinical privileges to the Chairman.

6.7.1.2 If the Credentialing Committee is unable to make a recommendation for reappointment or clinical privileges without further evidence of training experience, competence, relationship with peers and patients, and/or ethics, it may recommend that UHCD obtain additional information from the applicant.

6.7.1.3 Recommendations to Clinical Council for reappointment and clinical privileges rest solely with the Chairman. Upon consideration of the Credentialing Committee and Division Chief (if applicable) recommendations; full range of privileges requested; substantive, practitioner-specific review of variations reported through hospital-wide and department-specific

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reporting and performance monitoring mechanisms, including but not limited to quality improvement activities, patient complaints, patient satisfaction and utilization management, the Chairman then submits his/her recommendations to the Clinical Council.

6.8 If the recommendations of the Credentialing Committee and Chairman for appointment and/or clinical privileges conflict, Clinical Council shall be informed of this fact.

6.9 Clinical Council. The Clinical Council or its Executive Committee shall review all reappointment and clinical privilege recommendations from the Clinical Department and transmit its recommendations to the next meeting of the Board of Directors or to the Board of Directors' authorized committee. If the Clinical Council's recommendation is to deny reappointment or clinical privileges, the Chief Medical Officer shall send notice to the applicant for reappointment of his/her right to a hearing pursuant to Section 11.

6.10 Board of Directors. The Board of Directors shall review all recommendations transmitted to it from Clinical Council; the Board of Directors has the final decision on all applications. The Board of Directors may elect to delegate the authority to render reappointment and clinical privileges decisions for those practitioners meeting eligibility criteria to a committee of the Board of Directors, containing three or more members of the Board of Directors. In the event a practitioner at UH Cleveland Medical Center receives an interim appointment or interim privileges within 90 days of the reappointment/renewal of privileges date for his/her clinical department, the Board of Directors shall take action on his/her initial application at the same time it takes action on the entire clinical department's applications for reappointment/renewal of privileges. If the Board of Directors denies a favorable recommendation of the Clinical Council, the Chief Medical Officer shall send notice to the applicant for reappointment and/or clinical privileges of his/her right to a hearing pursuant to Section 11.

6.11 Notification of Reappointment. UHCD will notify all applicants of the Board of Directors' final decision on their requests for reappointment and/or clinical privileges no later than 60 days after recommendation from the Credentials Committee.

6.12 Late Penalties. Reinstatement to the Medical Staff due to submission of a Request for Application and/or a reappointment application after the final deadline requires approval by the Chairman and each will be subject to a reappointment reinstatement fee.

7.0 OTHER MEDICAL STAFF MEMBER ACTIONS

7.1 Appointments to the Honorary Staff. An appointment to the Honorary category of the Medical Staff is reserved for members of the Medical Staff who are retiring from clinical practice. Members of the Honorary Staff are not required to meet any of the reappointment requirements of the Active, Courtesy, Fellow or Associate Staff as they do not have clinical privileges or any patient contact. Termination of the appointment is necessary upon the Medical Staff member's death, or by personal request, or as deemed necessary by the Chief Medical Officer. Honorary appointments must be recommended by the Chairman, and approved by the Clinical Council and Board of Directors.

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7.2 Change in Appointment Status or Clinical Privileges.

7.2.1 A Medical Staff member requesting to make a change in Medical Staff status between appointment periods must make application in writing including the reason for the request, to the Chairman. The request shall be referred to UHCD for processing and final approval by the Credentialing Committee, Chairman, Clinical Council and Board of Directors. If change in status requires addition of clinical privileges, section 7.2.2 shall apply,

7.2.2 Clinical privileges are site-specific as defined by the individual clinical departments on the applicable departmental site-specific privilege delineation form, and as approved by Clinical Council and the Board of Directors A Medical Staff member requesting a change in clinical privileges and/or the site where clinical privileges are to be exercised between appointment periods shall make such request in writing to the Chairman, who shall submit approved requests to UHCD for processing.

7.2.2.1 Change in site where clinical privileges are exercised. The Medical Staff member must meet eligibility criteria as defined by the individual clinical departments on the applicable departmental site-specific privilege delineation form, and as approved by Clinical Council and the Board of Directors

7.2.2.2 Addition of clinical privileges.

7.2.2.2.1 The Medical Staff member must provide evidence of training or experience in accordance with the applicable policies of the clinical department as approved by the Board of Directors for those privileges being requested.

7.2.2.3 After processing by UHCD, requests are submitted for final approval by the Credentialing Committee, Chairman, Clinical Council and Board of Directors.

7.2.2.4 If privileges are being relinquished, no additional documentation is required.

7.2.2.5 UHCD queries the following entities for information:

7.2.2.5.1 The National Practitioner Data Bank;

7.2.2.5.2 The applicable State of Ohio licensure board(s).

7.3 Secondary Appointments.

7.3.1 In order to obtain a Medical Staff appointment and/or clinical privileges in a second department, the applicant must make written application to the appropriate Chairman. Secondary appointments are subject to the conditions under Section 4.3 of these Bylaws.

7.3.2 Such application shall be processed and approved in a similar manner as an initial application as outlined under Sections 5.3 through 5.12, and

7.3.3 Subject to all requirements for interim appointments as outlined under section 5.8.

7.4 Leave of Absence.

7.4.1 Request for voluntary leave of absence from the Medical Staff shall be submitted in writing to the Chairman for a minimum of three (3) months,

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but not to exceed a two (2) year period. A leave of absence (LOA) may be granted to Medical Staff members for any reason deemed appropriate by the Chairman, such as illness, personal reasons, further clinical or academic training or military duty.

7.4.2 The Chairman is responsible for completing an LOA request form (indicating terms of LOA) and submitting it to UHCD, which will notify the Medical Staff member and other appropriate Hospital departments in writing of the terms of the LOA.

7.4.3 A member on LOA status shall not have admitting or clinical privileges in the Hospital during the LOA period. He/she shall be excused from liability insurance requirements of the Hospital and departmental responsibilities such as: committee meetings, teaching responsibilities, clinical responsibilities, etc.

7.4.4 Before the Medical Staff member resumes his/her previous status and clinical privileges, the Medical Staff member must provide to UHCD:

7.4.4.1 documentation verifying liability insurance coverage;
7.4.4.2 proof of current, unrestricted DEA registration valid in the State of Ohio (unless such registration is not required for the member's discipline, scope of practice, or requested privileges);
7.4.4.3 proofs of compliance with the Hospitals communicable diseases policy; and
7.4.4.4 information regarding his/her activities and whereabouts during the LOA for verification and processing by UHCD.

7.4.5 Queries for Information. UHCD queries the following entities:

7.4.5.1 National Practitioner Data Bank;
7.4.5.2 the applicable State of Ohio licensure board(s);
7.4.5.3 source for professional background check, if not previously documented; and
7.4.5.4 verifies status of faculty appointment at the University, as defined by the individual clinical departments on the applicable departmental site-specific privilege delineation form as approved by Clinical Council and the Board of Directors.

7.4.6 A requested return from LOA must be recommended by the Chairman and reviewed by the Credentialing Committee before an interim return from LOA becomes effective, subject to the criteria for interim appointment to the Medical Staff, Section 5.8.1.1.

7.4.7 The Chairman shall make a preliminary recommendation for return from LOA and clinical privileges subject to further review by the Credentialing Committee. After review and favorable recommendation by the Credentialing Committee and upon recommendation of the Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant the Medical Staff member an interim return from LOA and clinical privileges for a period not to exceed 120 days in order to complete the approval process. UHCD will notify applicants of the approval of his/her interim return from LOA and clinical privileges no later than 10 days after Credentialing Committee approval.

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7.4.8 Recommendations for return from LOA are submitted to the Clinical Council and the Board of Directors for final approval.

7.4.9 Notification of Appointment. UHCD shall notify practitioners of the Board of Directors' approval of their requests for return from LOA and clinical privileges.

7.4.10 It is the Medical Staff member's responsibility to submit a request to return from LOA prior to the LOA's expiration. If the Medical Staff member does not submit a request to return from LOA or a letter of resignation prior to LOA expiration, the clinical department and/or UHCD has no responsibility and shall not be required to make any effort to locate the practitioner. If the practitioner is unable to be located prior to the LOA expiration, he/she shall be terminated from the Medical Staff upon recommendation from the Chairman. Such terminations shall be effective on the date of notification to UHCD by the Chairman, and shall be reported to the Clinical Council and Board of Directors. Termination from the Medical Staff resulting from this Section 7.4.10 shall be considered a voluntary resignation.

7.5 Resignations and Terminations.

7.5.1 Resignations.

7.5.1.1 Resignations from the Medical Staff shall be submitted in writing to the Chairman, who shall notify UHCD, or directly to UHCD.
7.5.1.2 Such resignations shall be effective on the date indicated by the resigning Medical Staff member.
7.5.1.3 Resignations shall be submitted to the Clinical Council and Board of Directors for information.
7.5.1.4 UHCD shall inform the appropriate Hospital departments and shall send the Medical Staff member written confirmation of the terminated appointment:
7.5.1.4.1 On receipt of notice of the resignation from Chairman or Medical Staff member, and
7.5.1.4.2 On final ratification of the termination by the Board of Directors.

7.5.2 Terminations.

7.5.2.1 If the Medical Staff member should die, he/she shall be terminated from the Medical Staff effective with verification of the death by UHCD. Such terminations shall be reported to the Clinical Council and Board of Directors.
7.5.2.2 When a Medical Staff member has left the geographic area, or is unable to be located as determined by the Clinical Department and/or UHCD following reasonable effort, without submitting a resignation letter, his/her Medical Staff appointment and clinical privileges shall be terminated upon recommendation of the Chairman. Such terminations shall be effective on the date of notification to UHCD by the Chairman, and shall be reported to the Clinical Council and Board of Directors.
7.5.2.3 Subject to Section 4.2.5, if a Medical Staff member's employment or affiliation with UHMG or UHMP is terminated such that the Medical Staff member has no employment or affiliation with either group, or membership in a UH Institute is terminated,

or his/her employment with a Locum Tenens Agency is terminated, his/her Medical Staff appointment and clinical privileges shall be terminated by UHCD effective upon the date of the group employment, affiliation or Agency termination. Such termination shall be reported to Clinical Council and the Board of Directors.

7.5.2.4 If a Medical Staff member fails to apply for reappointment or renewal of privileges within the required time and reappointment or renewal of privileges therefore does not occur, the membership and clinical privileges of the individual shall automatically be terminated. The individual shall be notified of the termination and of the need to submit an initial application, if membership or clinical privileges are sought.

7.5.2.5 UHCD shall inform the appropriate Hospital departments and shall send the Medical Staff member written confirmation of the terminated appointment and clinical privileges, with the exception of Section 7.5.2.1:

7.5.2.5.1 On notice of termination from the Chairman or by UHCD when automatically imposed according to Sections 7.5.2.3-7.5.2.5, and

7.5.2.5.2 On final ratification of termination from the Board of Directors.

7.5.2.6 The tenure status of a Medical Staff member at Case Western School of Medicine has no impact on his/her salary or financial compensation at UH.

7.6 Reinstatement of Medical Staff Appointment. Practitioners seeking reinstatement following resignation or termination from the Medical Staff may apply for reinstatement pursuant to the reappointment procedures in Section 6 if they submit their application for reinstatement within ninety (90) days of their resignation or termination. All other applicants for reinstatement must follow the procedures for initial outlined in Section 5.

7.7 Address Changes. The Medical Staff member shall be responsible for contacting his/her clinical department and UHCD with any changes in his/her office or home address or telephone or facsimile number.

7.8 Electronic Mail (E-mail) Address Changes. The Medical Staff member (except for member of the Honorary Staff) is responsible for contacting UHCD and his/her clinical department with any changes in his/her personal, confidential electronic mail (e-mail) address. The member is further required to refrain from using any e-mail account other than his/her UH-issued e-mail account for sending or receiving protected health information of UH patients, privileged information, or information on other Hospital-related matters.

7.9 Changes in Professional Liability Insurance Coverage. The Medical Staff member shall be responsible for contacting UHCD with any changes in professional liability insurance coverage, including but not limited to name of carrier, limits of coverage, effective and expiration dates, and date of early termination, if any. The Medical Staff member shall be responsible for obtaining appropriate tail or nose coverage with appropriate retroactive date when changing carriers, according to the University Hospitals Cleveland Medical Center Policy on Professional Liability Insurance delineated in Section 2.0 of the Rules and Regulations.

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8.0 ADMITTING PRIVILEGES

8.1 Upon recommendation of the Chairman with concurrence of Clinical Council, the Board of Directors may grant admitting privileges in accordance with state law to a Medical Staff member who has fulfilled all requirements for and has been appointed to the Medical Staff as an Active or Fellow member.

8.2 The granting of admitting privileges permits the Medical Staff member to arrange for the admission of patients to appropriate patient care areas within the Hospital, subject to the availability of services, clinical privileges granted (Section 9 of these Bylaws), Rules and Regulations of the Medical Staff and rules established by the Chairman of the clinical department to which the Medical Staff member is appointed. The Medical Staff member shall be responsible for the direction and supervision of medical care for all patients so admitted until or unless this responsibility is formally transferred to another Medical Staff member.

8.3 Admitting privileges to a clinical department shall be automatically terminated when the Medical Staff appointment or temporary privileges to that clinical department are terminated.

8.4 Admitting privileges may be suspended or rescinded independent of membership to the Medical Staff pursuant to Section 10 in accordance with the due process provisions detailed in Section 11. In addition, admitting privileges may be suspended temporarily by the Chairman of the Clinical Department to which the Medical Staff member is appointed or by the Chief Medical Officer for reasons of administrative discipline including, but not limited to, the reasons stated below. Suspension of admitting privileges shall occur in such a manner so as not to create hardships for or jeopardize the medical care of patients under the care of the Medical Staff member.

8.4.1 Continuing failure to comply with the Medical Staff requirements for documentation of patient care in the medical record.

8.4.2 Evidence of continuing actions on the part of the practitioner contrary to established policies and procedures and/or which interfere with the delivery of patient care.

9.0 CLINICAL PRIVILEGES

9.1 Exercise of Clinical Privileges. Every licensed independent practitioner providing direct clinical services at the Hospital, by virtue of Medical Staff membership, professional services agreement, employment, or authorization to practice pursuant to the Policy for Privileging Licensed Independent Affiliate Healthcare Practitioner (LIAP) and Allied Health Professionals (AHP), shall, in connection with such practice, be entitled to exercise only those setting-specific clinical privileges or provide patient care services as are specifically granted to him/her by the Board of Directors.

9.1.1 All clinical privileges are subject to a period of focused professional practice evaluation (FPPE) consisting of a time-limited period during which the Hospital evaluates and determines the practitioner's professional performance.

9.1.2 FPPE is conducted in the following circumstances:

9.1.2.1 initial privileges are granted to a practitioner;

9.1.2.2 a practitioner with existing privileges requests new, additional privileges; or

9.1.2.3 patterns or trends indicate that a practitioner requires further review of his/her performance of a privilege that he/she already holds.

9.2 Delineation of Clinical Privileges.

9.2.1 Subspecialty privileges may be denied to part-time Medical Staff based upon the need to recruit and retain full-time Medical Staff members and to fulfill institutional objectives of patient care, teaching and research.

9.2.2 If the Hospital lacks adequate facilities, equipment, number and types of qualified support personnel, or other resources for a specific service or procedure, clinical privileges are not granted in those areas.

9.2.3 Prior to granting, renewing or revising clinical privileges, the Chairman shall determine and indicate by approval that sufficient space, equipment, staffing, and financial resources necessary to support the requested privileges are currently available or available within a specified time frame. In the event that necessary resources become unavailable, the Chairman advises UHCD to amend the clinical privileges accordingly.

9.2.4 Every application for Medical Staff appointment and reappointment must contain a request for the particular clinical privileges desired by the applicant. The clinical privilege request shall be site-specific, accurate, precise, and describe in detail the scope of practice permitted at the Hospital site. Clinical privileges are organization- and site-specific, and the evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, ability, peer references, and other relevant information, as appraised by the Credentialing Committee and Chairman. Each applicant must meet the appropriate departmental training/experience and board certification requirements as outlined on the departmental privilege delineation form or in departmental policies for specialized procedures as approved by the Board of Directors. However, special exceptions to these requirements may be requested at the discretion of the Chairman. Exceptions shall be submitted in writing for approval to the Chief Medical Officer and the President (or, in the absence of the President, his/her designee) who will forward approved requests to UHCD for processing; this documentation shall become part of the credentialing file. The applicant shall have the responsibility of establishing his/her qualifications and competency in the area of clinical privileges requested.

9.2.5 There are mechanisms to ensure that Medical Staff members provide services within the scope of privileges delineated.

9.3 Temporary Clinical Privileges. Temporary privileges are those that are granted on a case by case basis when an important patient care need mandates an immediate authorization to practice. Temporary privileges may be granted to physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, optometrists, or nurse midwives who are not members of the Medical Staff for the purpose of teaching, research, providing replacement services for full time

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practitioners on leave (*locum tenens*), or under special circumstances approved by the President (or, in the absence of the President, when necessary, his/her designee) upon recommendation of the Chief Medical Officer and Chairman of the applicable clinical department. Temporary privileges are granted on a time limited basis; in most cases, these privileges are granted for one to two days, or are granted to allow performance of a limited number of procedures, or *locum tenens* services over a period of time not to exceed 120 days. Temporary privileges are not intended to be utilized by current applicants to the Medical Staff who have not yet received their Medical Staff appointments. Granting of temporary clinical privileges shall be subject to a processing fee and the discretion of the Hospital.

9.3.1 Procedure. The following procedures shall be followed and criteria shall be met prior to the granting of temporary clinical privileges:

9.3.1.1 A written request for temporary privileges shall be submitted to the Chief Medical Officer by the Chairman; the Chief Medical Officer shall forward such request to the President (or, in the absence of the President, his/her designee) with his/her recommendation. The following information shall be included in the request:

9.3.1.1.1 reason for the request;
9.3.1.1.2 name of the physician, dentist, oral and maxillofacial surgeon, podiatrist, psychologist, optometrist, or nurse midwife requesting temporary privileges;
9.3.1.1.3 specific clinical and/or admitting privileges being requested
9.3.1.1.3.1 if duration of temporary privileges requested is greater than thirty days, the applicant shall complete the applicable clinical department privilege delineation form and submit appropriate documentation for specialized procedures; and
9.3.1.1.4 date and time (duration) privileges are needed.

9.3.1.2 The following documents shall be attached to the request and forwarded to the Chief Medical Officer's office or UHCD:

9.3.1.2.1 proof of current Ohio professional license;
9.3.1.2.2 current certificate of professional liability insurance covering the scope of privileges requested, in compliance with Hospital policy;
9.3.1.2.3 current curriculum vitae;
9.3.1.2.4 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;
9.3.1.2.5 documentation demonstrating current competence in the area of privileges requested;
9.3.1.2.6 completed temporary privileges application
9.3.1.2.6.1 If duration of temporary privileges requested is greater than thirty days, the applicant shall complete the credentialing application form prescribed

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by the Ohio Department of Insurance and UH Initial Credentialing Application; and

9.3.1.2.7 signed University Hospitals Health System Corporate Compliance Certification;

9.3.1.2.8 signed Physician Acknowledgement Statement wherein the applicant acknowledges the following: *Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws;* provided, however, that by maintaining Medical Staff membership, the applicant acknowledges having received this statement.

9.3.2 If approved by the President (or, in the absence of the President, when necessary, his/her designee), the written request and/or documents shall be forwarded to UHCD for processing and filing.

9.3.3 UHCD is responsible for querying the National Practitioner Data Bank; verifying Ohio licensure, criminal background check, liability insurance, and clinical competence; entering the information into the applicable information system; and notifying the appropriate Hospital departments.

9.3.4 Any practitioner for whom temporary privileges are requested must satisfy the requirements of the UH Communicable Diseases Policy. Temporary privileges will only be granted when the practitioner provides written results of Hepatitis B and TB screening (in accordance with the UH Communicable Diseases Policy) to UH Corporate Health.

9.3.5 Submission of processing fee.

9.3.6 A minimum of one week's advance notice shall be required for processing temporary privilege requests. Granting of temporary privileges is contingent upon satisfaction of all above criteria.

9.3.7 UHCD will notify the applicant of approval of his/her request for temporary privileges no later than 10 days after approval.

9.3.8 The denial, termination, reduction or restriction of temporary privileges shall not give rise to any right to a hearing or appellate review under Section 11.

9.4 Telemedicine Privileges.

9.4.1 Definitions.

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9.4.1.1 Telemedicine: The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

9.4.1.2 Telemedicine privileges: Any licensed independent practitioner who has either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services through a telemedicine link) is credentialed and privileged according to this Section 9.4.

9.4.1.3 Originating site: site where the patient is located at the time the service is provided.

9.4.1.4 Distant site: the site where the practitioner providing the professional service is located.

9.4.2 Services The Medical Staffs at both the originating and distant sites recommend in writing the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites, consistent with commonly accepted quality standards.

9.4.3 Credentialing and privileging standards:

9.4.3.1 Hospital as originating site:

9.4.3.1.1 Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site via one of the following mechanisms:

9.4.3.1.1.1 Hospital fully credential and privilege the practitioner according to Section 5.0 of these Bylaws, or;

9.4.3.1.1.2 practitioner may be privileged for procedures performed via telemedicine link at the Hospital using credentialing information from the distant site if the distant site is Joint Commission-accredited.

9.4.3.1.1.3 out of state practitioners may obtain a telemedicine certificate from the State Medical Board of Ohio according to **§** 4731.296 in lieu of full licensure to practice medicine and surgery in the State of Ohio. The telemedicine certificate holder is subject to all requirements of **§** 4731.296.

9.4.3.1.2 Retains responsibility for overseeing safety and quality of services offered to its patients.

9.4.4 Term of Privileges. A practitioner may be granted telemedicine privileges for a maximum period of two years, according to the staggered appointment schedule of the clinical department where telemedicine privileges are granted. Renewal of telemedicine privileges may be requested by the Chairman, subject to the procedures in Section. 6.0. or practitioner may be privileged for procedures performed via telemedicine link at the Hospital

using credentialing information from the distant site if the distant site is Joint Commission-accredited. Unless renewed, telemedicine privileges will automatically be terminated on the last day of the approved privileges period.

9.5 Peer Review Consulting Privileges. Peer review consulting privileges are those which are granted to physicians, dentists, oral and maxillofacial surgeons or other licensed independent practitioners who are not members of the Medical Staff for the purpose of participating in the Hospital's Medical Staff peer review process and approved by the President (or, in the absence of the President, when necessary, his/her designee) upon recommendation of the Chief Medical Officer and Chairman of the applicable clinical department. Peer review consulting privileges are granted on a time-limited basis; in most cases, these privileges are granted for no more than six months.

9.5.1 Procedure. The following procedures shall be followed and criteria shall be met prior to the granting of peer review consulting privileges:

9.5.1.1 A written request for peer review consulting privileges shall be submitted to the Chief Medical Officer by the Chairman. The Chief Medical Officer shall forward such request to the President with his/her recommendation. The following information shall be included in the request:

9.5.1.1.1 name of the practitioner requesting peer review consulting privileges;
9.5.1.1.2 reason for the request as outlined in Section 13.3 of the Medical Staff Rules and Regulations entitled "Circumstances Requiring External Peer Review;"
9.5.1.1.3 practitioner's specific qualifications and clinical expertise relating to the peer review activity being requested;
9.5.1.1.4 current Ohio professional license; and
9.5.1.1.5 date and time (duration) privileges are needed.

9.5.1.2 If approved by the President (or, in the absence of the President, when necessary, his/her designee), the written request and/or documents shall be forwarded to UHCD for processing and filing.

9.5.1.3 UHCD is responsible for querying the National Practitioner Data Bank, verifying the license and insurance, and entering the information into the credentialing database.

9.5.1.4 A minimum of one week's advance notice shall be required for processing peer review consulting privilege requests. Granting of peer review consulting privileges is contingent upon satisfaction of all above criteria.

9.5.1.5 The denial, termination, reduction or restriction of peer review consulting privileges shall not give rise to any right to a hearing or appellate review under Section 11.

9.6 Medical Staff Plan for Disaster Privileging. During a local, state, or national disaster in which the Hospital's emergency management plan has been activated, and the Hospital is unable to handle the immediate needs of patients, disaster

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privileges may be granted to volunteers eligible to be licensed independent practitioners who are not privileged by the Medical Staff.

9.6.1 Policy and Prerequisites: Any practitioner providing patient care must be granted privileges prior to providing patient care, even in an emergency/disaster situation. The practitioner granted disaster privileges (a modified credentialing and privileging process) is assigned to a clinical department of the Medical Staff and paired with a member of the Active Medical Staff in the same specialty and discipline. Disaster privileges are granted on a time-limited basis, for the duration dictated by the emergency management plan. Disaster privileges do not confer any status on the Medical Staff.

9.6.2 Types of Practitioners Covered: Any physician, oral and maxillofacial surgeon, dentist, psychologist, advanced practice nurse, or physician assistant not privileged by the Medical Staff, or other licensed independent practitioners approved by the President and Chief Medical Officer, and presenting themselves as volunteers to render their services during an emergency or disaster shall be processed accordingly.

9.6.3 Who May Grant Disaster Privileges ("Privileging Authority"): President or Chief Medical Officer, or their designee.

9.6.4 Responsibilities of Privileging Authority:

9.6.4.1 Not required to grant privileges to any individual;
9.6.4.2 Granting of disaster privileges is on a case-by-case basis when an emergent patient care need mandates an immediate authorization to practice, in accordance with the needs of the Hospital and its patients, and on the qualifications of its volunteer practitioners;
9.6.4.3 Authorization based on, at minimum, receipt of a key identification document (see below), completion of the *Medical Staff Plan for Disaster Privileges Request Form* and acknowledgement of *Medical Staff Plan for Disaster Privileging: Practitioner Responsibilities;*
9.6.4.4 Assign, or appoint designee to assign, the volunteer practitioner to a clinical department and assign an Active Medical Staff member of the same specialty and discipline to pair with/supervise the volunteer practitioner for the duration of the disaster privileges;
9.6.4.5 Document initial authorization to practice;
9.6.4.6 Review verified credentials once immediate situation is under control; and
9.6.4.7 Include responsibilities of the Privileging Authority and the mechanism for managing individuals who receive disaster privileges in Hospital's emergency management plan.

9.6.5 Mechanism for Managing Individuals Who Receive Disaster Privileges. The practitioner shall first be routed to the UHCD Office (or specified area) for:

9.6.5.1 Identification
9.6.5.2 Pairing
9.6.5.3 Authorization
9.6.5.4 Verification

9.6.5.5 Documentation

9.6.6 Disaster Privileging Process: Identification

9.6.6.1 Personal Identification and Authorization to Practice, evidenced by a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

9.6.6.1.1 Current Hospital/entity identification card that clearly identifies the professional designation, or

9.6.6.1.2 Proof of current license to practice (e.g., documentation from Ohio licensure board), or

9.6.6.1.3 Primary source verification of the license, or

9.6.6.1.4 Identification indicating that the individual is a member of a Disaster Medical Assistant Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups, or

9.6.6.1.5 Identification indicating that 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

9.6.6.1.6 Identification by a current member of the Hospital or Medical Staff member who possesses personal knowledge regarding practitioner's ability to act as a licensed independent practitioner during a disaster.

9.6.6.2 After completion of the personal identification process detailed above, the practitioner shall be given the standardized regional Disaster Privileges badge by UHCD to ensure ready identification of the volunteer. The badge shall include name, degree/title, ID number, start date of disaster privileges, any limitations, name of Medical Staff member paired with volunteer, name of issuing UHCD staff, and authorization to practice by the Privileging Authority if clinical practice approved for immediate situation, prior to completion of credentials verification.

9.6.7 Disaster Privileging Process: Pairing

9.6.7.1 The medical staff shall oversee the professional practice (care, treatment, and services provided) of volunteer licensed independent practitioners through direct observation, mentoring, and clinical record review. The Privileging Authority or designee shall assign the volunteer practitioner to a clinical department and assign a member of the Active Medical Staff in the same specialty and discipline to pair with/supervise the volunteer practitioner for the duration of the disaster privileges.

9.6.8 Disaster Privileging Process: Authorization

9.6.8.1 The Privileging Authority may authorize disaster privileges for the immediate situation after all of the following requirements are met:

9.6.8.1.1 Presentation of key identification document by practitioner per Section 9.6.6.1.;

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9.6.8.1.2 Completion of the *Medical Staff Plan for Disaster Privileges Request Form* and acknowledgement of *Medical Staff Plan for Disaster Privileging: Practitioner Responsibilities* by practitioner;

9.6.8.1.3 Assignment to clinical department and pairing with Active Medical Staff member in same specialty and discipline by privileging authority or designee; and

9.6.8.1.4 Standardized regional Disaster Privileges badge issued by UHCD personnel.

9.6.8.1.5 The Hospital makes a decision based on information obtained regarding the professional practice of the volunteer within 72 hours related to the continuation of the disaster privileges initially granted.

9.6.9 Disaster Privileging Process: Verification of Credentials and Privileges:

9.6.9.1 A disaster privileges credentials file shall be maintained by UHCD for each practitioner granted disaster privileges;

9.6.9.2 Practitioner shall fully complete a *Medical Staff Plan for Disaster Privileges Request Form*, including attestation;

9.6.9.3 Practitioner shall present proof of Ohio licensure/certification/registration, DEA (if applicable) and current certificate of liability insurance, where feasible;

9.6.9.4 UHCD shall primary source verify the following Ohio professional licensure/certification/registration as soon as the immediate situation is under control, within 72 hours from the time the volunteer presents to the Hospital.

9.6.9.4.1 If extraordinary circumstances prevent primary source verification within 72 hours (e.g., no means of communication or lack of resources), verification will be done as soon as possible. UHCD shall document the following:

9.6.9.4.1.1 Why the verification could not be performed in the required time frame

9.6.9.4.1.2 Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services, and

9.6.9.4.1.3 An attempt to rectify the situation as soon as possible.

9.6.9.4.1.4 Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

9.6.9.5 UHCD shall verify/query the following when possible:

9.6.9.5.1 Proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

9.6.9.5.2 Current certificate of professional liability insurance;

9.6.9.5.3 DEA certification, if applicable;

9.6.9.5.4 Board certification or education and training if not board certified;

9.6.9.5.5 Privileges and status at primary hospital/entity; and

9.6.9.5.6 National Practitioner Data Bank.

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9.6.9.5.7 Primary source verification or inquiry is not required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

9.6.9.6 The Privileging Authority or designee will review and sign off on the credentials file of each practitioner granted disaster privileges.

9.6.9.7 UHCD shall notify appropriate Hospital departments, when feasible.

9.6.9.8 If any negative information is obtained during the credentials verification process, it shall be reviewed by the Privileging Authority, who shall determine if the practitioner shall be required to immediately cease and desist clinical services, relinquish the standardized regional Disaster Privileges badge, and submit documentation of all clinical activities performed on the *Medical Staff Plan for Disaster Privileges Patient Documentation Form*.

9.6.9.9 The denial, termination, reduction or restriction of disaster privileges shall not give rise to any rights contained in the bylaws, rules, or policies and procedures of the Hospital and Medical Staff or UH, including but not limited to a hearing or appellate review.

9.6.10 Disaster Privileging Process: Documentation.

9.6.10.1 Disaster privileges credentials file is created by and maintained in UHCD for each practitioner. It shall contain the following, when feasible:

9.6.10.1.1 Completed *Medical Staff Plan for Disaster Privileges Request Form* (application) with credentials checklist

9.6.10.1.2 Signed *Medical Staff Plan for Disaster Privileging: Practitioner Responsibilities*

9.6.10.1.3 Copy of personal identification per Section 9.6.6.1

9.6.10.1.4 Copy of proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

9.6.10.1.5 Verification of Ohio licensure or exemption per ORC 4731.36

9.6.10.1.6 Verification of board certification or education and training

9.6.10.1.7 Verification of status at primary hospital/entity

9.6.10.1.8 Verification of professional liability insurance coverage

9.6.10.1.9 Verification of DEA certification, if applicable

9.6.10.1.10 National Practitioner Data Bank query

9.6.10.1.11 Approval of Privileging Authority

9.6.10.1.12 Medical Staff Plan for Disaster Privileges Patient Treatment Documentation Form

9.6.11 Duration of Disaster Privileges: Disaster privileges are valid only for the duration of the declared disaster and terminate automatically when the Hospital's emergency management plan is deactivated.

9.6.12 Patients Treated. A list of patients treated by the practitioner granted disaster privileges shall be documented on the *Medical Staff Plan for*

Disaster Privileges Patient Documentation Form and maintained in the practitioner's credentials file.

9.7 Emergency Privileges for Existing Medical Staff members. In the case of an emergency, any individual member of the Medical Staff with clinical privileges is "temporary privileged" to provide any type of patient care necessary as a life-saving measure or to prevent serious harm—regardless of his or her current clinical privileges—if the care provided is within the scope of his/her license.

9.8 Medical Staff Proctoring Program. Clinical privileges with supervision may be granted to a Medical Staff member in accordance with Hospital policy. Proctoring shall not be considered an adverse privileging action, provided that the action is for an evaluative or teaching purpose.

9.9 Medical Staff Observer Policy. Refer to policy UH GM 7, located in the UH Policy & Procedure Manual located on the UH Intranet.

9.10 Bylaws Exceptions. Any qualifications, requirements or limitations in this section or any other section of these Bylaws not required by law or governmental regulation, may be waived at the discretion of the President (or, in the absence of the President, when necessary, his/her designee), upon determination that such waiver will serve the best interests of the patients and of the Hospital, and provided that the Chief Medical Officer has given prior approval of such request. All such requests shall be submitted in writing to the Chief Medical Officer.

The President of the Hospital may grant individual exceptions to the Hospital policy prohibiting members of the Medical Staff from having a material financial relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System for appropriate reasons. The reasons for such exceptions will be documented in writing and the benefits accruing to the Hospital must sufficiently outweigh the risks presented by the economic conflict of interest caused by the material financial relationship present between the practitioner and the competing health system. Approved exceptions shall be forwarded to the Chief Medical Officer who will forward to UHCD for processing. This documentation shall become part of the credentialing file.

10.0 CORRECTIVE ACTION

10.1 Corrective Action.

10.1.1 Staff appointments and clinical privileges may be suspended, permanently revoked, or limited for due cause, including, but not limited to, physical or mental disability, impairment (regardless of cause), failure to provide adequate patient care, or failure to abide by these Bylaws, or the Rules and Regulations and policies of the Medical Staff, Hospital, or UH, including approved and published policies of Departments, Sections, and Committees.

10.1.1.1 The corrective action procedures in this section and Section 11 shall be followed if there is an allegation that a physician's professional competence or professional conduct, including ethical lapses or addiction, adversely affects, or could adversely affect, the health or welfare of a patient. For Medical Staff members who are employed by a UH wholly-owned entity, all other allegations shall be handled through the

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applicable human resources function, and outside of this process.

10.1.1.2 Any person may provide information to the Medical Staff about the conduct, performance, behavior or competence of any member of the Medical Staff. In such circumstances, corrective action under this section and Section 11 may be initiated by the Chief Medical Officer, any Chairman, by the President, or by the Board of Directors. Initiation of corrective action pursuant to this section and Section 11 does not preclude imposition of summary suspension, nor does it require the prior imposition of such a suspension.

10.1.2 All requests for corrective action shall be in writing, submitted to the Chief Medical Officer and supported by a detailed description of the specific conduct or activity or non-performance that constitutes the grounds for the request. The Chief Medical Officer shall review the request for corrective action to determine whether there is probable cause to believe that any corrective action may be taken against such Medical Staff member. If, based upon the information provided, the Chief Medical Officer determines that there is no probable cause to believe that any corrective action should be initiated, the request shall be rejected and the Office of the Chief Medical Officer will report its findings to the requesting party. All other requests for corrective action will be referred to the Clinical Council.

10.1.3 After consideration of the request, the Clinical Council shall either reject the request and report the reasons for its decision to the Chief Medical Officer or appoint an ad hoc committee to investigate. The Medical Staff member who is under investigation shall be entitled to submit to the Clinical Council a written statement of his/her position regarding the investigation. The Medical Staff member may also be invited to appear before the investigating committee, but any such appearance shall be informal in nature and shall not constitute a hearing**.** The ad hoc committee that is performing the investigation may, in their sole discretion, take notice of and/or request and obtain any information or materials that such committee deem relevant to the investigation. Upon completion of the investigation, the Chairman of the investigating committee shall forward a written report of the investigation to the Clinical Council. After consideration, the Clinical Council shall either reject or approve the extension request.

10.1.4 Within thirty (30) days following receipt of the report of the investigation or the next regularly scheduled meeting of the Clinical Council, whichever is later, the Clinical Council shall take action upon the request. In the event the Medical Staff member is a member of the Clinical Council, he/she shall be excluded from all deliberations related to his/her case. Such action may include, without limitation:

10.1.4.1 Rejecting the request for corrective action;
10.1.4.2 Issuing a warning, a letter of admonition, or a letter of reprimand;
10.1.4.3 Recommending terms of probation or requirements of consultation, without restriction on privileges;
10.1.4.4 Recommending reduction, restriction, suspension or revocation of clinical privileges; and
10.1.4.5 Recommending suspension or revocation of Medical Staff appointment.

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10.1.5 Any action taken by the Clinical Council pursuant to Sections 10.1.4.4. or 10.1.4.5 shall entitle the Medical Staff member to the procedural rights as provided in Section 11.0.

10.1.6 Nothing in Section 10.1 shall preclude Medical Staff leadership from engaging in efforts to address performance, behavioral or competency issues prior to resorting to formal corrective action as described in Section 10.1.4. Such collegial interventions shall not be deemed to be corrective actions and shall not give rise to Hearing or Appellate rights and shall not subject the practitioner to reporting to the Ohio State Medical Board or the NPDB, except as otherwise provided in these Bylaws. By way of example, alternatives to corrective action may include, without limitation:

10.1.6.1 Informal discussions or meetings concerning the performance, behavior or competency that gave rise to the complaint,

10.1.6.2 Written letters of guidance

10.1.6.3 Notification of the potential for future monitoring and of expectations for improvement or compliance,

10.1.6.4 Suggestions for methods to improve behaviors, performance or competency.

10.1.7 In the event formal corrective action is taken against a practitioner holding privileges at other UH wholly-owned facilities, the President, Chief Medical Officer, Medical Executive Committee, and Credentialing Committee of each such facility, the division chief to which the practitioner reports at such facility, and the UH Chief Medical Officer shall be notified that such corrective action has been taken at the Hospital; provided that such dissemination be conducted in accordance with the provisions of Section 16 below. Where applicable, the President of any UH-owned entity that employs the practitioner shall be notified in the same manner. For purposes of this section only, "formal corrective action" means corrective action as described in Sections 10.1.4.2 through 10.1.4.5 above, summary suspension, and automatic suspension unrelated to completion of medical records. In instances where a practitioner is entitled to rights under Section 11, such dissemination shall not occur until the practitioner has either waived or fully exhausted such rights, except in cases of summary suspension.

10.1.8 Medical Staff members are obligated to follow all UH policies concerning use and disclosure of patient protected health information ("PHI"). In instances where applicable UH policy calls for termination of employment for a person's unauthorized use or disclosure of PHI, such behavior shall also result in termination of that person's Medical Staff appointment and all clinical privileges, regardless of whether that person has an employment relationship with UH. The corrective action procedures outlined in this Section 10.1 shall otherwise apply. Medical Staff members shall be entitled to due process rights, as set forth in Section 11, for purposes of demonstrating that they did not violate such policy, but they may not challenge the applicability or appropriateness of the policy or argue for a lesser penalty.

10.2 <u>Summary Suspension</u>

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10.2.1 When a Medical Staff member willfully disregards or grossly violates these Bylaws, Rules and Regulations, University Hospitals Health System Corporate Compliance, departmental rules, or other Hospital policies, or whenever his/her conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Medical Staff member materially disrupts the operations of any department or unit of the Hospital, the Chief Medical Officer, or the President, shall have the authority to suspend summarily the Medical Staff appointment, or all or any portion of the admitting and/or clinical privileges, of such Medical Staff member. Such summary suspension shall become effective immediately upon imposition, and the Chief Medical Officer shall promptly give notice of the suspension to the Medical Staff member, and notice to the Clinical Council.

10.2.2 As soon as reasonably possible after such summary suspension, a meeting of the Clinical Council shall be convened to review and consider the action taken. The Clinical Council shall recommend to the Board of Directors modification, continuation, or termination of the terms of the summary suspension.

10.2.3 Unless the Clinical Council recommends immediate termination and revocation of the suspension and of all further corrective action, the Medical Staff member shall be entitled to the procedural rights as provided in Section 11. The terms of the summary suspension as sustained by the Clinical Council shall remain in effect pending a final decision by the Board of Directors.

10.3 Automatic Suspension and Revocation

10.3.1 License: If a Medical Staff member's license to practice his/her profession in the State of Ohio is suspended or otherwise limited in any way, or if a Medical Staff member's respective licensing board materially limits the Medical Staff member's authority to practice without actually restricting or limiting the member's license, or he/she fails to renew such license, then the admitting and clinical privileges of such Medical Staff member shall immediately and automatically be suspended. If a Medical Staff member's license to practice his/her profession in the State of Ohio is revoked, then the Medical Staff appointment, admitting and clinical privileges of such Medical Staff member shall immediately and automatically be revoked.

10.3.2 Drug Enforcement Administration Registration:

10.3.2.1 A Medical Staff member shall maintain a current, valid DEA registration in order to prescribe medications covered by such registration (unless such registration is not required for the member's discipline, scope of practice, or requested privileges). A Medical Staff member who does not provide satisfactory evidence of current, valid DEA registration shall have his/her admitting and clinical privileges suspended immediately and automatically until the Medical Staff member has complied with such policy to the satisfaction of the Clinical Council, acting reasonably.

10.3.2.2 A Medical Staff member whose DEA registration is revoked or suspended or voluntarily relinquished shall have his/her admitting and clinical privileges suspended immediately and automatically. As soon as reasonably possible after such automatic suspension, the Clinical Council shall convene to review and consider the facts under which the DEA registration was revoked or suspended or relinquished. The Clinical Council may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

10.3.3 Conviction of a Felony: Upon exhaustion of appeals after conviction of a felony of a Medical Staff member, or upon the member's plea of guilty thereto, in any court in the United States, either federal or state, the Medical Staff Member's appointment and clinical privileges shall be automatically revoked. Revocation pursuant to this Section of the Bylaws does not preclude the Medical Staff member from subsequently applying for Medical Staff appointment.

10.3.4 Program Exclusion. A Medical Staff member's appointment, admitting and clinical privileges shall be automatically suspended in the event the member is excluded or debarred from participation in Medicare, Medicaid or any other federal or state health care program.

10.3.5 Medical Records. Every medical record shall be completed (including signed and dated) as soon as possible after a patient is discharged. A medical record that is incomplete at thirty (30) days after discharge shall be deemed "delinquent." In order to prevent records from being deemed delinquent, penalties shall be imposed prior to the effective date of a delinquency.

10.3.5.1 A Medical Staff member who fails to complete a medical record within twenty-eight (28) days after the patient is discharged shall have elective and emergency admitting privileges suspended pursuant to a notification process.

10.3.5.2 A Medical Staff member who has five (5) or more incomplete medical records twenty-eight (28) or more days following patient discharge or any number of medical records that are incomplete more than ninety (90) days after a patient is discharged, shall be suspended from all admitting and clinical privileges ("clinical suspension"), pursuant to a notice of suspension issued by the Chief Medical Officer. The clinical suspension shall continue until the Director of Health Information Services determines that the Medical Staff member has completed all incomplete medical records and the Chief Medical Officer determines that the clinical suspension should end. Such clinical suspension will include suspension of access to all Information Systems within the Hospital.

10.3.5.3 A Medical Staff member who has extenuating circumstances that prevent him/her from completing his/her medical records should notify Health Information Services as soon as possible. Extenuating circumstances that may be considered permissible reasons for failing to complete medical records on a timely basis are limited to serious illness or extended absence from the Northeast Ohio area.

10.3.5.4 A Medical Staff member who has been clinically suspended pursuant to this section three (3) times within any twelve (12) month period shall be terminated from the Medical Staff. Once terminated, admitting and clinical privileges may be restored only according to the reinstatement process set forth in Section 7.6 of the Bylaws.

10.3.5.5 A Medical Staff member under suspension according to this Section 10.3.4 shall be entitled to all procedural rights provided in Section 11 only for the purpose of establishing justification for the delay in completing medical records.

10.3.6 Communicable Disease Policy. A Medical Staff member who does not comply with the Hospital's communicable disease policy by failing to be tested for tuberculosis, hepatitis B, or other diseases identified by such policy from time to time, or by failing to submit the results of such screenings, shall have his/her admitting and clinical privileges suspended immediately and automatically until the Medical Staff member has complied with such policy.

10.3.7 Professional Liability Insurance Coverage. A Medical Staff member who does not provide satisfactory evidence of current professional liability insurance coverage in accordance with Hospital policy, shall have his/her admitting and clinical privileges suspended immediately and automatically until the Medical Staff member has complied with such policy to the satisfaction of the Clinical Council, acting reasonably.

10.3.8 Mandatory Professional Education. A Medical Staff member who does not provide satisfactory evidence of completing Hospital mandatory professional education programs, as defined by the Chief Medical Officer and the President, shall have his/her admitting and clinical privileges suspended immediately and automatically until the Medical Staff member has provided such evidence.

10.3.9 UH Corporate Compliance Programs. A Medical Staff member who has failed to comply with the training and reporting requirements of any Hospital or UH Compliance Program or Policy, in accordance with the stated program or policy, shall have his/her admitting and clinical privileges suspended immediately and automatically until the Medical Staff member demonstrates that he/she has complied with all such requirements.

10.3.10 Three Month Limit for Suspensions. In the event that a Medical Staff member has failed to cure the violation resulting in his or her automatic suspension within three (3) months, such Medical Staff member shall be automatically terminated from the Medical Staff. Such Medical Staff member shall be considered to have voluntarily resigned from the Medical Staff and shall have no hearing rights under Section 11.0 or otherwise.

10.4 Continuity of Patient Care. Upon the imposition of summary suspension or the occurrence of an automatic suspension, the Chief Medical Officer or the Chairman of the Clinical Department to which the suspended Medical Staff member is assigned, shall provide for alternative coverage of the Hospital patients assigned to the suspended Medical Staff member. The wishes of the patient shall be considered, where feasible, in choosing a substitute Medical Staff member; the suspended Medical Staff member shall confer with the substitute Medical Staff member to the extent necessary to safeguard the patient.

10.5 Consistency of Action. By signing and submitting an application for medical staff

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appointment and/or privileges, the applicant acknowledges that the Hospital is part of a healthcare system with other hospitals within University Hospital Health System ("Affiliate Hospitals") and that information is shared among the Hospital and Affiliate Hospitals. As a condition of appointment and/or grant of privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her appointment and/or privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospitals may be shared among the Hospital and Affiliate Hospitals. The applicant further understands that this information may be used as part of the respective Hospital's or an Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

10.5.1 So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospitals are part of the same healthcare system and that the Hospital and the Affiliate Hospitals have agreed to share information regarding appointment and/or privileges, the following automatic actions shall occur:

10.5.1.1 With the exception of an automatic suspension for delinquent medical records and/or non-payment of dues, if a practitioner's appointment and/or privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the practitioner's appointment and/or Privileges at this Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations.

10.5.1.2 If a practitioner's appointment and/or privileges are summarily suspended or if a practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the practitioner's appointment and/or Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

10.5.1.3 If a practitioner's appointment and/or privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations unless otherwise provided in the final decision at the Affiliate Hospital.

10.5.1.4 If a practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of Privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the practitioner's Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural due process rights set forth in these Bylaws and the Rules and Regulations.

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11.0 FAIR HEARING AND APPELLATE REVIEW FOR MEDICAL STAFF MEMBERS AND APPLICANTS

11.1 Hearing and Appellate Review

11.1.1 Adverse Clinical Council Recommendation. When any Medical Staff member or applicant for membership receives notice of an adverse recommendation or action of the Clinical Council, as described in Section 10.1.4 or 10.1.5, he/she shall be entitled, upon request, to a hearing before an ad hoc hearing committee of the Medical Staff. If the recommendation of the Clinical Council following such hearing is still adverse to the Medical Staff member, he/she shall then be entitled, upon request, to an appellate review by the Board of Directors before a final decision is rendered.

11.1.2 Adverse Board Decision. When any Medical Staff member or applicant for membership receives notice of an adverse decision by the Board of Directors taken either contrary to a favorable recommendation by the Clinical Council under circumstances where no right to a hearing existed, or on the initiative of the Board of Directors without benefit of a prior recommendation by the Clinical Council under circumstances where no right to a hearing existed, such Medical Staff member shall be entitled, upon request, to a hearing by an ad hoc hearing committee appointed by the Board of Directors. If such hearing does not result in a favorable recommendation, he/she shall then be entitled, upon request, to an appellate review by the Board of Directors before a final decision is rendered.

11.1.3 Procedure and Process. All hearings and appellate reviews shall be in accordance with the procedure set forth in this Section 11.0. Where applicable, the limitations in Section 10.8 shall apply.

11.1.4 Exceptions. The denial, termination, reduction or restriction or any other actions, except those specified in this Section 11.0 shall not give rise to a hearing or appellate review.

11.1.5 Status of Medical Staff Appointment. Except in the case of a summary suspension under Section 10.2 or automatic suspension and revocation under Section 10.3 any corrective action against a Medical Staff member shall not become effective in the event that such Medical Staff member makes a written request for a hearing under this Section 11. The appointment and/or clinical privileges of the Medical Staff member shall continue pending the outcome of the Fair Hearing process.

11.2. Definitions. The following definitions, in addition to those stated in other provisions of the Medical Staff Bylaws, shall apply to the provisions of this Section 11.0:

11.2.1 Appellate Review Body means the group designated pursuant to Section 11.4.3 to hear a request for appellate review properly filed and pursued by a practitioner.

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11.2.2 Hearing Committee means the committee appointed pursuant to Section 11.4.3 to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

11.2.3 Parties means the practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review request is predicated.

11.3 Initiation of Hearing.

11.3.1 Recommendations or Actions. The following recommendations or actions shall, if deemed adverse pursuant to Section 11.3.2, entitle the practitioner affected thereby to a hearing:

11.3.1.1 Denial of initial Medical Staff appointment;
11.3.1.2 Termination of appointment following provisional period;
11.3.1.3 Denial of reappointment;
11.3.1.4 Suspension of Medical Staff appointment;
11.3.1.5 Revocation of Medical Staff appointment;
11.3.1.6 Denial of requested modification of Medical Staff category;
11.3.1.7 Denial of requested Department or Division assignment;
11.3.1.8 Denial of requested clinical privileges;
11.3.1.9 Reduction or restrictions of clinical privileges;
11.3.1.10 Suspension of clinical privileges;
11.3.1.11 Revocation of clinical privileges;
11.3.1.12 Limitation of admitting privileges;

11.3.2 When Deemed Adverse. A recommendation or action listed in Section 11.3.1 shall be deemed an adverse action only when it has been:

11.3.2.1 Recommended by the Clinical Council; or
11.3.2.2 A suspension continued in effect after review by the Clinical Council and/or the Board of Directors; or
11.3.2.3 Taken by the Board of Directors contrary to a favorable recommendation by the Clinical Council under circumstances where no prior right to a hearing existed; or
11.3.2.4 Taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Clinical Council; or
11.3.2.5 Imposed automatically under Section 10.0.

11.3.3 Notice of Adverse Recommendation or Action. A practitioner against whom adverse action has been taken pursuant to Section 11.3.2. shall promptly be given notice of such action and reason(s) for such action by the Chief Medical Officer. The notice shall indicate that the practitioner may request a hearing in accordance with Section 11.3.4, and shall contain a summary of the rights in the hearing. Where adverse action was taken pursuant to Section 10.8, the notice to the practitioner shall advise him/her of the limited scope of the hearing.

11.3.4 Request for Hearing. A practitioner shall have thirty (30) calendar days following his/her receipt of a notice pursuant to Section 11.3.3 to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the Chief Medical Officer in person or when sent by certified mail to the Chief Medical Officer properly addressed and

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postage paid. Where applicable, a request for hearing must comply with the provisions of Section 10.1.8.

11.3.5. 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 11.3.4. waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

11.4 Hearing Prerequisites.

11.4.1 Notice of Time and Place of Hearing. The Chief Medical Officer or the Chairman of the Board of Directors, depending on whose recommendation or action prompted the request for hearing, shall promptly schedule and arrange for a hearing. The President (or his/her designee) shall send the practitioner notice of the time, place, and date of the hearing. Reasonable efforts shall be used to schedule the hearing between thirty (30) and forty-five (45) calendar days from the date of receipt of the request for hearing.

11.4.2 Statement of Charges and Witness Lists. The notice of hearing required by Section 11.4.1 shall contain a concise statement of the practitioner's alleged acts or omissions, and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. Not less than fourteen (14) days prior to the scheduled date of the hearing, the Hospital and the practitioner shall exchange lists of the witnesses and evidence each intends to introduce or rely upon during the hearing. Additional witnesses may be permitted to testify at the hearing at the discretion of the hearing committee.

11.4.3 Appointment of Hearing Committee.

11.4.3.1 By Medical Staff. A hearing occasioned by the Clinical Council pursuant to Section 11.3.2.1 shall be conducted before a Hearing Committee of the Medical Staff selected by the Chief Medical Officer. The Members selected to serve on the Hearing Committee shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level.

11.4.3.2.1 The Hearing Committee shall consist of three (3) Members of the Medical Staff. If the request for corrective action substantially involves matters unique to the medical/surgical specialty of the Member who requested the hearing, the Hearing Committee shall, wherever possible, include at least one (1) Member who is a physician from that same specialty.

11.4.3.2.2 Each Hearing Committee shall choose from among its number a Presiding Officer who shall arrange for the conduct of the Committee's administration, act to maintain decorum, and assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Presiding Officer shall have the authority to determine the order of

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procedure during the hearing, and shall make all rulings on matters of law, procedure, and the relevance and admissibility of evidence.

11.4.3.2.3 All three (3) members of the Hearing Committee shall be required to hear the evidence presented at any hearing and subsequently conduct private deliberations. Any decision adopted by two (2) members of the Committee shall be the decision of the Committee. Counsel for the Hearing Committee may participate in the deliberations of the Hearing Committee, but may not vote. All expenses for the conduct of any hearing by a Hearing Committee shall be borne by the Hospital.

11.4.3.2 By Board of Directors. A hearing occasioned by an adverse action of the Board of Directors pursuant to Section 11.3.2.2, 11.3.2.3 or 11.3.2.4, shall be conducted before a hearing committee appointed by the Chairman of the Board of Directors and composed of at least five (5) Members of the Board of Directors, one of whom shall be designated as Chairman.

11.4.3.3 Service on Hearing Committee. All members of a hearing committee shall be required to consider and decide the case with good faith objectivity. A Member of the Medical Staff or the Board of Directors so appointed shall not be in direct economic competition with the practitioner involved. The fact that an individual is employed by a UH-owned entity, in and of itself, shall not be construed as direct economic competition.

11.5 Hearing Procedure.

11.5.1 Personal Presence. The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 11.3.5.

11.5.2 Counsel to the Hearing Committee. The Chief Medical Officer shall, after consultation with the parties, also appoint a Counsel to the Hearing Committee. The Counsel shall be an independent attorney at law, shall be free from professional conflicts of interest, and shall have experience in Medical Staff matters. The Counsel shall advise the Hearing Committee generally on the discharge of its functions, and shall draft the findings and conclusions of the Hearing Committee as requested by and in consultation with the Hearing Committee. The Counsel may participate in the deliberations of the Hearing Committee, but may not vote.

11.5.3 Representation. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Medical Staff member in good standing, by a member of his/her local professional society, or by an attorney, or other person of the practitioner's choice. The Clinical Council or the Board of Directors, depending upon whose recommendation has prompted the hearing, shall appoint one of its members, or in the case of the Clinical Council, any Medical Staff member

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or legal counsel to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses.

11.5.4 Rights of Parties. During a hearing, each of the parties shall have the right to:

11.5.4.1 Call and examine witnesses;
11.5.4.2 Introduce exhibits;
11.5.4.3 Cross-examine any witness on any matter relevant to the issues;
11.5.4.4 Impeach any witness;
11.5.4.5 Rebut any evidence; and/or
11.5.4.6 Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

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

11.5.5 Procedure and Evidence. The hearing shall not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons 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 or during the hearing, be entitled to submit a written summary of the facts, and such summary shall become a part of the hearing record. The hearing committee may require one or both parties to prepare and submit to the committee, written statements of their position on the issues, prior to, during, or at the close of the hearing. The hearing committee may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and exhibits. The presiding officer shall not require that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents.

11.5.6 Pertinent Material. The committee, as well as the practitioner, shall be entitled to consider any pertinent material contained in the practitioner's Hospital credentialing file. In the event that the practitioner has been subjected to any final disciplinary sanction at another UH wholly-owned entity, the existence of such sanction, as well as the complete hearing record relating to that sanction (if any), are admissible as evidence. However, the committee shall not be bound by the findings of the earlier proceeding, and is entitled to give such findings whatever weight it deems appropriate. For purposes of this section, "final disciplinary sanction" refers to any action described in sections 10.1.4.2 through 10.1.4.5 which has been imposed after exhaustion or waiver of all available due process rights.

11.5.7 Burden of Proof. When a hearing relates to Sections 11.3.1.1, 11.3.1.3, 11.3.1.6, 11.3.1.7, or 11.3.1.8, the practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Otherwise, the body, whose adverse recommendation or action under Sections 11.3.1.2, 11.3.1.4, 11.3.1.5, 11.3.1.9,

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11.3.1.10, 11.3.1.11, or 11.3.1.12, occasioned the hearing, shall have the initial obligation to present evidence in support thereof, but the practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or action by clear and convincing evidence that the grounds therefor lack any factual basis or that such basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. Where applicable, the scope of the hearing and the burden of proof shall be limited as set forth in Section 10.8.

11.5.8 Record of Hearing. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing committee chairman, unless his/her decision is reversed by a majority vote of the hearing committee, shall select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A practitioner requesting an alternate method under Section 11.5.4.6 shall bear the cost thereof.

11.5.9 Postponement. Requests for postponement of hearing shall be granted by the hearing committee only upon a showing of good cause or by mutual consent of the parties.

11.5.10 Recesses and Adjournment. 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 or consultation. Upon conclusion of the presentation of oral and written evidence, 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. Upon the conclusion of its deliberation, the hearing shall be declared finally adjourned.

11.6 Hearing Committee Report and Further Action.

11.6.1 Hearing Committee Report. As promptly as is reasonably practicable after final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Clinical Council or the Board of Directors, as the case may be, or a subcommittee acting on its behalf. The practitioner shall have the right to receive the written recommendation of the hearing committee including a statement of the basis for the recommendation.

11.6.2 Action on Hearing Committee Report. At its next meeting, the Clinical Council or the Board of Directors, as the case may be, shall consider the hearing committee report and affirm, modify or reverse the hearing committee's report recommendation. The Clinical Council or the Board of Directors shall transmit the result, together with the hearing record, the report of the hearing committee and all other documentation considered to the Chief Medical Officer. A copy of the hearing record may be obtained by the practitioner upon payment of reasonable charges associated with its preparation.

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11.6.3 Notice and Effect of Result.

11.6.3.1 Notice. The Chief Medical Officer shall promptly send a copy of the result to the practitioner.

11.6.3.2 Effect of Favorable Result.

11.6.3.2.1 Adopted by the Clinical Council. If the Clinical Council's result pursuant to Section 11.6.2. is favorable to the practitioner, the Chief Medical Officer shall promptly forward it, together with all supporting documentation, to the Board of Directors for its final action. The Board of Directors shall take action thereon by adopting or rejecting the Clinical Council's result in whole or in part, or by referring the matter back to the Clinical Council for further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Directors shall take final action. The Chief Medical Officer shall promptly send the practitioner notice informing him/her of each action taken pursuant to this Section. Favorable action shall become the final decision of the Board of Directors, and the matter shall be considered finally closed. If the action of the Board of Directors is adverse in any of the respects listed in Section 11.3.1, the notice shall inform the practitioner of his/her right to request an appellate review by the Board of Directors as provided in Section 11.7.1.

11.6.3.2.2 Adopted by the Board of Directors. If the action of the Board of Directors pursuant to Section 11.6.2 is favorable to the practitioner, such action shall become the final decision of the Board of Directors and the matter shall be considered closed.

11.6.3.3 Effect of Adverse Result. If the result of the action of the Clinical Council or of the Board of Directors pursuant to Section 11.6.2 continues to be adverse to the practitioner in any of the respects listed in Section 11.3.1, the notice required by Section 11.6.3.1 shall inform the practitioner of his/her right to request an appellate review by the Board of Directors as provided in Section 11.7.1.

11.7 Initiation and Prerequisites of Appellate Review.

11.7.1 Request for Appellate Review. A practitioner shall have thirty (30) calendar days following his/her receipt of a notice pursuant to Section 11.6.3 to submit a written request for an appellate review. Such request shall be deemed to have been made when delivered to the Chief Medical Officer in person or when sent by certified mail to the Chief Medical Officer,

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properly addressed and postage prepaid, and may include a request for a copy of the Hearing Committee's written recommendation, including a statement of the basis for the recommendation(s) and record of the hearing.

11.7.2 Waiver by Failure to Request Appellate Review. A practitioner who fails to request an appellate review within the time and in the manner specified in Section 11.7.1, waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 11.3.5.

11.7.3 Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the Chief Medical Officer shall deliver such request to the Board of Directors. The Board of Directors shall promptly schedule and arrange for an appellate review, using reasonable efforts to schedule the review not less than thirty (30) calendar days nor more than forty-five (45) calendar days from the date of receipt of the appellate review request. At least fourteen (14) calendar days prior to the appellate review, the Chief Medical Officer shall send the practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause.

11.7.4 Appellate Review Body. The Board of Directors shall determine whether the appellate review shall be conducted by the Board of Directors as a whole or by an appellate review committee composed of at least five (5) members of the Board of Directors appointed by the Chairman. If a committee is appointed, one of its members shall be designated as chairman.

11.8 Appellate Review Procedure.

11.8.1 Nature of Proceedings. The proceedings 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 results and actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section 11.8.2 and such other materials as may be presented and accepted under Sections 11.8.4 and 11.8.5.

11.8.2 Written Statements. The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her 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 notice given in Section 11.7.3 shall set forth the deadlines by which written statements and reply statements (if any) must be submitted to the appellate review body.

11.8.3 Presiding Officer. The chairman of the appellate review body shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

11.8.4 Oral Statement. The appellate review body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so

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appearing shall be required to answer questions put to him/her by any member of the appellate review body.

11.8.5 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 and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The appellate review body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

11.8.6 Powers. The appellate review body shall have all power granted to a hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

11.8.7 Recesses and Adjournment. The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

11.8.8 Action Taken. The appellate review body may recommend that the Board of Directors affirm, modify or reverse the adverse result or action taken by the Clinical Council, or the Board of Directors pursuant to Section 11.6.2 or 11.6.3.2.1, in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within thirty (30) calendar days. Within fourteen (14) calendar days after receipt of such recommendation after referral, the appellate review body shall make its recommendation to the Board of Directors as provided in this Section 11.

11.8.9 Conclusion. The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 11 have been completed or waived.

11.9 Final Decision of the Board of Directors. Within thirty (30) calendar days after the conclusion of the appellate review, or at its next scheduled meeting, whichever is later, the Board of Directors shall render its final decision in the matter in writing and the Chief Medical Officer shall send notice thereof to the practitioner. The practitioner shall have the right to receive the written decision of the Board of Directors including a statement of the basis for the decision.

11.10 General Provisions.

11.10.1 Waiver. If at any time after receipt of notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with the provisions of Section 11, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Section 11 with respect to the matter involved.

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11.10.2 Number of Reviews. Notwithstanding any other provisions of the Medical Staff Bylaws or of this Section 11, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

11.10.3 Extensions. Stated time periods and limits for actions, notices, requests, submissions of material and scheduling in this Section 11 may be extended upon the agreement of the parties and, when necessary, the hearing committee or appellate review body.

11.10.4 Release. By requesting a hearing or appellate review, a practitioner agrees to be bound by the provisions of this Section of the Medical Staff Bylaws in all matters relating thereto.

11.10.5 The foregoing procedures for a hearing are intended as guidelines for ensuring the affected Member a fair hearing and are not to be construed as establishing a rigid format for the hearing or action by the Hearing Committee.

12.0 STRUCTURE OF THE MEDICAL STAFF

12.1 The Chief Medical Officer. The Chief Medical Officer is the Chief Administrative Officer of the Medical Staff. He/she shall be a physician, and a Medical Staff member. He/she is appointed by the President of the Hospital. The individual's appointment as Chief Medical Officer may be removed by the President of the Hospital upon recommendation to and approval of such action by the Board of Directors. This action is limited to the Chief Medical Officer administrative appointment, and is separate from his or her Medical Staff appointment, clinical privileges, and faculty appointment. The President and representatives of the Administration shall consult the Chief Medical Officer regarding all significant operational and fiscal matters which concern the clinical departments and medical programs of the Hospital, including the development of operating and capital budgets, and the award of grants from special funds of the Hospital for medical service, teaching, or research activities. The Chief Medical Officer shall be provided budgetary support necessary to discharge the responsibilities of his/her office. The Chief Medical Officer shall be responsible for review and approval of medical services by contract, as well as receipt and review of regular performance improvement activity reports from such contractors.

12.2 Clinical Council. There shall be a Clinical Council that serves as the Medical Staff executive committee and is composed of the Chief Medical Officer, as chairman, all of the Clinical Chairmen, the President of Rainbow Babies & Children's Hospital/MacDonald Hospital for Women, the President of the Seidman Cancer Center, the Medical Director of the Seidman Cancer Center, the UH Chief Quality Officer, the President of University Hospitals Physician Services, all of the Cleveland Medical Center Chief Officers, and other members, including any member of the organized medical staff, of any discipline or specialty, as designated by the Chairman of Clinical Council. The Board of Directors shall designate one or two of its members who shall be ex officio members, with vote, of Clinical Council. The President of the Hospital shall be an ex officio member, with vote, of Clinical Council. The Director of Medical Education shall be an ex officio member, without vote, of Clinical Council. The majority of voting Clinical Council members are fully licensed physicians actively practicing in the Hospital. Clinical Council members who cannot attend a meeting are urged to send a

substitute. Subject to the rules and regulations of the Board of Directors, the Clinical Council shall adopt such rules and regulations as it judges proper for its own government. The Clinical Council shall act in an advisory capacity to the Board of Directors in matters pertaining to the professional conduct and education of the Medical Staff members, other licensed independent practitioners with clinical privileges, house staff and medical students, the medical care and treatment of patients, and research within the jurisdiction of the Hospital. Questions of policy pertaining to the above matters may be originated by the Clinical Council and submitted to the Board of Directors, together with its recommendation for action. Such policies, when approved, shall be placed in operation over the signature of the President and/or Chief Medical Officer. Members of Clinical Council serve as a result of their administrative position at the Hospital or by the individual's appointment by the Chief Medical Officer. Individuals may then be removed due to a change in their administrative positions or, if appointed by the Chief Medical Officer, removed by action of the Chief Medical Officer. This action is limited to service as a member of Clinical Council, and is separate from his or her Medical Staff appointment, clinical privileges, and faculty appointment.

12.2.1 Clinical Council Responsibilities. Clinical Council reviews and acts on reports and recommendations from Medical Staff committees, departments, and other assigned activity groups. Clinical Council requests evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt about an applicant's ability to perform the privileges requested. Clinical Council is responsible for making recommendations directly to the Board of Directors for its approval. Such recommendations pertain to the following:

12.2.1.1 the Medical Staff's structure;
12.2.1.2 the process used to review credentials and to delineate individual clinical privileges;
12.2.1.3 recommendations of individuals for Medical Staff membership at appointment and reappointment;
12.2.1.4 the delineation of clinical privileges for each eligible member of the Medical Staff , at appointment and reappointment;
12.2.1.5 the delineation of clinical privileges for other eligible licensed independent practitioners privileged through the Medical Staff process, at initial privileging and renewal of clinical privileges;
12.2.1.6 recommendations for changes in Medical Staff status and/or clinical privileges between appointment or privileging periods;
12.2.1.7 recommendations for Medical Staff membership following successful completion of focused professional practice evaluation (FPPE);
12.2.1.8 the participation of the Medical Staff in organizational performance improvement activities as well as the mechanism used to conduct, evaluate, and revise such activities;
12.2.1.9 the mechanism for peer review as described in Section 13 of the Medical Staff Rules and Regulations;
12.2.1.10 the mechanism for Licensed Independent Practitioner health as described in Section 4 of the Medical Staff Rules and Regulations;
12.2.1.11 the mechanism by which Medical Staff membership may be terminated; and
12.2.1.12 the mechanism for fair-hearing and appellate review procedures.

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12.2.2 Clinical Council and Peer Review. Clinical Council and its members may act as agents of the protected peer review process.

12.3 The Medical Staff Organization. The Medical Staff shall be organized into clinical departments within the Hospital consisting of the Departments of Anesthesiology and Perioperative Medicine, Dermatology, Emergency Medicine, Family Medicine and Community Health, Genetics, Medicine, Neurology, Neurological Surgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology-Head and Neck Surgery, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, Surgery and Urology. Each clinical department of the Medical Staff shall be organized separately and shall have a Chairman.

12.4 Chairman. The Chairman shall be a Medical Staff member and, where applicable, a faculty member of the Case Western Reserve University School of Medicine in an academic department corresponding to his/her hospital clinical department. He/she shall be appointed by the Board of Directors of the Hospital upon recommendation of the President and Chief Medical Officer. He/she shall serve at the pleasure of the President of the Hospital. He/she shall be certified by an appropriate specialty board, or shall possess comparable competence, as recommended by the Clinical Department Credentialing Committee and approved by the Credentialing Committee, Clinical Council and Board of Directors.

12.4.1 Chairman Responsibilities. The Chairman shall organize the department as appropriate to achieve the purposes of the Medical Staff. The involvement of an organized professional corporation or association in the management of the department, shall be approved by the Hospital and the Case Western Reserve University School of Medicine. This includes the appointment of Division Chiefs of clinical subspecialties. The Chairman shall be responsible, either personally or through delegation, for the following:

12.4.1.1 all clinically related activities of the department;
12.4.1.2 all administratively related activities of the department, unless otherwise provided for by the Hospital;
12.4.1.3 the integration of the department into the primary functions of the organization;
12.4.1.4 the coordination and integration of interdepartmental and intradepartmental services;
12.4.1.5 the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
12.4.1.6 recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
12.4.1.7 continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
12.4.1.8 recommending to Clinical Council the criteria to be assessed, and the type of data to be collected, for ongoing professional practice evaluation used to determine the granting, revision, limitation, or revocation of privileges;
12.4.1.9 recommending to the Clinical Council the criteria for clinical privileges that are relevant to the care provided in the department;

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12.4.1.10 recommending Medical Staff appointment and clinical privileges for each member of the department at appointment and reappointment;

12.4.1.11 recommending changes in Medical Staff status and/or clinical privileges between appointment periods;

12.4.1.12 determining that sufficient space, equipment, staffing, and financial resources necessary to support the recommended privileges are currently available or available within a specified time frame; in the event that necessary resources become unavailable, the Chairman advises UHCD to amend the clinical privileges accordingly;

12.4.1.13 recommending Medical Staff membership following successful completion of professional practice evaluation (FPPE);

12.4.1.14 the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

12.4.1.15 the continuous assessment and improvement of the quality of care, treatment, and services provided, including the stimulus, mission, vision, and resources that allow the Hospital's performance improvement plan to be successfully implemented;

12.4.1.16 adopting an approach to performance improvement that includes at least the following: planning the process of improvement, setting priorities for improvement, assessing performance systematically, implementing performance improvement activities based on assessment, and maintaining achieved improvements;

12.4.1.17 the orientation and continuing education of all persons in the department or service, including those related to performance improvement;

12.4.1.18 recommendations for space and other resources needed by the department or service;

12.4.1.19 evaluating progress toward implementation of the performance improvement plan in the department;

12.4.1.20 assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;

12.4.1.21 the maintenance of quality control programs, as appropriate;

12.4.1.22 appointing and monitoring of performance of members as appropriate on the Clinical Department Credentialing Committees;

12.4.1.23 monitoring compliance by all persons within the department with Bylaws, Rules and Regulations, University Hospitals Health System Corporate Compliance, departmental rules, or other Hospitals policies;

12.4.1.24 all research activities of the department;

12.4.1.25 proper implementation of the peer review process as described in Section 13 of the Medical Staff Rules and Regulations;

12.4.1.26 oversight of health status and recommendation/referral of Medical Staff members and other practitioners privileged by Medical Staff mechanisms as described in Section 4, Licensed Independent Practitioner Health, of the Medical Staff Rules and Regulations and of all other persons in the department as defined by Hospital policy.

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12.5 Credentialing Committee. The Credentialing Committee shall consist of at least nine (9) members representing Administration and Nursing, as well as physician members of the departments of Medicine, Surgery, Pediatrics, OB/GYN, Radiology, and one rotating department chosen biannually, upon recommendation of the applicable Chairman. All members shall be appointed by the Chief Medical Officer, who shall also be a member and shall select the Committee Chairman. Fifty percent (50%) of the total membership of the Credentialing Committee shall constitute a quorum. The Credentialing Committee has the following duties:

12.5.1 serve as a professional review committee for the Medical Staff, using the peer review mechanism.
12.5.2 schedule and conduct regular Credentialing Committee meetings to adequately perform the peer review function;
12.5.3 review the credentials of applicants for appointment and clinical privileges, reappointment and clinical privileges, changes in clinical privileges, changes in status, and changes in staff category, and make recommendations to the applicable Chairman;
12.5.4 provide consistency and uniformity in the credentialing and privileging function throughout the hospital;
12.5.5 conduct credentialing decision-making activities in a confidential and non-discriminatory manner;
12.5.6 approve Hospital and Clinical Department policies and privilege delineation forms and to make recommendations for approval or denial to Clinical Council and the Board of Directors;
12.5.7 review and make recommendations on requested clinical procedures that are not listed on the approved privilege delineation form;
12.5.8 review of with-issue Ongoing and Focused Professional Practice Evaluations;
12.5.9 assure parity of privileging criteria for procedures performed across clinical specialties; and
12.5.10 review and recommend clinical appointments and privileges for the Clinical Chairmen.

12.6 The Chairman may elect to appoint a Clinical Department Credentialing Committee, composed of at least three members of the clinical department, that shall:

12.6.1 make recommendations for policies on minimum requirements for specialized procedures;
12.6.2 review and revise departmental privilege delineation forms and policies for specialized procedures as needed, at least every two (2) years;
12.6.3 serve as a professional review committee for department-specific peer review functions, including reviewing the credentials of applicants for appointment and clinical privileges, reappointment and clinical privileges, changes in clinical privileges, changes in status, and changes in staff category; and
12.6.4 shall make all of its recommendations to the Chairman.

12.7 For all matters requiring approval by the organized Medical Staff, the members of the organized Medical Staff eligible to vote shall be those individuals with voting rights as set forth in §12.2.

13.0 COMMITTEES

The following Committees of Clinical Council shall be appointed by the Chief Medical Officer with consultation from the Chairmen. Fifty percent (50%) of the total membership of the committee shall constitute a quorum. Members are expected to attend no less than fifty percent (50%) of the scheduled meetings. A Member may designate a representative to act on his/her behalf. The Chief Medical Officer shall appoint the Chairs of the following committees, which shall report to Clinical Council. The Committee Chairs, in consultation with the Chief Medical Officer, shall appoint members to their respective committees. Additional committees may be added by the Chief Medical Officer as needed.

13.1 Executive Committee of Clinical Council.

13.1.1 Membership: The Committee shall include the President of the Hospital, Senior Operating Officer, the Chief Medical Officer, the Chairmen and the Chief Nursing Officer. The Chief Medical Officer shall serve as Chairperson of the Executive Committee of Clinical Council. The Committee meets on call.

13.1.2 Charge: To provide a forum to discuss matters relating to Medical Staff policy and procedures including the medical care of patients, teaching and research and to make recommendations to Clinical Council. The Executive Committee of Clinical Council may act for Clinical Council where deemed necessary or appropriate by the Committee Chairperson, who shall be responsible for reporting such action(s) by way of written minutes to Clinical Council for its approval.

13.2 Licensed Independent Practitioner (LIP) Health Committee.

13.2.1 Membership: The Chief Medical Officer shall serve as chairman of the Committee. Other members shall include the Psychiatrist-in-Chief, who shall serve as vice chairman; the Physician-in-Chief; the Anesthesiologist-in-Chief; the Surgeon-in-Chief; the Chief Nursing Officer; the Chairman of the Department of Pediatrics; and the Director of Graduate Medical Education. Members unable to attend may send designees to act on their behalf. The CMO, at his/her discretion, may appoint additional Committee members, to serve with or without vote.

13.2.2 Charge:

13.2.2.1 to operate as an "impaired practitioner committee" pursuant to Chapter 4731 of the Ohio Revised Code, and as a "peer review committee" pursuant to Chapter 2305 of the Code.

13.2.2.2 to provide advice to the Chief Medical Officer regarding the rehabilitation of Licensed Independent Practitioners (LIPs) who may be impaired, or require assistance, because of physical and/or emotional problems, including addiction.

13.2.2.3 to assist the Chief Medical Officer, as outlined in Section 4.0 of the Medical Staff Rules and Regulations.

13.2.2.4 to develop programs to educate Licensed Independent Practitioners (LIPs) in matters of personal physical and mental health.

13.3 Clinical Ethics Committee.

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13.3.1 Membership: There shall be up to twenty-five (25) members on the Committee representing Medical Staff, Nursing, and other departments as well as and Clergy and Administration. The Committee shall meet monthly or on call as needed.

13.3.2 Charge: To develop, review and revise policies related to ethics in the areas of patient care and conduct of staff and employees, including policies governing treatment limitation and use of advance directives. To provide consultation to Medical Staff members, nurses and other health professionals, patients and their families concerning specific ethical issues or questions. Identify educational needs and implement educational programs as appropriate to meet the needs of the hospital community for ethics education.

13.4 Infection Control Committee.

13.4.1 Membership: There shall be nine (9) members on the Committee representing Medical Staff, Nursing and Administration. The Committee meets at least four (4) times per year.

13.4.2 Charge: To maintain surveillance of endemic and epidemic infections and develop policies to reduce the risks of nosocomial infections in patients, health care workers, and Medical Staff.

13.5 Institutional Review Board

13.5.1 Membership: The Hospital's three Institutional Review Boards (IRBs) shall comprise one Committee for purposes of these Bylaws. Each IRB shall consist of representatives of various clinical departments of the Medical Staff, Nursing, Administration, Clergy, community, and Case Western Reserve University, including a member of the Department of Pediatrics internal review committee. Each Hospital IRB meets at a minimum of twice per month.

13.5.2 Charge: The Hospital IRBs are charged with the following: To protect the rights of human research subjects when serving as IRB of record; to be the IRB of record and review and approve all research programs and studies of human experimentation involving patients, except for research protocols when, in accordance with law, Hospital policies, and a written agreement, the Hospital IRBs may rely on review and oversight by an external IRB as IRB of record; to review, when the IRB of record, proposed protocols for experimentation to determine that the methodology is in accordance with established policy and procedure; and to establish a mechanism to review, not less than annually, the protocols on all ongoing human experimentation for which the Hospital IRB serves as the IRB of record.

13.6 Medication Safety and Therapeutics Committee.

13.6.1 Membership: There shall be up to twenty-one (21) members on the Committee representing Medical Staff, Pharmacy, Nursing, Quality, Risk and Administration. The Committee meets monthly.

13.6.2 Charge: Establish the medication-use process for formulary management, medication safety, and disease-bases therapeutics. Develop medication

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related policy and procedures. Monitor the effectiveness of medications. Review medication event data for trends and implement performance improvement initiatives. .

13.7 Radiation Safety Committee.

13.7.1 Membership: There shall be at least six (6) voting members of the Committee representing Medical Staff, Nursing, House Staff and Administration, including the Radiation Safety Officer. The Committee meets at least quarterly.

13.7.2 Charge: To develop and maintain a program for using ionizing radiation safely in the Hospital and to ensure that all such uses are in compliance with applicable local, state and federal regulations.

13.8 Transfusion Committee.

13.8.1 Membership: There shall be up to twenty-five (25) members on the Committee representing Medical Staff, Nursing, House Staff and Administration. The Committee shall meet quarterly.

13.8.2 Charge: To monitor blood and blood component ordering, distribution, handling, dispensing and administration. To monitor the effects of blood and blood components on patients. To maintain clinically valid standards relating to blood and blood component use and to assess blood and blood component utilization within the clinical departments.

13.9 Continuing Medical Education Committee.

13.9.1 Membership: There shall be up to eighteen (18) members of the Committee representing clinical faculty, continuing medical education providers, clinical department leadership and affiliated primary care physicians, and the Chief Medical Officer. The Committee shall meet quarterly.

13.9.2 Charge: To develop and maintain the knowledge, skills and professional performance of physicians at the Hospital to support the services they provide to patients, the public, and the profession. To prepare all physicians to adapt to changes in the healthcare environment. To offer the highest quality postgraduate medical education for physicians in Northeast Ohio and nationwide by producing, supporting or jointly sponsoring outreach programs, including enduring materials, videoconferencing and telemedicine, that include appropriate audience needs assessment, program design, learning objectives, conference management and evaluation. To develop educational programming in response to clinical outcomes and educational needs that relate to performance improvement findings and the type of care provided in the organization. To foster strong relationships and support clinical integration among practicing physicians affiliated with the Hospital and University Hospitals Health System, and other community physicians.

13.10 Graduate Medical Education Committee.

13.10.1 Membership: There shall be up to thirty (30) members on the Committee representing Residency & Fellowship Program Directors, Medical Staff,

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Nursing, House Staff, Case Western Reserve University, and Administration including the Chief Medical Officer. The Committee meets monthly and is chaired by the Director of Graduate Medical Education.

13.10.2 Charge: To establish and implement policies that affect all residency programs regarding the quality of education and the work environment for all residents and fellows. To establish and maintain appropriate oversight of the education and work environment of all affiliated training sites for Hospital residents and fellows. To regularly review all residency programs to assess their compliance with both the institutional requirements and program requirements of the relevant ACGME review committees. To provide a mechanism for effective communication between committee(s) responsible for graduate medical education at the Hospital and affiliated training sites, the Medical Staff and the Board of Directors about the safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in the training programs.

13.11 Resuscitation Committee.

13.11.1 Membership: There shall be twelve (12) members of the Committee representing Medical Staff, Nursing, House Staff, Clinical Risk Management, Administration and Pharmacy. The Committee meets at least bimonthly.

13.11.2 Charge: To review all aspects related to emergency resuscitation of patients, to review those items, which must be maintained on all emergency resuscitation carts and baskets, and to recommend any changes.

13.12 Search Committee Appointment and Membership.

13.12.1 UHCMC believes that a search committee is an integral part of an effective search for defined positions. A search committee shall be established depending upon the type of position to be filled. Search committees are required for all Department Chairs, Division Chiefs, and senior administrative positions. In some instances a search committee may also be appropriate for highly specialized positions or those with a high level of public exposure.

13.12.2 The establishment of a search committee reflects UHCMC's interest in locating and considering for employment a wide pool of applicants, including minority persons, women, veterans and disabled individuals. Searches should communicate to the largest and most diverse group of candidates the merits of UHCMC as a place in which professional growth is promoted and in which performance and achievement are rewarded.

13.12.3 The appointment of a search committee chair for a Department Chair is made collaboratively between the President of the hospital and the Dean of the Medical School. The appointment of a search committee chair for a Division Chief is made by the Department Chairperson. The appointment of a search committee Chair for a senior administrative position is made by the President of the hospital.

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13.12.4 Search committee members are selected by the search committee Chair in collaboration with the President, Dean or Dept Chair (whoever appoints the chairperson). The search committee normally should be composed of several members drawn from the constituencies served by the position, taking care to ensure that women and minorities are represented. A representative of the Department of Human Resources must be included for administrative positions. Additionally,

13.12.4.1 All faculty openings are to be forwarded to under-represented ethnic minority (URM) faculty for recommendation of candidates. A URM faculty member is to serve on all search committees for division chiefs or department chair.
13.12.4.2 All URM faculty candidates are to be seen and interviewed by a minority faculty member.
13.12.4.3 The Office of Senior Advisor to the President and CEO of UH will expedite connecting minority faculty and/or minority post graduate trainees with candidates.

13.13 Quality and Patient Safety Council.

13.13.1 Membership: The Council shall have a broad membership including hospital senior leadership; physician quality liaisons; department chairmen and division chiefs; leadership from hospital clinical departments; and representatives of the Quality Center, Law Department, Risk Management, Accreditation, Credentialing, Finance, and other support services.

13.13.2 Charge: The Council is a joint management/medical staff committee charged with providing cross-departmental oversight, prioritization, and support of quality and patient safety programs at UHCMC. The Council reports to Clinical Council and the Board of Directors, and functions as the hospital's Patient Safety Committee.

14.0 MEETINGS

14.1 Quarterly Meetings. Meetings in each Clinical Department/Division shall be held at least two times per year to review policies, procedures and general Medical Staff operations. Medical Staff members should attend at least one of the these meetings each year.

14.2 Monthly Meetings.

14.2.1 Meetings. Meetings shall be held at least monthly in each Clinical Department/Division to:

14.2.1.1 consider the activities of the department/division;
14.2.1.2 review education within the department/division; and
14.2.1.3 evaluate the quality and appropriateness of patient care provided within the department/division.

14.2.2 Written Minutes. Written minutes shall be prepared and maintained for all department and division meetings and shall be made available for inspection as required and authorized by the President and Chief Medical Officer.

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14.3 Medical Staff members should attend at least 25% of the monthly department meetings.

15.0 MEDICO-ADMINISTRATIVE APPOINTMENTS

15.1 Physicians who fill medico-administrative positions shall be appointed by the appropriate Administrative Officer and/or the Chief Medical Officer. Rules regarding the performance of physicians in such positions shall be the same as for all other non-medical management employees of the Hospital. Incumbents of medico-administrative positions may be terminated for cause according to the same guidelines that apply to other Hospital employees. Physicians appointed to medico-administrative positions shall be members of the Medical Staff of the Hospital and the Faculty of the School of Medicine of the University and shall be certified by an appropriate specialty board, or shall possess comparable competence, as determined by the Clinical Department Credentialing Committee and approved by the Clinical Council and Board of Directors. In addition, termination from the Medical Staff shall automatically result in termination from the medico-administrative position. However, termination from the medico-administrative position shall not automatically result in termination from the Medical Staff. Rules regarding appointment, reappointment and termination from the Medical Staff for incumbents of medico-administrative positions shall be the same as for all other members of the Medical Staff.

16.0 CONFIDENTIALITY, IMMUNITY FROM LIABILITY, AND RELEASES

The following shall be express conditions to any Medical Staff member's application for, or exercise of, clinical privileges at the Hospital.

16.1 The Medical Staff member authorizes representatives of Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, his/her professional ability, qualifications, competence, and conduct.

16.2 The Medical Staff member agrees to be bound by the provisions of this Section 16, and agrees that he/she will not commence a legal action against the Medical Staff or any department, committee, subdivision or member of the Medical Staff of Hospital, or an employee of Hospital, or the Board or any member thereof, for any investigation or action taken in accordance with the provisions of the Bylaws.

16.3 The Medical Staff member acknowledges that the provisions of this Section 16 are express conditions to his/her application for, and continuation of, Medical Staff membership, and to his/her exercise of clinical privileges at the Hospital.

16.4 The Medical Staff member agrees and acknowledges that Hospital may confidentially share any information about the member, including, but not limited to credentialing, privileging, peer review, and/or disciplinary information about the member, with any other University Hospital Health System hospital or entity regardless of whether that information has been forwarded to the Ohio State Medical Board or the National Practitioner Data Bank.

16.5 Confidentiality of Information. Medical Staff, department, division, or committee minutes, files, and records, including information regarding any member of or applicant to this Medical Staff, shall be confidential as mandated by Ohio Revised Code Section 2305.24 et seq. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially

adopted policies of the Medical Staff or Hospital, which at all times shall be consistent with Ohio Revised Code Section 2305.24 et seq. Disclosure of information may only be done as required by law.

16.6 Breach of Confidentiality. Inasmuch as effective peer review and consideration of the qualifications of members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with another hospital, professional society, or licensing authority, is outside appropriate standards of conduct for the Medical Staff and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the Clinical Council, or the Board, may undertake such corrective action as it deems appropriate.

16.7 Immunity from Liability for Action Taken. Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or Member for damages or other relief for any action taken or statements or recommendations made within the scope of his duties as a representative of the Medical Staff or Hospital.

16.8 Immunity from Liability for Providing Information. Each representative of the medical staff and Hospital and all third parties shall be exempt as mandated by Ohio Revised Code Sections 2305.24 et seq. and 42 U.S.C. 11111, from liability to an applicant or a Member for damages for providing information to a representative of the Medical Staff or Hospital concerning such individual who is, or has been, an applicant to the Staff or Member or who did, or does, exercise clinical privileges or provide services at this Hospital.

16.9 Activities Covered. The confidentiality and immunity provided by this Section 16 shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the activities of this or any other educational or health-related institution or organization concerning, but not limited to:

16.9.1 Applications for appointment and clinical privileges;
16.9.2 Periodic reappraisals for appointment and clinical privileges;
16.9.3 Corrective action, including summary suspension;
16.9.4 Hearings and appellate reviews;
16.9.5 Performance improvement activities;
16.9.6 Utilization reviews;
16.9.7 Participation in the UH or Hospital's delegated credentialing program;
16.9.8 Other Hospital, department, division, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
16.9.9 Peer review and patient safety organizations, State Medical Board of Ohio, and similar reports.

16.10 Information Covered. The acts, communications, reports, recommendations, disclosures and other information referred to in this Section 16 may relate to a Medical Staff member's or practitioner's professional qualifications, clinical ability, judgment, character, information regarding ability to perform any of the physical or mental health functions related to the specific clinical privileges requested as a member of the Medical Staff, with or without accommodation, professional ethics, ability to work cooperatively with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

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16.11 Releases. Each applicant or member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the expressed provisions and general intent of this Section 16. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Section.

17.0 MEDICAL STAFF RULES AND REGULATIONS

17.1 The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws subject to the approval of the Board of Directors. The Medical Staff Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Medical Staff member in the Hospital, and shall be reviewed every two (2) years.

17.2 The Medical Staff Rules and Regulations shall be a part of these Medical Staff Bylaws, except that in the event the terms of the Bylaws and the terms of the Rules and Regulations conflict, the Bylaws shall control. The Rules and Regulations may be amended or repealed pursuant to a vote of a majority of the voting members of the organized Medical Staff. Such changes shall become effective when approved by the Board of Directors.

17.3 Each department and division may adopt such rules and regulations for the proper conduct of its intradepartmental and intradivisional functions and the discharge of its responsibilities, subject to the approval of the Clinical Council. Such rules and regulations shall not be at variance with these Medical Staff Bylaws, the Rules and Regulations of the Medical Staff, or other policies of the Hospital.

18.0 POLICY FOR PRIVILEGING LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONERS (LIAPS) AND ALLIED HEALTH PROFESSIONALS (AHPS)

18.1 Licensed Independent Affiliate Health Care Practitioner (LIAP) refers to clinical nurse specialists, nurse practitioners, and others as approved by the Board of Directors, authorized to independently practice or provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or in collaboration with a member, in good standing, of the Active Medical Staff who is in the same specialty.

18.2 Allied Health Professional (AHP) refers to certified registered nurse anesthetists, physician assistants, and others as approved by the Board of Directors, privileged by Medical Staff process to provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or supervised by a member of the same specialty, in good standing, of the Active Medical Staff.

18.3 LIAPs and AHPs are permitted to practice or provide services in the Hospital, and are credentialed and privileged by UHCD through Medical Staff mechanisms, but are not members of the Medical Staff. Only those types of LIAPs and AHPs that have been approved by the Board of Directors shall be permitted to practice at the Hospital.

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18.4 Permission to practice in the Hospital as a LIAP or AHP is a privilege which shall be extended only to those individuals who have successfully completed the application process, been approved for specific clinical privileges, continually meet the qualifications, standards, requirements, and competencies set forth in the Privileging Policy for Licensed Independent Affiliate Health Care Practitioners (LIAP) and Allied Health Professionals (AHP) and shall be limited to the needs of the patient population served by the Hospital as determined by the Board of Directors.

18.5 All members of the Medical Staff shall abide by the Medical Staff, Departmental, and Hospital policies and procedures, including the Licensed Independent Affiliate Health Care Practitioners (LIAP) Policy as approved by the Clinical Council and Board of Directors and distributed with the Medical Staff Bylaws and Medical Staff Rules and Regulations.

19.0 ADOPTION AND AMENDMENT OF BYLAWS

The Medical Staff Bylaws are adopted by the Medical Staff and approved by the Board of Directors before becoming effective. Neither body may unilaterally amend the Medical Staff Bylaws.

19.1 Medical Staff Responsibility and Authority. The organized Medical Staff, through its eligible voting members, shall have the initial responsibility to formulate and submit recommendations directly to the Board of Directors regarding the Medical Staff Bylaws and amendments thereto. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. A standing or special committee shall review and revise the Medical Staff Bylaws at least every two (2) years.

19.2 Method of Adoption, Amendment or Repeal of Medical Staff Bylaws. The members of the organized Medical Staff eligible to vote must receive nine (9) days' written notice of any amendments to the Medical Staff Bylaws. They may recommend adoption, amendment, or repeal of the Medical Staff Bylaws by an affirmative vote of the majority.

19.3 Board of Directors Action. All amendments and revisions to the Medical Staff Bylaws shall be effective upon an affirmative vote of a majority of the Board of Directors. In the event that the voting members of the organized Medical Staff do not exercise their responsibility and authority as required by this Section XVII, and after notice from the Board of Directors to such effect including a thirty (30) day period of time for response, the Board of Directors may resort to its own initiative in formulating or amending the Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Board of Directors during its deliberations and in its actions.

19.4 Communication of Amendments to Medical Staff Bylaws. If significant changes are made to Medical Staff Bylaws, Medical Staff members and others with delineated clinical privileges shall be provided access to revised texts of the written materials.

Approved by Clinical Council
on September 18, 2024

Approved and Adopted by Board of Directors
on February 27, 2025.

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Brett Glotzbecker, M.D. Chair, Clinical Council

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Harlin G. Adelman
Secretary of the Board of Directors

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