NASSAU HEALTH CARE CORPORATION

HEALTHCARE SYSTEM

BYLAWS OF THE MEDICAL STAFF

Nassau University Medical Center

A. Holly Patterson Extended Care Facility

Community Health Centers
# BYLAWS OF THE MEDICAL STAFF

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BYLAWS
of the
MEDICAL STAFF
of the
NASSAU HEALTH CARE CORPORATION

PREAMBLE

WHEREAS, the NASSAU HEALTH CARE SYSTEM, hereinafter known as the “Healthcare System” is owned and operated by the Nassau Health Care Corporation (hereinafter referred to as “NHCC”) pursuant to the laws of the State of New York; and

WHEREAS, its purpose is to serve to provide patient care, education and research in accordance with the mission of the Healthcare System; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Healthcare System and must accept and discharge this responsibility, subject to the ultimate authority of the Board of Directors, and that the cooperative efforts of the Medical Staff, the President/Chief Executive Officer and the Board of Directors is necessary to fulfill the Healthcare System’s obligations to its patients;

THEREFORE, members of the Medical Staff practicing in this Healthcare System hereby organize themselves in conformity with these Bylaws.
DEFINITIONS

The term “professional staff” refers to members of the Medical Staff as hereinafter defined.

The term “Medical Staff” means all medical physicians, osteopathic physicians and dentists duly licensed by the State of New York who are privileged to attend patients in the Healthcare System.

The terms “allied health professional” and “allied health practitioner” mean appropriately licensed psychologists, physicists, nurse practitioners, certified registered nurse anesthetists, licensed nurse midwives, physician’s assistants and others who may be accorded specified practice privileges in the Healthcare System limited to their areas of competence and within the scope of their licensure. Members of the Allied Health Professional Staff shall not be deemed eligible for Medical Staff membership or the rights thereof. They shall, however, be organized for administrative purposes only into a staff as hereinafter set forth.

The term “practitioner” means an appropriately licensed medical physician, an osteopathic physician with an unlimited license, an appropriately licensed dentist, an appropriately licenses podiatrist, or a licensed professional who has been appointed a member of the Allied Health Professional Staff.

The term “peer review” means the process by which the practices of a physician or independent practitioner are examined to determine whether medical care services are being provided in compliance with applicable standards of care.

The term “medical education” means education not limited to the education of physicians, dentists and podiatrists but is considered as embracing education in all of the disciplines, at all levels, in all of the professional and technical fields that can contribute to the effectiveness of health and medical care.

The term “governing body” means the Board of Directors of the Nassau Health Care Corporation.

The term “Hospital Management” means the Executive Staff of the Nassau Health Care Corporation or their designees.

The term “Graduate Staff” means the residents and clinical fellows in training at the Healthcare System.

The term “executive committee” or “ECMS” means the Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the governing body.
The term “chief executive officer” means the individual appointed by the governing body to act in its behalf in the overall management of the Healthcare System bearing the title of “President/Chief Executive Officer”.

The Medical Staff year corresponds to the calendar year.
ARTICLE I

NAME

The name of this organization shall be the “Medical Staff of the Nassau Health Care Corporation”.
ARTICLE II
PURPOSES

The purposes of this organization are:

1) To carry out the mission of the Healthcare System;

2) To ensure that all patients admitted to or treated in any of the facilities, departments or services of the Healthcare System shall receive appropriate care and that one level of care is provided to all patients;

3) To ensure a high level of professional performance of all practitioners and allied healthcare professionals authorized to practice in the Healthcare System through the appropriate delineation of the clinical privileges that each practitioner/allied healthcare professional may exercise in the Healthcare System and through an ongoing review and evaluation of each practitioner’s/allied healthcare professional’s performance in the Healthcare System;

4) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill, thereby resulting in the continued cooperation between the Healthcare System and the Health Sciences Center of the State University of New York at Stony Brook;

5) To conduct clinical research;

6) To initiate and maintain rules and regulations for self-government of the Medical Staff;

7) To provide a means whereby issues concerning the Medical Staff and the Healthcare System may be discussed by the Medical staff with the governing body and the President/Chief Executive Officer;

8) To support programs associated with community public health needs; and

9) To support and assume responsibility for Continuing Medical Education of the Healthcare System members, the local medical community and health professionals.
ARTICLE III

MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of the Nassau Healthcare System is a privilege that shall be extended only to physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and who agree to provide for continuous care to patients.

Section 2. Qualifications for Membership

a) Only physicians, dentists, and podiatrists, licensed to practice in the State of New York who can document their background, experience, training and demonstrated competence, adherence to the professional ethics, good reputation, eligibility to bill for Medicaid and Medicare, physical and mental ability to fulfill the duties and responsibilities commensurate with membership on the Medical Staff, and demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams, with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by them in the Healthcare System will be given a high quality of medical care, shall be qualified for membership on the Medical Staff. No physician, dentist, or podiatrist shall be entitled to active staff membership on the Medical Staff or to the exercise of particular clinical privileges in the Healthcare System merely by virtue of the fact that he/she is duly licensed to practice medicine, dentistry, or podiatry in this or in any other state, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.

b) No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of race, color, creed, religion, sex, national origin, sexual orientation, veteran’s status, marital status, age, disability (provided such person’s age or disability does not interfere with their provision of the patient care for which such person seeks Medical Staff membership or particular privileges), or on the basis of any other criterion unrelated to the delivery of quality patient care in the Healthcare System, to professional qualifications and judgment, including academic credentials, to the Healthcare System’s purposes, needs and capabilities, to community need or to any requirements set forth in these Bylaws.

c) Information concerning involuntary and voluntary loss of privileges, licensure or membership will be taken into consideration whether occurring in the State of New York or any other state.

d) Material misstatements or omissions on appointment or reappointment applications and any materials submitted in support thereof may be grounds for automatic
suspension or dismissal from the Medical Staff for which the applicant shall have no right of appeal granted under these Bylaws.

Section 3. Conditions of Appointment

Acceptance of membership on the Medical Staff shall constitute the staff member’s agreement that he or she will strictly abide by the Principles of Medical Ethics of the American Medical Association or the Principles of the American Osteopathic Association or by the Code of Ethics of the American Dental Association, whichever is applicable. Acceptance of membership on the Medical Staff shall also constitute the staff member’s agreement that he or she will abide by NHCC’s policies, procedures, and guidelines as well as all federal, state, and local laws, rules, and regulations applicable to the staff member. Acceptance of membership on the Medical Staff shall further constitute the staff member’s agreement that he or she will abide by NHCC’s Code of Ethical Conduct.

Section 4. Continuing Education Requirements

As a condition of continued staff membership in the Healthcare System, all individuals with clinical privileges shall participate in continuing education the adequacy of which shall be determined by each Department Chair.
ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Emeritus, Active, Special Services, and Locum Tenens staff:

Section 2. The Emeritus Staff

The Emeritus staff shall consist of members of the Medical Staff who have served on the active staff in the Healthcare System, and Allied Health Professionals, and are retired from practice, and who the Healthcare System desires to honor because of their prior service. Physicians or Allied Health Professional Staff, as applicable, who are appointed as Emeritus Staff members, after approval by the Executive Committee of the Medical Staff and Board of Trustees, shall not have privileges to admit, care for or provide consultations respecting the care of hospital patients, nor shall they be eligible for membership on the Executive Committee of the Medical Staff, or hold office or vote with respect to the Medical Staff. Membership on the Emeritus Staff does not carry any obligations to attend departmental meetings, carry malpractice insurance, or perform any other activities required of Active Staff or Allied Health Professional Staff members under these Bylaws.

Section 3. The Active Staff

a) The active staff shall consist of physicians, dentists, and podiatrists, salaried, and non-salaried, appointed by the Board of Directors to attend patients and to participate in the training of residents and other teaching assignments. Members of the active staff shall:

1) Be assigned to one clinical department and may hold privileges in another department, as qualified by training and experience.

2) Assume all functions and responsibilities of membership on the active staff including clinical and educational assignments as are required by the department, whether such duties relate to inpatients, outpatients, or Emergency Department patients.

3) Be eligible to vote, to hold office, and to serve on Medical Staff committees.

4) Be required to attend regular Medical Staff and departmental meetings.

5) Be responsible for the part of their patient's history and physical examination that relates to medicine and dentistry.
6) Active Staff members who have admitting privileges shall admit patients only in accordance with the admitting policies of the Healthcare System and such members' clinical privileges as delineated and shall comply with all applicable statutes, rules, regulations, and Healthcare System policies relating to patient admissions and inpatient discharge review procedures.

b) The only rank in the Active Staff shall be Attending.

Section 4. The Special Services Staff

The Special Services Staff shall consist of those physicians and dentists whose reputation, training, or experience makes their availability as consultants desirable in the Healthcare System. A qualified physician may be appointed to the Special Services Staff upon the recommendation of the Department Chair, and with the approval of the Executive Committee of the Medical Staff, and the Board of Trustees. A physician appointed to the Special Services Staff shall have all of the qualifications and fulfill all of the requirements for membership on the Medical Staff; his or her special service shall be limited and stipulated; he or she shall not have the right to vote, hold office, serve on committees or sit with the Executive Committee of the Medical Staff; he or she shall not have admitting privileges; he or she shall be encouraged but not required to attend designated departmental and/or divisional meetings; and his or her appointment to the Special Services staff may be terminated without any of the procedural rights set forth in Articles VI and VII of these Bylaws when, in the opinion of the Department Chair, the need for that special service no longer exists.

Section 5. Locum Tenens Staff

a) The Locum Tenens category shall consist of physicians, dentists, podiatrists, and other practitioners that are obtained by the Healthcare System to work on a temporary basis as a replacement for another physician, dentist, podiatrist, or other practitioner.

b) Locum Tenens shall be credentialed and privileged as any other physician, dentist, podiatrist, or other practitioner and shall be assigned to departments but shall not be eligible to vote or hold office in the Medical Staff organization. They are not required to attend staff or departmental meetings.

Section 6. Provisional Appointments

a) All initial appointments to any category of the Medical Staff shall be provisional for one (1) year.

b) Reappointments to provisional membership may not exceed one (1) full year at which time the failure to advance an appointee from provisional to regular staff status shall be deemed a termination of his/her staff appointment.
c) A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed.

d) Provisional staff members shall be assigned to a department where their performance shall be observed by the Chair of the department or his/her representative to determine the eligibility of such provisional members for regular staff membership and for exercising the clinical privileges provisionally granted to them.

Section 7. Temporary Privileges

Temporary privileges are accorded for a time period to qualified healthcare professionals in the manner prescribed in the Policy & Procedure MS-026. The two types are Pre-Appointment and Restricted Temporary Privileges.
ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT
AND
DELINEATION OF PRIVILEGES

Section 1. Credentialing

a) Credentialing and delineation of privileges in the Nassau Healthcare System will be in conformance with the standards of New York State Department of Health (DOH), New York State Education Department and current standards of the Joint Commission.

b) The specific credentialing, privileging and reappointment procedures are explained in the Medical Staff section of the NHCC Corporate Policy and Procedure Manual, and are attached at the end of these Bylaws and incorporated herein by reference.

Section 2. Emergency Privileges

a) In the case of emergency, any physician or dentist member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable.

b) When an emergency situation no longer exists, such physician or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 3. Protection from Liability

In matters relating to clinical privileges, all Medical Staff members and other practitioners and all appropriate hospital personnel including members of the Board of Directors and the hospital administration shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Sections 1 and 2 of Article V of these Bylaws.

Section 4. Leave of Absence

Leave of absence for up to one (1) year may be granted for:

a) ill health (physician or member of his/her family)
b) an educational commitment which would make it impossible for the physician or dentist to maintain his/her commitments
c) a temporary relocation of the doctor
d) the Executive Committee shall recommend such leave to the Board of Directors only after the approval of the Chair of the department has been obtained
e) requests for an extension beyond a one-year period shall require the recommendation of the department Chair.

Section 5. Resignation from the Medical Staff

a) To resign from the Medical Staff, the practitioner must submit a letter of resignation to the Department Chair. The letter shall include the reason(s) for his/her resignation, and shall include a statement to the effect that he/she has on or prior to the date of the letter fulfilled all the obligations of his/her Medical Staff membership, including, but not limited to, the completion of all of his/her outstanding charts and records.

b) Upon receipt of a Staff member’s letter of resignation, the Department Chair shall confirm that the Staff member has fulfilled all of the obligations of his Medical Staff membership, including, but not limited to, the completion of all of his/her outstanding charts and records and any quality management obligations. The Department Chair shall only recommend acceptance of the Staff member’s application to resign, the Medical Director and the Board of Directors shall only accept such recommendation, if the Staff member has fulfilled all of the obligations of his medical Staff membership. In the event that the Staff member shall not have completed all of the obligations of his Medical Staff membership he will not be considered to have resigned in good standing from the Healthcare System and any appropriate facility or credentialing body contacting the Healthcare System to inquire as to the status of the physician or dentist shall be so notified.

c) A Staff member who shall have resigned in good standing may reapply for membership to the Medical Staff at any time in accordance with the procedures contained in these Bylaws.
ARTICLE VI
CORRECTIVE ACTION

Rights granted under this Article apply only to Medical Staff membership.

Section 1. Procedure

a) Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be below the standards or aims of the Medical Staff or to be disruptive to the operations of the Healthcare System, corrective action against such practitioner may be requested by any officer of the Medical Staff, the Chair of any clinical department, the Chair of any standing committee of the Medical Staff, the President/Chief Executive Officer, the Medical Director or by the Board of Directors. All requests for corrective action shall be in writing, shall be made to the Executive Committee of the Medical Staff, and shall be supported by reference to the specific activities or conduct that constitute the ground for the request.

b) The Chair of the Executive Committee of the Medical Staff shall promptly notify the President/Chief Executive Officer in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the President/Chief Executive Officer fully informed of all action taken in connection with such request.

c) Upon receipt of a request for corrective action, the Executive Committee of the Medical Staff, as soon as reasonably possible, convene and conduct an independent review of the request as well as the supporting information or appoint an investigating committee to fulfill this role.

d) Following its review, the Executive Committee shall, within a reasonable amount of time, act upon the request for corrective action. Such action may include, but is not limited to the following:

1) Rejecting the request for corrective action;
2) Issuing a warning a letter of admonition or a letter of reprimand;
3) Imposing terms of probation;
4) Imposing requirements for consultation, retraining, additional training or continuing education;
5) Recommending reduction, suspension or revocation of clinical privileges;
6) Recommending suspension or revocation of Medical Staff appointment

e) A recommendation by the Executive Committee for suspension or revocation of clinical privileges; or for suspension or revocation of Medical Staff appointment shall
entitle the affected practitioner to a hearing and appellate review, as soon as reasonably possible, as provided in Article VII of these Bylaws.

f) Actions by the Executive Committee rejecting the request for corrective action; issuing a warning, a letter of admonition or a letter of reprimand; or imposing terms of probation, or requirements of consultation, retraining, additional training or continuing education; shall not entitle the affected practitioner to a hearing and appellate review as provided in Article VII of these Bylaws.

g) The Executive Committee’s action shall be reported to the President/Chief Executive Officer as soon as practicable. The President/Chief Executive Officer shall, if applicable, inform the practitioner of such action, as well as his/her right to a hearing and appellate review, as soon as reasonably possible, in accordance with Section 2 of this Article VI. Actions taken which do not entitle the practitioner to a hearing and appellate review shall be reported by the President/Chief Executive Officer to the Board of Directors for informational purposes.

Section 2. Summary Suspension

a) The Chair of the Executive Committee of the Medical Staff, the Chair of a Clinical Department, the Medical Director or the President/Chief Executive Officer shall each have the authority, whenever action must be taken immediately in the best interests of patient care in the Healthcare System, to summarily suspend all or a portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition.

b) All summary suspension actions shall immediately be reported to the Chair of the Executive Committee of the Medical Staff who shall, within fourteen (14) days, convene the Executive Committee of the Medical Staff to review the summary suspension. At this time, the Executive Committee of the Medical Staff shall review the basis for and scope of the summary suspension and recommend modification, continuance or termination of the terms of the summary suspension.

c) Unless the Executive Committee of the Medical Staff terminates the summary suspension, the affected practitioner shall be entitled to a hearing and appellate review as soon as reasonably possible, as provided in Article VII of these Bylaws. However, the terms of the summary suspension as sustained or as modified by the Executive Committee of the Medical Staff shall remain in effect pending any hearing, appellate review and final decision by the Board of Directors.

d) Immediately upon the imposition of a summary suspension, the Chair of the Executive Committee or responsible departmental Chair shall have authority to provide for alternative medical coverage for the patients of the suspended practitioner remaining in the Healthcare System at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.
Section 3. Automatic Suspension

a) Whenever a practitioner’s license, certificate or other legal credential authorizing him/her to practice in the State of New York is revoked or has lapsed, his/her Medical Staff membership and clinical privilege shall be immediately and automatically revoked. Whenever such legal credential is limited or restricted by the applicable licensing or certifying authority, those clinical privileges which he/she has been granted and which are within the scope of said limitation or restriction shall be immediately and automatically revoked. Whenever such legal credentials are suspended, his/her staff membership and clinical privileges shall be immediately and automatically suspended for at least the term of the suspension.

b) Whenever a practitioner’s drug enforcement administration controlled substance registration number is revoked, he/she shall immediately and automatically be divested of his/her right to prescribe substances governed by that number and the same divestiture shall be automatic upon suspension of the practitioner’s drug enforcement administration control substances registration number or when he/she is placed on probation with respect to the use of said number. Whenever such registration is suspended or revoked, the practitioner’s staff membership and clinical privileges shall be immediately and automatically suspended for at least the term of the suspension.

c) Whenever a practitioner fails to complete medical records in a timely fashion and without justification, his/her clinical privileges, except with respect to patients already in the Healthcare System, and his/her right to admit patients and to consult with patients shall, after written warning from the Medical Director of the delinquency, be automatically suspended and remain suspended until such medical and other records are completed in accordance with the Healthcare System’s policy of medical records completion. For the purposes of these Bylaws, justified reasons for delay in completing medical records shall include, but not be limited to the following:

1) the attending physician or any other individual contributing to the records is ill, on vacation, absent from the community or otherwise unavailable for a period of time;

2) the attending physician is waiting for the results of a late report and the medical record is otherwise complete except for the discharge summary and the final diagnosis, or

3) the attending physician has dictated the report and is waiting for personnel to transcribe it.

In the event the practitioner has been suspended for six (6) consecutive months, or for six (6) months in any one calendar year for failing to complete medical records, the practitioner shall be deemed to have resigned from the Medical Staff. Any such practitioner must therefore seek admission to the Medical Staff ab initio. The procedural mechanisms afforded by Article VII of these Bylaws are not available for such suspension and/or subsequent resignation for failure to complete medical records.
d) Failure of practitioners who must continuously maintain professional liability insurance in amounts and in a form acceptable to the Healthcare System shall result in the practitioner’s automatic suspension from the Medical Staff and from practicing at the Healthcare System.

e) A practitioner excluded from participation in Medicare or Medicaid programs, or other federal healthcare programs, will be automatically suspended from the Medical Staff.

f) A conviction or guilty plea in a healthcare fraud action will lead to automatic suspension from the Medical Staff.

g) Material misstatements or omissions on appointment or reappointment applications and any materials submitted in support thereof may be grounds for automatic suspension or dismissal from the Medical Staff for which the applicant shall have no right of appeal granted under these Bylaws.

h) The automatic suspension shall be immediately reported to the Chair of the Executive Committee of the Medical Staff and the procedures for review by the Executive Committee of the Medical Staff outlined in Section, b) of this Article VI applicable to a summary suspension shall apply to the automatic suspension. The affected practitioner shall not be entitled to the hearing and appellate review provided in Article VII of these Bylaws if suspended pursuant to an automatic suspension.

Section 4. Protection from Liability

In all investigations, hearings and reviews of matters relating to corrective action, summary suspension or automatic suspension, all individuals including but not limited to Medical Staff members, Healthcare System practitioners and personnel, members of the Board of Directors and the Healthcare System Administration shall be acting pursuant to the same rights, privileges, immunities and authority as are provided in Section 1 and Section 2 of Article V of these Bylaws.

Section 5. Reporting Requirements

All requests for corrective action and summary suspension will be reviewed by the Healthcare System to ensure compliance with applicable New York State and federal reporting requirements.
ARTICLE VII

HEARING AND APPELLATE REVIEW

Rights granted under this Article apply only to Medical Staff membership.

Section 1. Right to Hearing and Appellate Review

a) When any practitioner receives notice of a recommendation of the Executive Committee of the Medical Staff, that, if ratified by a decision of the Board of Directors, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an ad hoc committee of the Medical Staff as soon as reasonably possible. If the recommendation of the Executive Committee of the Medical Staff following such hearing is still adverse to the affected practitioner, he/she shall then be entitled to an appellate review by the Board of Directors, as soon as reasonably possible, prior to the Board of Directors’ final decision on the matter.

b) When any practitioner receives notice of a decision by the Board of Directors that will adversely affect his/her appointment to the Medical Staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing within a reasonable amount of time by a committee appointed by the Board of Directors. If such hearing does not result in a favorable recommendation by the hearing committee, the affected practitioner shall be entitled to an appellate review by the Board of Directors, before the Board of Directors makes a final decision on the matter.

c) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Article VII to assure that the affected practitioner’s rights are not violated.

d) Any notices referred to in this Article shall be in writing and sent by Certified Mail, Return Receipt Requested, by the President/Chief Executive Officer.

Section 2. Hearing by Ad Hoc Committee of the Medical Staff or by a Committee Appointed by the Board of Directors

a) Request for Hearing

1) the President/Chief Executive Officer shall, as soon as possible, provide written notice of an adverse recommendation by the Executive Committee of the Medical Staff, or decision by the Board of Directors that will adversely affect a practitioner’s appointment to the Medical...
Staff or his/her exercise of clinical privileges when such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff, to any affected practitioner who is entitled to a hearing or to an appellate review, by Certified Mail, Return Receipt Requested. Such notice shall state the following:

i) the adverse recommendation or decision; the basis for the adverse recommendation or decision including the acts or omissions with which the practitioner is charged and/or a list of specific or representative cases being questioned, which may be amended as necessary;

ii) that the practitioner, if he/she wishes to avail himself of the hearing and appellate review to which he/she may be entitled, must submit his request for a hearing to the President/Chief Executive Officer by Certified Mail, Return Receipt Requested, within thirty (30) days from his receipt of such notice;

iii) that the failure of the practitioner to request a hearing within thirty (30) days from his/her receipt of such notice and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter;

iv) a summary of the affected practitioner’s rights in the hearing as set forth in Section 2.d) of this Article VII of these Bylaws.

2) When a waived hearing and appellate review follows an adverse recommendation by the Executive Committee of the Medical Staff or an Adverse Decision by the Board of Directors which is not based on a prior adverse recommendation or the Board of Directors’ decision shall become effective upon such waiver and remain in effect against the practitioner pending the Board of Director’s final decision on the matter. The President/Chief Executive Officer shall, as soon as possible, notify the affected practitioner of his/her status following the waiver of a hearing by Certified Mail, Return Receipt Requested.

b) Notice of Hearing

1) Following his/her receipt of a request for a hearing from the affected practitioner, the President/Chief Executive Officer shall immediately forward such request to the Medical Staff President. The Medical Staff President shall establish an Ad Hoc Hearing Committee of the Medical Staff, shall schedule such hearing, and notify the practitioner of the time, place and date so scheduled by Certified Mail, Return Receipt Requested. Such hearing shall be scheduled at least thirty (30) days after the date of the notice of hearing.
2) At least fourteen (14) days prior to the actual hearing date, lists of witnesses, if any, expected to testify at the hearing, shall be exchanged.

c) Composition of Hearing Committee

1) When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an Ad Hoc Hearing Committee of the Medical Staff of not less than three (3) nor more than five (5) members of the Medical Staff appointed by the President of the Medical Staff and one of the members so appointed shall be designated as Chair by the President of the Medical Staff. No Medical Staff member who has participated in the consideration of the adverse recommendation or who is in direct economic competition with the affected practitioner shall be appointed a member of this hearing committee.

2) When a hearing relates to an adverse decision of the Board of Directors that is contrary to the recommendation of the Executive Committee of the Medical Staff, the Board of Directors shall appoint a Hearing Committee of not less than five (5) individuals to conduct such hearing and shall designate one of the members of this Hearing Committee as Chair. Medical Staff members may be appointed to this Hearing Committee. However, no Medical Staff member who has participated in the consideration of any prior recommendation or who is in direct economic competition with the affected practitioner shall be appointed a member of this Hearing Committee.

d) Conduct of Hearing

1) There shall be at least a majority of the members of the hearing committee present when the hearing takes place.

2) An accurate record of the hearing must be kept. The mechanism shall be established by the Ad Hoc Hearing Committee, and may be accomplished by use of a stenographer or electronic recording unit. Following the hearing, a written transcript shall be made and distributed to the practitioner and ECMS, or their representatives, and the hearing committee.

3) The personal presence of the practitioner for whom the hearing has been scheduled shall be required. The practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner as provided in Section 2.a.2 of this Article VII and to have accepted the adverse recommendation
or decision involved and the same shall thereupon become and remain in effect as provided in Section 2.a.2.

4) Postponement of hearings beyond the time scheduled shall be made only with the approval of the Ad Hoc Hearing Committee. Granting of such postponement shall only be made for good cause shown and in the sole discretion of the Ad Hoc Hearing Committee.

5) The affected practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, a member of his/her local professional society or by counsel at his/her expense.

6) The Chair of the Hearing Committee or his/her designee shall preside over the hearing to determine the procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

7) The hearing need not be conducted strictly according to the 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 considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in a civil or criminal action. The practitioner for whom the hearing is being held or the ECMS, or the Board of Directors when its action has prompted the hearing, shall, prior to or during a hearing, be entitled to submit memoranda concerning any issue relevant to the hearing, and such memoranda shall become a part of the hearing record.

8) Within thirty (30) days after receipt of the written transcript of the hearing, the practitioner and the ECMS, or the Board of Directors, shall be entitled to submit final memoranda to the hearing committee, which shall become part of the record and exchanged.

9) The Executive Committee of the Medical Staff, when its action has prompted the hearing, shall be represented by one of its members, another Medical Staff member or by legal counsel at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The Board of Directors, when its action has prompted the hearing, shall be represented by one of its members or legal counsel at the hearing, to present the facts in support of its adverse decision and to examine witnesses. The affected practitioner shall be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the
charges or grounds involved lacked any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

10) The affected practitioner, ECMS, or the Board of Directors, or their representatives, shall have the following rights: to call and examine witnesses to present evidence determined to be relevant by the Chair of the Hearing Committee, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness, to rebut any evidence and to submit a written statement at the close of the hearing. If the practitioner does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

11) The hearing Committee may recess the hearing and reconvene the same 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 or written evidence, including final memoranda, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to its members, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened.

12) The Hearing Committee may obtain independent outside consultation or conduct its own investigation with respect to any issue or matter pertinent to the action against the physician. No consultant shall be considered independent if he/she receives referrals from or has an economic relationship (other than the fee for the consultation in the matter under review) with the Healthcare System or any of its practitioners in any matter whatsoever.

13) As soon as possible after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all of the documentation, to the Executive Committee of the Medical Staff or to the Board of Directors, whichever appointed it. The report may recommend confirmation, modification or rejection of the original adverse recommendation of the Executive Committee of the Medical Staff or decision of the Board of Directors.

14) As soon as convenient, the Executive Committee shall meet and consider the report and recommendation of the Ad Hoc Hearing Committee of the Medical Staff. The Executive Committee may recommend confirmation, modification or rejection of its original adverse recommendation. The affected practitioner shall be notified through the President/Chief Executive Officer of the recommendation of the Ad Hoc Hearing Committee, and the recommendation of the
Executive Committee of the Medical Staff, including the basis for the recommendation and a copy of the hearing record. Thereafter, the procedures to be followed shall be as provided in Section 3 of this Article VII of these Bylaws.

Section 3. Appeal to the Board of Directors

a) Within thirty (30) days after receipt by an affected practitioner of a notice of an adverse recommendation or decision made or adhered to after a hearing as provided above, he or she may, by written notice to the Board of Directors, delivered through the President/Chief Executive Officer, by Certified Mail, Return Receipt Requested, request an appellate review by the Board of Directors. The practitioner may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner’s written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

b) If such appellate review is not received within thirty (30) days, the affected practitioner shall be deemed to have waived his/her rights to the appellate review, and to have accepted the adverse recommendation or decision which shall become effective immediately.

c) Following receipt of notice of a request for an appellate review, the Board of Directors shall, in a reasonable amount of time, schedule a date for such review including a time and place for oral argument if such has been requested and shall, through the President/Chief Executive Officer, by written notice sent by Certified Mail, Return Receipt Requested, notify the affected practitioner of the review.

d) The Appellate Review shall be conducted by the Board of Directors or by an appointed appellate review committee of the Board of Directors of not less than three (3) members, one of whom shall be the designated Chair.

e) The affected practitioner shall have access to the report and record of the Ad Hoc Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. He/she shall be permitted to submit a written statement on his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and the reasons for such disagreement shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statements shall be submitted to the President of the Board of Directors or to the Chair of the Appellate Review Committee of the Board of Directors or the Chair of the Appellate Review Committee of the Board of Directors, whichever is appropriate, at least ten (10) days prior to the scheduled date for appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the Chair of the Hearing Committee appointed by the Board of Directors to the President of the Board of Directors or the Chair of the Appellate Review Committee or the Board of Directors, whichever is appropriate, at least seven (7) days prior to the date of the appellate review. Such written
statements shall be provided to the affected practitioner and the Executive Committee of the Medical Staff. This schedule may be modified for the convenience of participants in the sole discretion of the Chair of the Appellate Review Committee.

f) The Board of Directors or its Appellate Review Committee shall act as an appellate body. It shall review the record created in the proceedings, and shall consider the written statement submitted pursuant to Subparagraph (e) of this Section 3, for the purpose of determining whether the adverse recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision and shall answer questions put to him/her by any member of the Appellate Review Committee. The Executive Committee of the Medical Staff or the Board of Directors, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the Appellate Review Committee.

g) New or additional matters not raised during the hearing by the Ad Hoc Hearing Committee or in the hearing committee’s report nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board of Directors or the Committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

h) Neither the affected practitioner, nor the Executive Committee of the Medical Staff or the Board of Directors shall be represented at the appellate review by legal counsel unless the Chair of the Appellate Review Committee, in his/her sole discretion, permits both sides to be represented by legal counsel. The foregoing shall not be deemed to deprive the physician, the Executive Committee of the Medical Staff or the Board of Directors of the right to legal counsel in connection with the preparation for the appellate review or any written submissions to the Appellate Review Committee.

i) The appellate review body may refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation. Such referral may include a request that the Executive Committee of the Medical Staff resolve specified issues. The Executive Committee of the Medical Staff shall provide its responses to the appellate review body as soon as practicable.

j) If the appellate review is conducted by a committee of the Board of Directors, such Committee shall, as soon as practicable, make a written report to the Board of Directors recommending that the Board of Directors affirm, modify or reverse the prior recommendation.

k) The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 3 have been completed or waived.
Section 4. Final Decision by the Board of Directors

a) At the next regularly scheduled meeting of the Board of Directors following the conclusion of the appellate review, the Board of Directors shall make its final decision in the matter and shall send notice thereof to the Executive Committee of the Medical Staff and, through the President/Chief Executive Officer to the affected practitioner by Certified Mail, Return Receipt Requested. If this decision is in accordance with the Executive Committee’s last recommendation in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee’s last recommendation, the Board of Directors shall refer the matter to the Joint Conference Committee for further review and recommendation, and shall include in such notice of its decision a statement that a final decision will not be made until the Joint Conference Committee’s recommendation has been received. At its next regularly scheduled meeting after receipt of the Joint Conference Committee’s recommendation, the Board of Directors shall make its final decision with like effect and notice as provided above in this paragraph (a).

b) Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee of the Medical Staff or the Board of Directors.
ARTICLE VIII

MEDICAL DIRECTOR

Section 1. Organization of the Medical Director

New York State 10 NYCRR Part 405, Section 405.2, subdivision (e) requires appointment of a Medical Director to be responsible for directing the Medical Staff organization. All clinical department Chairs and freestanding clinical service directors shall report directly to the Medical Director. The Medical Director shall report to the President/Chief Executive Officer and serve as the liaison between the Board of Directors and the Medical Staff for the quality of medical care provided to all patients.

Section 2. Qualifications and Selection

The Medical Director must be qualified for membership on the Medical Staff. The same procedure used to credential all other members of the Medical Staff will be used to credential the Medical Director.

A search committee shall be appointed by the President/Chief Executive Officer, in consultation with the Executive Committee of the Medical Staff, to find qualified candidates whenever the Medical Director’s position becomes vacant. The President/Chief Executive Officer shall make the selection for a Medical Director subject to final approval by the Board of Directors.

Section 3. Functions of the Medical Director

The Medical Director shall:

a) Provide leadership and guidance in development and coordination of medical and administrative policies of the hospital and Medical Staff;

b) Coordinate the functioning of the Medical Staff and assist in the implementation and enforcement of hospital policies, Medical Staff Bylaws and clinical policies and procedures; ensure the implementation of written criteria for the selection, appointment and reappointment of Medical Staff members and for the delineation of their medical privileges;

c) Convey the views, policies, needs and concerns of the clinical staff to the President/Chief Executive Officer and the Board of Directors;

d) Receive and interpret the policies of the Board of Directors for the Medical Staff and report to the Board of Directors on medical capabilities, medical education programs, quality of medical care provided, and other health care issues;
e) Exercise overall responsibility for quality management, risk management, infection control and credentialing and privileging;

f) Oversee all aspects of educational and research activities of the clinical staff;

g) Provide clinical leadership in the strategic planning process;

h) Evaluate department budget requests and make recommendations to the President/Chief Executive Officer on department resource levels;

i) Conduct a periodic review and analysis of medical operations to improve efficiency and the medical services provided to the community.
ARTICLE IX

OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

1. President
2. Vice President
3. Immediate Past-President
4. Secretary-Treasurer

Section 2. Qualifications of Officers

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 3. Election of Officers

a) Officers shall be elected in alternate years at the annual meeting of the Medical Staff. Only members of the Active Staff shall be eligible to vote.

b) The manner of voting shall be by written ballot or hand count. In situations where there are three or more candidates and no candidate receives a majority, there shall be successive balloting so that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority vote is obtained by one candidate.

c) The nominating Committee shall consist of five (5) staff members, at least two (2) of whom shall be members of the full-time Medical Staff. Three (3) members (including one designated to be the Chair of the committee) are to be appointed by the President of the Medical Staff, including at least one (1) full-time member. The remaining two (2) members are to be appointed by the existing Nominating Committee, including at least one (1) full-time member. This committee will nominate members of the staff in good standing for the offices of President, Vice President, Secretary-Treasurer and three (3) members of the Executive Committee to serve for a term of two (2) years.

d) Nominations may also be made from the floor at the time of the annual meeting.

Section 4. Term of Office

All officers shall serve a two (2) year term or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.
Section 5. Removal from Office

Removal of an officer prior to the end of his/her term may be achieved by majority vote of the Medical Staff at a regularly scheduled or in a special meeting called by the Chair of the Executive Committee.

Conditions for removal shall include, but not be limited to:

1) failure to perform the duties of the position;
2) violation of ethics;
3) criminal offense or proven medical misconduct, or;
4) any condition listed under Section 3 of Article VI, Corrective Action.

Section 6. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Executive Committee of the Medical Staff. If there is a vacancy in the office of the President, the Vice President shall serve out the remaining term.

Section 7. Duties of Officers

a) President: the president shall serve as the chief elected representative of the Medical Staff to:

1) act in coordination and cooperation with the Medical Director and President/CEO in all matters of mutual concern within the hospital;
2) call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;
3) serve on the Executive Committee of the Medical Staff;
4) serve as ex officio member of all other Medical Staff committees without vote;
5) represent the views, policies, needs and grievances of the Medical Staff to the Medical Director and the President/CEO;

b) Vice President: In the absence of the President the Vice-President shall assume all the duties and have the authority of the President. He or she shall be a member of the Executive Committee of the Medical Staff. He or she shall automatically succeed the President when the latter fails to serve for any reason.

c) Immediate Past President: Duties shall be advisory in nature.
d) Secretary-Treasurer: The secretary-treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his or her office. The secretary-treasurer shall be accountable for all the funds of the organization entrusted to him or her and shall be responsible for the deposit and disbursement of such funds.
ARTICLE X

CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments and Services

   a) Each department shall be organized as a separate part of the Medical Staff and shall have a Chair that shall be responsible for the overall supervision of the clinical work with his or her department.

   b) The clinical departments shall be as follows:

   1) Department of Anesthesiology
   2) Department of Community Medicine
   3) Department of Dentistry and Oral Surgery
   4) Department of Emergency Medicine
   5) Department of Medicine
   6) Department of Neurology
   7) Department of Obstetrics and Gynecology
   8) Department of Ophthalmology
   9) Department of Orthopedic Surgery
  10) Department of Pathology & Laboratory Medicine
  11) Department of Pediatrics
  12) Department of Physical Medicine and Rehabilitation
  13) Department of Psychiatry & Behavioral Science
  14) Department of Radiology
  15) Department of Surgery

Section 2. Qualifications, Selection and Tenure of Department Chairs

   a) Each Chair shall, before assuming duties, be a member of the Attending Staff.

   b) Each Chair shall be appointed by the Executive Committee of the Medical Staff for an indefinite term, subject to approval of the Board of Directors. Chairs serve at the pleasure of the Board of Directors.

   c) The Chair of each Department shall be responsible for the overall administration of his/her department. He/she shall organize his/her department and make appropriate rules for its administration taking into consideration the recommendations of the directors and chiefs of his/her department’s sub-divisions. The Chair may also further sub-divide or consolidate divisions, subject to the approval of the Medical Director.
Section 3. Functions of Department Chairs

Each Chair shall:

a) be accountable for all professional, educational, research and administrative activities within his/her department;

b) be responsible for assuring the implementation of a quality assurance plan with logistical support from the Quality Management Department;

c) assess and recommend to the ECMS, the Medical Director, and/or the President/CEO sources for needed patient care, treatment, and services not provided by the department or the Healthcare System;

d) ensure the integration of the department into the primary functions of the Healthcare System;

e) ensure the coordination and integration of interdepartmental and intradepartmental services;

f) be a member of the Executive Committee giving guidance on the overall medical policies of the Healthcare System and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care;

f) be a member of the Executive Committee giving guidance on the overall medical policies of the Healthcare System and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care;

g) be responsible for enforcement of the Medical Staff Bylaws, and Policy and Procedures within his/her department;

h) be responsible for enforcement of all departmental policies and procedures;

i) be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff and the Medical Director;

j) maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and transmit to the Executive Committee his/her recommendations concerning the staff classification, appointment and delineation of clinical privileges for all practitioners in his/her department;

k) determine continuing education requirements;

l) assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Medical Director, the President/Chief Executive Officer, or the Board of Directors.
Section 4. Functions of Departments

a) Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and the Board of Directors, for the granting of clinical privileges and for the holding of office in the department.

b) Medical care shall be evaluated by each department on a continuing basis.

c) Each department shall have at least quarterly meetings to consider findings from the on-going monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

d) A record shall be maintained of departmental quality improvement meetings that include the findings, conclusions, recommendations and actions taken. A copy of this record shall be submitted to the Department of Clinical Effectiveness and the Medical Director.
ARTICLE XI

COMMITTEES

Part A – General Provisions

Section 1. Appointment

a) The procedure for appointment or election to membership on the Executive Committee of the Medical Staff is as prescribed hereunder.

b) Appointment and reappointment to all other committees of the Medical Staff and the designation of the Chair (and Vice Chair) thereof shall be made jointly by the Medical Director and the President of the Medical Staff in consultation with the Chair of the Executive Committee of the Medical Staff.

c) Except as otherwise specified, appointment and or reappointment to all Medical Staff committees shall be for a period of two (2) years.

Section 2. Attendance Requirements

Members of all committees and subcommittees are expected to attend all meetings thereof unless excused by the Chair. Failure to attend at least 50% of regularly scheduled meetings may be cause for automatic replacement of a member.

Section 3. Quorum

Unless otherwise specified, the presence of fifty percent (50%) of the voting members of a Medical Staff committee or subcommittee shall constitute a quorum for the transaction of business at any meeting.

Section 4. Voting Privileges

Only members of the Medical Staff may vote on Medical Staff committees unless otherwise specified herein. No member of the Medical Staff, by virtue of possessing multiple titles, shall have more than one vote.

Section 5. Rights of Ex Officio Members

Unless otherwise specified, persons serving under these Bylaws as ex officio members of a committee shall not have voting privileges and shall not be counted in determining the existence of a quorum.

Section 6. Manner of Action
Unless otherwise specified, the action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of the committee or subcommittee.

Section 7. Frequency and Notice of Meetings

a) Regular Meetings: Unless otherwise specified, regular meetings or each committee or subcommittee shall be held at least quarterly. Deviations from established times or dates may be made upon three (3) days written or oral notice to each member.

b) Special Meetings: Unless otherwise specified, special or emergency of committees or subcommittees meetings may be called by the Chair of the Executive Committee, the Chair of the committee or subcommittee, or upon the written request of a majority of its members. Notice of all special meetings must be given at least forty-eight (48) hours prior to the meeting and must include place, day, hour and purpose of meeting.

Section 8. Minutes

Minutes shall be kept of all meetings of all committees and subcommittees of the Medical Staff and copies shall be sent to the Executive Committee with recommendations to the Executive Committee placed at the conclusion of the minutes in bold type. Minutes shall include date and duration of the meeting, the names of those in attendance, identification of topics and a brief summary of matters discussed, recommendations and actions taken, results of actions taken and the signature of one (1) member of the committee appointed to act as its secretary. Recommendations to the Executive Committee shall be placed at the conclusion of the minutes and shall be in bold type.

Section 9. Responsibilities

Each committee and subcommittee shall carry out those responsibilities described for it under Article XI, Part B, and shall make recommendations to the Executive Committee as documented in its minutes.

Section 10. Other Committees

Unless otherwise specified elsewhere in these Bylaws, other special committees and subcommittees may be appointed by the Chair of the Executive Committee in such number and of such composition as the Executive Committee may deem necessary or desirable to properly carry out the responsibilities of the Executive Committee and the Medical Staff. Such committees and subcommittees shall confine their activities to the purposes for which they were appointed, shall report to the Executive Committee, and shall have only such power of action as is specifically granted by the Executive Committee.
Part B – Committees

Section 1. Executive Committee

a) Composition:

1) The membership of the Executive Committee shall consist of the President and Vice President of the Medical Staff, the Chairs of each clinical department, the Medical Director, the Associate Medical Director, the Medical Director of the A. Holly Patterson Extended Care Facility, the Medical Director for Correctional Health Services, the Medical Director of the Community Health Centers, the Vice President for Clinical Effectiveness or designee, and the Director of Graduate and Undergraduate Medical Education, however, if the Director of Graduate and Undergraduate Medical Education is not a member of the Medical Staff, he or she shall serve as an ex officio member. The President/Chief Executive Officer, or his/her designee, and the Chief Nursing Officer, or his/her designee, shall also be members of the committee. A member of the Graduate Staff shall also serve as an ex officio member. The Chief Nursing Officer shall have voting rights on this committee. In addition, three (3) members of the Medical Staff shall serve as at-large members following their recommendation by the President of the Medical Staff and approval by the ECMS by a majority vote and three (3) members of the Medical Staff shall serve as at-large members after being elected at the annual meeting of the Medical Staff. At-large members elected at the annual meeting shall serve a two (2) year term or until a successor is elected and shall take their positions on the first day of the Medical Staff year following the annual meeting, or immediately following their election if the election occurred subsequent to the end of a full term.

2) The Medical Director and Associate Medical Director are prohibited from serving as Chair of the Executive Committee.

3) At the last meeting of the Executive Committee in each calendar year, the members thereof shall elect a Chair, Vice Chair and Secretary from their body. These officers will serve for the subsequent calendar year.

b) Duties: The Executive Committee shall:

1) represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

2) coordinate the activities and general policies of the various departments;
3) receive and act upon committee and subcommittee reports;

4) implement policies of the Medical Staff not otherwise the responsibility of the clinical departments;

5) provide liaison between Medical Staff, the President/Chief Executive Officer and the Board of Directors;

6) recommend action to the Board of Directors on matters of a medical-administrative nature;

7) make recommendations on hospital management matters (for example, long-range planning to the Board of Directors through the President/Chief Executive Officer);

8) fulfill the Medical Staff’s accountability to the Board of Directors for the medical care rendered to patients in the hospital;

9) ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;

10) provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent;

11) review the credential of all applicants and make recommendations for staff membership, assignments to department and delineation of clinical privileges;

12) review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges and as a result of such reviews, make recommendations for reappointments and renewal or changes in clinical privileges;

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

14) report at each general staff meeting; and

15) review clinical contracts.

Section 2. Credentials Committee
a) Composition: The Credentials Committee shall consist of representatives of the clinical departments. Representatives from the Medical Staff Office and the Office of Legal Affairs shall be ex officio members of the committee.

b) Duties: The Credentials Committee shall:

1) review the application of all applicants for membership on the Medical Staff submitted to it by the department Chairs and make recommendations to the Executive Committee on each such applicant regarding initial appointment, reappointment, and delineation of clinical privileges in compliance with Article V of these Bylaws; and

2) assure an impartial and objective evaluation of the qualifications and competence of each practitioner.

Section 3. Medical Records Committee

a) Composition: The Medical Records Committee shall consist of representatives from the clinical departments, nursing and Hospital Management. The Chief Information Officer, the Director of Medical Records, and a member of the Graduate Staff shall also be members of this committee. The Director of Medical Records shall have voting rights on this committee.

b) Duties: The Medical Records Committee shall:

1) be responsible for assuring that each medical record, or a representative sample, reflects the diagnosis, diagnostic test results, therapy rendered, condition and in-hospital progress of the patient and condition of patient at discharge. The committee shall conduct a regular review of summary information regarding the timely completion of all medical records, both concurrently and at discharge;

2) be responsible for recommending the format of the medical record, the forms used in the medical record and the use of electronic data processing and storage systems for medical record purposes;

3) be responsible for ensuring that there is proper filing, indexing, and availability of medical records; and

4) with the aid of legal counsel, develop and recommend policies regarding privileged communication and release of information. Such policies shall be consistent with Federal, State and Local laws.

Section 4. Pharmacy and Therapeutics Committee
a) Composition: Membership shall consist of at least five (5) representatives of the Medical Staff and one each from nursing and from Hospital Management. A representative of the Pharmacy Department and a member of the Graduate Staff shall serve as ex officio members.

b) Duties: The Pharmacy and Therapeutics Committee shall;

1) be responsible for the development, recommendation and surveillance of all drug utilization policies and practices within the hospital;

2) assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital;

3) serve as an advisory group to the hospital Medical Staff and the pharmacist on matters pertaining to the choice of available drugs;

4) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

5) develop and review periodically a formulary or drug list for use in the hospital;

6) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

7) evaluate clinical data concerning new drugs or preparations requested for use in the hospital;

8) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

9) define and review all significant untoward drug reactions, including all adverse reactions;

10) develop and coordinate a criteria-based, ongoing, planned and systematic process that includes measurement, ordering, preparation, administration and monitoring to evaluate the use of drugs to continuously improve the safety, appropriateness and effectiveness of their use.

Section 5. Infection Control Committee
a) Composition: This committee shall consist of representatives from clinical departments and at least one each from nursing, Pathology and Laboratories and Hospital Management. A nurse epidemiologist shall also be a member of this committee and shall have voting rights. The Director of Housekeeping and a member of the Graduate Staff shall be ex officio members. The Chief of Infectious Disease shall Chair the committee. Invited guests, who shall have no voting rights, shall include a representative from each of the following: Housekeeping, Central Services, Laundry, Dietary, Engineering, Pharmacy and the Operating Room.

b) Duties: The Infection Control Committee shall:

1) be responsible for surveillance of nosocomial infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and supervision of infection control in all phases of the hospital’s activities;

2) provide standard criteria for reporting all types of infections;

3) recommend corrective action based on records and reports of infections and infection potential;

4) assess the effectiveness of the hospital infection control program; and

5) assure that pertinent findings are included in orientation and continuing education programs.

Section 6. Cancer Committee

a) Composition: The Cancer Committee shall consist of representatives of Diagnostic Radiology, Medical Oncology, Pathology and Laboratories, Pediatrics, Radiation Oncology and Surgery. Representatives of Hospital Management, Social Work, Nursing, Tumor Registry, the Clinical Effectiveness Department, and a member of the Graduate Staff shall be ex officio members.

b) Duties: The Cancer Committee shall oversee multidisciplinary cancer patient-oriented conferences, evaluate quality of care of cancer patients, ensure that patients have access to consultative services in all major disciplines, and ensure that compliance with all regulatory requirements is maintained.

Section 7. Tissue Review Committee

a) Composition: The Tissue Review Committee shall consist of representatives of the clinical departments representing a cross-section of disciplines involved in operative procedures as well as a representative from Pathology. A member of the Graduate Staff, as
well as representation from Nursing and the Clinical Effectiveness Department shall serve as ex officio members.

b) Duties: the duties of the Tissue Review Committee shall include but not be limited to:

1) review the relationship and correlation between preoperative, post-operative and pathological diagnoses;

2) review includes adequate number of cases to permit valid assessment for effectiveness and appropriateness;

3) use results of review findings to continuously improve the processes involved in the selection and performance of surgical and other invasive procedures.

Section 8. Transfusion Practices Committee

a) Composition: The Transfusion Practices Committee shall consist of the Director of the Blood Bank, Director of the Division of Hematology and Medical Oncology, a member of the Critical Care Committee, and other representatives from the clinical departments, specifically including surgery and the Emergency Department. Representatives from clinical laboratory and Hospital Management as well as the Chief Nursing Officer or his/her designee shall be ex officio members.

b) Duties: The Transfusion Practices Committee shall:

1) evaluate the appropriateness of all cases in which patients were administered transfusions, including the use of whole blood and blood components. When such evaluation consistently supports the justification and appropriateness of blood use, the review of an adequate sample of cases shall be acceptable;

2) evaluate all confirmed transfusion reactions;

3) make recommendations to the Medical Staff regarding improvements in transfusion practices and administration of blood and blood components;

4) review the adequacy of transfusion services to meet the needs of patients; and

5) review ordering practices for blood and blood products.

Section 9. Operating Room Committee
a) Composition: The Operating Room Committee shall consist of representatives of the clinical departments representing a cross-section of disciplines involved in operative and perioperative care. The Chief Nursing Officer, or his or her designee, the Operating Room Supervisor, a member of the Graduate Staff, and representatives from Pharmacy and Hospital Management shall be ex officio members.

b) Duties: The Operating Room Committee shall:

1) Deal with all patient-related perioperative issues;

2) recommend all rules and regulations regarding the operating room; and

3) make recommendations for the coordination of all professional activities in the operating room.

Section 10. Institutional Review Board Committee

a) Composition: The Institutional Review Board Committee shall consist of not less than eleven (11) voting members, of which at least two shall be lay members, at least one of which shall be a community member not otherwise affiliated with the Healthcare System. Representatives from the Finance Department and the Department of Academic Affairs and a member of the Graduate Staff shall serve as ex officio members.

b) Duties: The Institutional Review Board Committee shall:

1) oversee healthcare system policy for research and monitoring of all research activity conducted within the healthcare system;

2) approve all research activities involving human subjects (as defined by the Department of Health and Human Services) to be undertaken at the Healthcare System by members of the Medical Staff;

3) function as the Institutional Review Board for the Hospital and protect human subjects in research in compliance with applicable federal and state regulations.

Section 11. Graduate Medical Education Committee

a) Composition: The Graduate Medical Education Committee ("GMEC") shall consist of the Training Program Director of every accredited Residency Training Program sponsored by the Nassau Health Care Corporation, Department Chairs who are not Program Directors, members of the Graduate Staff nominated by their peers, and the Director of Graduate and Undergraduate Medical Education who shall serve as Chair.
b) Duties: The GMEC shall be responsible for monitoring and advising on all aspects of graduate medical education. The GMEC will ensure the quality of the education and the work environment for residents in graduate medical education programs, including appropriate oversight of program structure; organization; goals and objectives; and processes for selection, promotion, evaluation, and corrective action.

c) The GMEC has one subcommittee:

1) Library Subcommittee – The Library Subcommittee shall consist of the Director of Graduate and Undergraduate Medical Education and not less than three (3) members of the Medical Staff representing various clinical departments. The Chief Nursing Officer and the chief librarian, or their designees, shall be ex officio members of this committee.

2) Duties – The Library Committee shall make recommendations regarding the proper organization, operation and use of the NUMC library. It shall promulgate rules and regulations governing the use of the library

Section 12. Radiation Safety Committee

a) Composition: The Radiation Safety Committee shall consist of the Radiation Safety Officer, a Hospital Management representative and representation from departments within the facility where radiation sources are used. Notwithstanding Article XI, Part A, Section 3 of the Bylaws, in order to constitute a quorum, the Radiation Safety Officer, an administrative representative and the presence of fifty-percent (+1) or more of the members of the Radiation Safety Committee, including at least one member of the Medical Staff, must be present.

b) Duties: The Radiation Safety Committee shall oversee all matters pertaining to radiation and its safe use, including all uses of radiation-producing equipment and radioactive materials within the facility. The committee shall review the activities of the Radiation Safety Officer and shall review the radiation protection program at least annually. The committee shall also oversee the administration of a quality assurance program.

Section 13. Nutrition Committee

a) Composition: The Nutrition Committee shall consist of representatives of the Medical Staff, Dietary, Nursing, Pharmacy, Hospital Management, and a speech therapist.

b) Duties: The Nutrition Committee shall be responsible for the surveillance of the nutritional support of all patients, and overseeing intravenous alimentation.

Section 14. Performance Improvement Coordinating Group
a) Composition: The Performance Improvement Coordinating Group may include, but shall not be limited to, the following: Medical Director, VP for Clinical Effectiveness, VP for Patient Care Services, Patient Safety Officer, VP for Nursing, Chief Operating Officer, Chief Financial Officer, Director of Graduate and Undergraduate Medical Education, VP for Support Services, VP for Planning, VP for Ambulatory Services, VP for Extended Care, VP for Behavioral Health, Chief Information Officer, all Clinical Chairs, Director of Infection Control, and Director of Clinical Effectiveness. Two members of the Governing Body and the President/CEO shall serve as ex officio members. The VP for Clinical Effectiveness shall chair this committee.

b) Duties:

1) Assure, through organization-wide mechanisms and related policies, the provision of safe, quality and effective patient care.

2) The performance of systematic review of data and information to ensure that the PI process is effective and ongoing, including Core Measure outcomes.

3) Receive, review, and act on the reports of the Clinical Effectiveness Committee.

4) Receive, review and act on direct reports of the Risk Management Committee.

5) Prioritize institutional quality efforts.

6) Perform ongoing review of the organizations compliance regulatory and/or oversight agency compliance including DOH; OMH; DOJ; and the Joint Commission.

7) Assure appropriate allocation of resources (financial, time and staff) is available to support performance improvement and patient safety.

8) Recommend to NHCC Board of Directors involvement in ongoing national initiatives (i.e. IHI, Leapfrog, etc.).

c) The Quality Council Committee has one subcommittee:

1) Clinical Effectiveness Committee: the composition of the Clinical Effectiveness Committee shall be in accordance with the Performance Improvement and Patient Safety Plan and has as its duties the following:
i) Develop and implement a hospital-wide Performance Improvement and Patient Safety Program utilizing the Joint Commission on Accreditation of Healthcare Organization’s (Joint Commission) principles and New York State Department of Health requirements.

ii) Maintain a centralized database of quality indicators and measures for comparative analysis for benchmarking performance improvement and safety initiatives.

iii) Assess, monitor, review and evaluate departmental quality indicators to promote consistent quality care and reduce medical/healthcare errors.

iv) Assist and direct individual departments in the identification of process improvement opportunities and support the efforts of teams in developing methodologies that are based on the NUMC Plan, Do, Check, Act (PDCA) format.

v) Use Quality Management tools and philosophy, the PDCA methodology, and work collaboratively across departments to maintain a safe environment for patient-centered care.

vi) Facilitate the implementation of and monitor compliance with the National Patient Safety Goals.

vii) Promote the use of evidence-based plans of care.

viii) Investigate identified issues related to the inefficient or inappropriate delivery of care and assure effective and sustained resolution to promote the achievement of optimal clinical outcomes.

ix) Assess the resource needs (financial, time and staff) needed to assure success with the Performance Improvement and Patient Safety Program and report such assessments to the Quality Council.

2) Standing agenda items at every meeting shall include reports from the Utilization Review Committee, the Patient Safety Officer, and presentations of Performance Improvement activities by individual departments.

Section 15. Bioethics Committee
a) Composition: Membership shall consist of a minimum of 12 members. Membership shall be multidisciplinary, with at least one member representing each of the following groups: Medical Staff, patient care services including nursing, patient care assistants, clergy, social work (certified) and patient representatives, a lay community member unaffiliated with the hospital, two (2) members of the Graduate Staff, and a member of the Clinical Effectiveness Department, as well as other relevant staff. No less than one person representing the A. Holly Patterson Extended Care Facility shall also be a member. All members of this committee shall have voting rights.

b) Duties: the Bioethics Committee shall:

1) function as a forum for the consideration of ethical issues arising in the care of patients;

2) provide education to caregivers, patients and family on ethical issues in health care;

3) review cases and make recommendations to the clinical staff with respect to ethical decision making;

4) enhance the patient-family-physician relationship;

5) respect and uphold the patient’s right to self-determination by ascertaining the patient’s wishes regarding treatment, and reconciling those wishes with legally required and medically appropriate care. This shall be done in consultation with the legal office with regard to sufficiency of evidence.

Section 16. Bylaws Committee

a) Composition: Membership shall consist of three (3) members of the ECMS appointed by the Chair of the ECMS. A representative from the Office of Legal Affairs shall serve as an ex officio member.

b) This committee shall submit the minutes of its meetings and its recommendations to the Executive Committee of the Medical Staff for approval prior to submission to the Medical Staff.

c) Duties: The Bylaws Committee shall receive, review, evaluate and offer recommendations regarding amendments and changes to the Bylaws of the Medical Staff, which recommendations shall be submitted to the Executive Committee of the Medical Staff in accordance with Article XIV of these Bylaws.

d) Meetings: This committee shall meet at least bi-annually, and as many additional times as necessary.
Section 17. Continuing Medical Education Committee

a) Composition: Membership shall consist of representatives from clinical departments and one from Hospital Management.

b) Duties: The Continuing Medical Education Committee shall:

1) provide convenient, cost-effective programs for all faculty at the Nassau Health Care Corporation and immediate community;

2) cooperate with other CE providers in the Long Island community to assure timely exposure of new and important clinical developments;

3) offer programs that reflect specialized expertise and interests of the Nassau Health Care Corporation to the region and beyond that improve and enhance patient care and health of the community.

Section 18. Critical Care Committee

a) Composition: The Critical Care Committee shall consist of members of the Medical Staff, representing the departments of medicine, surgery, pediatrics, anesthesiology, emergency medicine and other departments and/or divisions as necessary. The Chief Nursing Officer, or his/her designee, shall be a member of this committee with voting rights. Other members of the patient care services staff deemed necessary, as well as Pharmacy and the Graduate Staff shall serve as ex officio members.

b) Duties: The Critical Care Committee shall be concerned with the activities of all critical care units in the hospital and shall:

1) Periodically review and evaluate the functioning of these clinical areas including policies and procedures, staffing patterns, equipment, etc.;

2) Evaluate and assure that proper clinical effectiveness programs are in place and report such activities to the Clinical Effectiveness Committee; and

3) Evaluate and assure that continuous critical care training programs are implemented.
ARTICLE XII

THE JOINT CONFERENCE/PROFESSIONAL AFFAIRS COMMITTEE

Joint Conference Committee

The Joint Conference/Professional Affairs Committee shall be comprised of representatives of the Board of Directors, the Medical Staff, and Hospital Management. This committee shall serve as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall provide a formal means of communication between the Board of Directors, Hospital Management, and the Medical Staff. Discussions should include consideration of ways to continuously improve and standardize the continuity and quality of health care services provided by the Healthcare System, discuss problems and issues affecting medical care that arise in the operation and affairs of the Healthcare System, and assist in the development of Healthcare System policies regarding the delivery of health care. The committee shall report its activities, findings and recommendations to the Board of Directors no less than four times a year.

The Joint Conference/Professional Affairs Committee may also service as a forum to resolve any conflicts between the Board of Directors and the Medical Staff (refer to Article XVI - Amendments) regarding these Bylaws.
ARTICLE XIII

MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

Regular meetings of the staff shall be held semi-annually, on the first Wednesday in May and the first Wednesday in November. The November meeting shall be the Annual Meeting. The agenda of such meetings shall include reports of review and evaluation of the work done in the clinical departments and the performance of the required Medical Staff functions.

Section 2. Special Meetings

Special meetings of the Medical Staff may be called at any time by the Board of Directors, the President, the Executive Committee and/or the President/Chief Executive Officer. The President of the Medical Staff shall call a special meeting within thirty (30) days after receipt by him or her of a written request for same signed by not less than five percent (5%) of the Active Staff and stating the purpose for such meeting. The Executive Committee shall designate the time and place of any special meeting.

Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Staff not less than seven (7) or more than thirty (30) days before the date of such meeting, by or at the direction of the President (or other persons authorized to call the meeting). If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Quorum

The physical presence of 50 members shall constitute a quorum at any Medical Staff meeting. However, once a determination has been made that a quorum is present at a Medical Staff meeting, the group does not lose its ability to transact business if members who were previously counted leave the meeting, thereby reducing the number of members physically present to less than 50, and are not present when the transaction of business takes place.

Absentee votes shall count towards a quorum only for the discussion of the question for which the absentee vote is presented. If an absentee vote is voided for any reason, it will no longer count towards a quorum.
Section 4. Voting Requirements

Unless otherwise specified in these Bylaws, the approval of any action taken or recommendation made by the Medical Staff at any Medical Staff meeting shall require a majority vote. Abstentions shall not be counted as votes cast.

Absentee voting by mail shall be allowed in Medical Staff elections and for amending these Bylaws. Ballots and return envelopes shall be mailed to the voting members with the notice of the meeting for which the vote will be called. Absentee votes must be received by the designated recipient no later than two (2) days prior to the meeting during which the official vote will take place. Absentee votes shall be counted and tallied prior to the meeting and the results shall be sealed. The results will only be revealed after the official vote has been taken at the meeting. All absentee ballots must be cast in writing and signed by the absent member. Those members having cast ballots shall be crossed off the membership roster to avoid duplication of votes at the meeting.

Section 5. Attendance Requirements

Each member of the Active Staff is strongly encouraged to attend at least fifty (50%) percent of the regular and special Medical Staff meetings in each calendar year. A member who is compelled to be absent from any regular staff meeting shall promptly submit to the president of the Medical Staff, in writing, his/her reason for such absence. Unless excused for cause by the Executive Committee, the failure to meet the foregoing attendance requirements shall be grounds for corrective action leading to revocation of Medical Staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment.

Section 6. Agenda

a) The agenda at any regular Medical Staff meeting shall be:

1) Call to order;
2) Acceptance of the minutes of the last regular and of all special meetings;
3) Reports:
   i. President’s report
   ii. Treasurer’s report
   iii. Director of Academic Affairs’ report
   iv. E.C.M.S. Chair’s report
   v. Medical Director’s report
   vi. President/Chief Executive Officer’s report
4) Unfinished Business
5) New Business
6) Adjournment

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b) The agenda at special meetings shall be:

1) Reading of the notice calling the meeting
2) Transaction of business for which the meeting was called
3) Adjournment

Section 7. Dues

a) The amount of the dues for the ensuing year will be determined at the annual meeting by a majority vote of the members of the active staff present. The payment of staff dues is mandatory for all Active and Courtesy staff members. Members of the Emeritus, Consultant and Allied Health Professional Staffs are not required to pay dues. Active staff members appointed to the staff after July 1st of any given year are required to pay only half of the annual dues previously established for that year. The dues collected shall be used to defray the expenses of the Medical Staff as approved by the Executive Committee. The vouchers, therefore, shall be signed by two of the three elected officers of the staff.

b) In the event that the Medical Staff of the Nassau Health Care Corporation should be dissolved for any reason, all funds and monies then remaining in the treasury of said organization at the time of such dissolution, shall be donated to the Meadowbrook Medical Education and Research Foundation, Inc.

Section 8. Parliamentary Authority

The rules contained in the current edition of Robert’s Rules of Order newly revised shall guide the Medical Staff in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and any special Rules of Order the Medical Staff may adopt.
ARTICLE XIV

THE ALLIED HEALTH PROFESSIONAL STAFF

Section 1. Nature of Allied Health Professional Staff Membership

a) The Executive Committee of the Medical Staff shall, with the approval of the Board of Directors, designate those professions that shall be considered allied health professions. The Allied Health Professional ("AHP") Staff shall consist of the members of those allied health professions, who, at a minimum, hold an advanced degree and are registered and/or licensed and/or certified, as applicable, pursuant to the New York State Education Law. Such Allied Health Professional Staff may be authorized from time to time to practice their professions at the Hospital. The list of professions currently considered allied health professions shall mean:

- psychologists,
- research scientists, as defined by the Executive Committee of the Medical Staff,
- certified registered nurse anesthetists,
- physicians' assistants,
- nurse practitioners,
- nurse midwives, and
- intra-operative technicians

An addition or deletion of a profession as an allied health profession shall not require the approval of the Medical Staff.

b) Allied Health Professional Staff members shall have their privileges reviewed every two years by the Board of Directors, upon the recommendations of the Department Chairs concerned, and the Executive Committee of the Medical Staff following evaluation thereby of the qualifications of such practitioners and only after all required inquiries have been made. Members of the Allied Health Professional Staff shall have completed acceptable courses of education and training and shall possess such licenses and authorizations to practice their professions as the law may require. Members of the Allied Health Professional Staff shall be assigned to appropriate clinical Departments, and when required by regulation, law, Joint Commission standards, or hospital policy shall practice only under the supervision and/or collaboration of a physician member of the Medical Staff designated in writing by the Department Chair concerned, or his or her designee. Each Department shall define in writing the duties and responsibilities of each category of Allied Health Professional performing patient care activities in that Department.

c) Where appropriate, the ECMS may establish particular qualifications required of members of a specific category of AHPs, provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformance with applicable law.
d) An AHP may write orders only to the extent established by the Executive Committee but not beyond the scope of the allied health practitioner’s license, certificate or other legal credential.

e) An AHP is not entitled to the hearing and review process outlined in Article VII, Sections 1-4 of these Bylaws but instead receives the rights contained in this Article as outlined below in Section 2.

f) Any right granted under this Article applies only to Allied Health Professional Staff membership and not to the termination of employment from NHCC.

Section 2. Due Process for Allied Health Professionals

a) Allied Health Professionals ("AHP") are not deemed members of the Medical Staff, but are organized into the Allied Health Professional Staff for administrative purposes only. AHPs are not eligible for the rights associated with membership on the Medical Staff. The purpose of this section is to provide AHPs with a due process.

b) AHPs shall comply with the Medical Staff Bylaws, all NHCC policies and procedures; federal, state and local laws, regulations and guidelines; and professional standards and ethics.

c) Whenever the activities or professional conduct of any AHP with clinical privileges is considered to be lower than the standards of the Medical Staff; inconsistent with the NHCC standards of patient care, patient welfare, or the objectives of the NHCC; detrimental to patient safety or to the delivery of quality patient care; disruptive to the operations of the NHCC; or reflects adversely on the NHCC, or the character or competence of such practitioner; or if such AHP refuses or fails to comply with any NHCC policy or procedure, or rule or regulation; a federal, state or local law, regulation or guideline, or a professional standard or ethic, the AHP is subject to summary suspension or corrective action.

d) The President of the Medical Staff, Medical Director, Chair of the Executive Committee of the Medical Staff, or Chair of the AHP’s clinical department shall have the authority to summarily suspend all or any portion of an AHP’s clinical privileges, or impose corrective action, when it is determined that continuation of such privileges may result in danger to the health, welfare and/or safety of any NHCC patient, staff or visitor, or that the suspension of the AHP or corrective action is otherwise justified. Such suspension or corrective action shall be effective immediately upon imposition, shall be communicated to the AHP orally, and shall remain in effect against the practitioner pending final decision by the President/CEO in accordance with the procedures contained in this Article XIV, Section 2. The President/CEO shall be informed of the summary suspension or corrective action.

e) Immediately upon the imposition of the summary suspension or corrective action, the Chair of the AHP’s clinical department or the Medical Director shall have authority to provide coverage for the suspended practitioner.
f) Within seventy-two (72) hours of the imposition of a summary suspension or corrective action, the Medical Director shall confirm in writing to the AHP that he or she has been summarily suspended. Such notice shall advise the AHP of the basis for the summary suspension or corrective action, and the AHP’s right to have this action reviewed in accordance with this Article XIV, Section 2.

g) The AHP shall be entitled to request a review by the Executive Committee of the Medical Staff of the summary suspension or corrective action in accordance with the procedures contained with this policy. The AHP’s failure to request a hearing within seven (7) days of the AHP’s receipt of the written confirmation from the Medical Director shall be deemed a waiver of the AHP’s right to such a review.

h) The AHP must request a hearing, in writing, to the Chair of the ECMS.

i) Should the AHP request a review by the ECMS, such review shall take place within fourteen (14) days of the ECMS Chair’s receipt of the request for review. The notice of review shall contain the date, time and place of this meeting and shall provide the practitioner with a copy of any pertinent documents relating to the summary suspension or corrective action.

j) For purposes of this review, the Chair of the ECMS may appoint a subcommittee.

k) At such review the AHP shall be entitled to present the AHP’s position regarding the circumstances that led to the summary suspension or corrective action. The AHP shall answer any questions from the ECMS or subcommittee and any pertinent documentation shall be reviewed. The AHP shall not be entitled to have an attorney present during the review but may provide a written submission or other documentation at the time of the review.

l) The ECMS or subcommittee in its sole discretion, may interview any person who may have pertinent information relative to the action taken against the AHP and shall have access to any and all written documents and materials which would provide assistance in the evaluation of the issues before it.

m) Within five (5) days following the conclusion of the review, the ECMS or subcommittee shall issue a written decision.

n) The decision of the ECMS or subcommittee shall be final and shall be sent to the AHP via certified mail, return receipt requested.

o) The AHP shall not be entitled to any further reviews, hearings or appeals.
p) The Board of Directors will be informed of the AHP’s summary suspension or corrective action and the ECMS’ decision, if any, at the Board of Director’s next regular meeting and its decision on the practitioner’s status will be final.
ARTICLE XV

IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner’s application for, or exercise of, clinical privileges at this hospital:

First, that any act, communication, report, recommendation or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, that such privilege shall extend to members of the NHCC’s Medical Staff and of its Board of Directors, its other practitioners, its President/CEO and his or her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XV, the term “third parties” means both individuals and organizations from which information has been requested by an authorized representative of the Board of Directors or of the Medical Staff.

Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institutions’ activities related, but not limited to: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews and (7) other hospital, departmental, service or committee activities related to quality patient care and interprofessional conduct.

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article XV may relate to a practitioner’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the Healthcare System execute releases in accordance with the tenor and import of this Article XV in favor of the individuals and organizations specified in paragraph Second, subject to such requirements including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State.
Seventh, that the consents, authorizations, releases, rights, privileges and immunities provided by Section 1 and 2 of Article V of these Bylaws for the protection of this hospital’s practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XV.
ARTICLE XVI

AMENDMENTS

These Bylaws shall be reviewed at least biennially and revised as necessary to reflect current practices and maintain consistency with applicable legal and other requirements. They may be amended only in accordance with the following procedures:

a) A proposed amendment shall be referred to the ECMS, which shall report on it at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The text of any proposed amendment and the report thereon of the ECMS will be circulated among the members of the Medical Staff by the Staff Secretary prior to any such meeting.

The amendment must then be presented for information and discussion at the meeting hereinabove referred to and then subsequently presented for vote at a second meeting, either regular or special, of the Medical Staff, said meeting to take place not less than ninety (90) days after the first meeting, and said amendment will require for final adoption a two-thirds vote of the quorum present (as specified in Article XII, Section 3, "Quorum"). Amendments so adopted shall be effective when approved by the Board of Directors.

b) In the alternative, an amendment to the Bylaws that requires a more timely promulgation may be effected as follows:

1) A proposed amendment change is presented to the ECMS, at which time a two-thirds vote of the quorum present at the ECMS meeting is obtained.

2) The text of the amendment will then be distributed to all Medical Staff members and the issue placed on the agenda for the next scheduled Medical Staff meeting or special meeting called for such purpose. Final adoption shall be recommended by a majority vote of the quorum present at that meeting and take effect immediately upon approval by the Board of Directors.

c) An amendment required to conform these Bylaws to a statute, regulation, or judicial decision, or to ensure compliance with Joint Commission standards to maintain accreditation, may be made by the ECMS, subject to approval by the Board of Directors, and without the approval of the Medical Staff.

d) Neither the Medical Staff nor the Board of Directors may unilaterally amend these Bylaws.
e) Technical Amendments – Amendments limited to renumbering, reorganizing, grammatical corrections, spelling, punctuation, and similar technicalities that can be made without changing the substantive contents of these Bylaws may be made by the ECMS, subject to the approval of the Board of Directors, and without the approval of the Medical Staff.
ARTICLE XVII

ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, and shall become effective when approved by the Board of Directors of the Nassau Health Care Corporation.

ADOPTED by the Medical Staff on: Date: January 8, 2008

Kamil Jaghab, M.D.
President of the Medical Staff

Lyn Weiss, M.D.
Chair - Executive Committee of the Medical Staff

APPROVED by the Board of Directors on: Date: January 28, 2008

Martin D. Payson
Chair - Board of Directors
APPENDIX

CREDENTIALING, PRIVILEGING AND APPOINTMENT

POLICIES AND PROCEDURES

MS 010 - CREDENTIALING INITIAL APPOINTMENT

MS 020 - CREDENTIALING REAPPOINTMENT

MS 022 - CREDENTIALING IN THE EVENT OF A DISASTER

MS 024 - ALLIED HEALTH PROFESSIONAL CREDENTIALING & PRIVILEGING

MS 026 - TEMPORARY PROFESSIONAL PRIVILEGES
NASSAU HEALTH CARE CORPORATION
EAST MEADOW, NEW YORK 11554

SECTION: MEDICAL STAFF
POLICY/PROCEDURE

TITLE:
MS 010 - CREDENTIALING INITIAL APPOINTMENT

Approved:
Julie Mirkin, Sr VP patient care services; Steven Walerstein, MD, Sr VP medical affairs;

Cross References:
None

PROCEDURE FOR PROCESSING INITIAL STAFF APPLICATIONS FOR MEDICAL STAFF OF
THE NASSAU HEALTH CARE CORPORATION

1.0 AUTHORITY
1.1 Final authority to grant approval for appointment/reappointment to the Medical Staff and to grant privileges rests with the Governing Body, i.e. Board of Directors.

1.2 The Board of Directors takes this action following processing of the completed application by Medical Staff Services, recommendations of the Department Chairs, the Credentials Committee and the Executive Committee of the Medical Staff. Sex, race, creed and/or national origin are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

1.3 Medical Staff Services maintains records of all credentialed practitioner staff and verifies relevant background information regarding appointment and reappointment. This process is overseen by of the Medical Staff Administrator.

2.0 APPLICATION FORMS
2.1 A New York State licensed practitioner desiring to become a staff member in the Nassau Health Care Corporation may make a request to Medical Staff Services. Departments receiving such requests should forward them to Medical Staff Services promptly.

2.2 Upon receipt of a request Medical Staff Services will promptly forward an application, hospital and department specific delineation of privilege form, and instructions to the applicant.

2.3 The application and delineation of privileges must be filled out completely. If there are any unanswered questions, the form will not be processed and will
be returned to the applicant for completion. The application form identifies those items that must be completed prior to consideration for appointment to the Medical Staff and the granting of clinical privileges at the Nassau University Medical Center.

2.4 The completed application must be returned by the applicant to Medical Staff Services along with the following documents:
2.4.1. Original license from the New York State Department of Education whenever possible;
2.4.2. Copy of current registration certificate from the New York State Department of Education;
2.4.3. Copy of current DEA certificate if applicable;
2.4.4. Listing of work history for the past ten (10) years to be verified by Medical Staff Services;
2.4.5. Name of malpractice insurance company, policy number, dates of coverage and amount of coverage if applicable. (Declaration page should be attached);
2.4.6. Malpractice history within the past ten (10) years;
2.4.7. Copy of completed Annual Health Assessment form;
2.4.8. Copy of CME(s) or signed Attestation Form.

3.0 PROCESSING OF APPLICATION BY MEDICAL STAFF SERVICES
3.1. On receipt of the completed application, Medical Staff Services will query the:
3.1.1. American Medical Association for profile on physician;
3.1.2. National Practitioner Data Bank, AMA, OPMC;
3.1.3. New York State Department of Education for primary verification of licensure;
3.1.4. Verify Board Certification;
3.1.5. Medical Staff Services and/or Department of Post Graduate Education where the applicant has staff privileges or where the practitioner has trained in order to verify certain data contained in the application. This is repeated for every hospital or facility listed in the application.

3.2 The initial application process should be completed within 150 days.

3.3 The completed application with all of the above-mentioned verifications is then forwarded by Medical Staff Services to the appropriate Department Chair with a recommendation sheet.

4.0 RESPONSIBILITIES OF THE DEPARTMENT CHAIRS REGARDING THE APPLICATION FOR APPOINTMENT TO THE STAFF:
4.1. The Department Chair will ask the applicant to provide three letters of reference from the practitioner’s peers. When possible, one reference must be from the Department Chair or program director where the applicant had staff privileges or where he/she received residency/fellowship training.
4.2 The Department Chair will review the applicant's reference letters and delineation of privileges requested, and will check off the privileges recommended and/or not recommended. The Department Chair will recommend privileges and attending rank with respect to the applicant's experience, education, training, current competence, health status and current licensure.

4.3 The Department Chair will then promptly forward the letters of reference, signed delineation of privileges form and recommendation sheet to Medical Staff Services.

4.4 If a Department Chair refuses to process an application for appointment, the Chair is required to document the reason for the rejection and return the form to MSS for Credentials Committee review.

4.5 The Medical Director will conduct the appointment of a new Chair. The Search Committee will submit all documents obtained during the search, including notes from phone calls and other investigations, to the Medical Director. The Medical Director will send the applicant a "Request for Privileges Form." The Medical Director will review the request and supporting material from previous hospitals, including privileges granted there. The Medical Director will then forward the privileging materials and the procedure will be followed as for other practitioners.

5.0 ROLE OF THE CREDENTIALS COMMITTEE

5.1 Medical Staff Services will promptly arrange the applicant's interview with the Credentials Committee. A Credentials Committee member will be assigned to review the application and all of its attachments prior to the committee meeting. The entire application along with its attached documentation will be available for review during the meeting.

5.2 The committee member who has reviewed the application will present all the information contained therein to the committee members in a narrative fashion following a uniform checklist.

5.3 The narrative concerning each applicant and the comments of the Credentials Committee will be recorded by the Medical Staff Coordinator who will attend the meeting or a secretary who will transcribe a tape recording of the meeting.

5.4 Any and/or all committee members may question the applicant concerning training, competence, health status, licensure, ethics, malpractice or any other pertinent factors in order make recommendations for staff appointment to the E.C.M.S.
5.5 At the time of the interview with the Credentials Committee, the Chair of the Credentials Committee will inform the candidate about any privileges which have not been approved by the Department Chair.

5.6 The Credentials Committee Chair, or designate, will indicate the committee’s recommendation for approval or disapproval of the practitioner’s staff appointment on the Recommendation for Initial Appointment sheet above his/her signature and return the application and its attached documentation to the Medical Staff Coordinator.

5.7 The Medical Staff Coordinator will forward the application and its attached documentation to the Executive Committee of the Medical Staff at its next meeting.

6.0 ROLE OF THE EXECUTIVE COMMITTEE OF THE MEDICAL STAFF (ECMS)

6.1 The ECMS will act on the application by recommending approval or disapproval of the practitioner’s staff appointment. The credentials folder of each applicant will be available for review by the ECMS.

6.1.1. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

6.1.2. When the recommendation of the Executive Committee is favorable to the applicant, the application shall promptly be forwarded, together with all supporting documentation, to the Board of Directors.

6.1.3. When the recommendation of the Executive Committee is adverse to the applicant either in respect to appointment or clinical privileges, the applicant shall be so notified by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Board of Directors until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII of the Medical Staff Bylaws.

6.1.4. If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with Article VII, Section 3 of the Medical Staff Bylaws. If such recommendation continues to be adverse, the applicant shall be so notified by certified mail, return receipt requested. Such recommendation and documentation shall also be forwarded to the Board of Directors, but the Board of Directors shall not take any action thereon until after the applicant has exercised or has been deemed to have waived his right to an appellate review as provided in Article VII of the Medical Staff Bylaws.
7.0 ACTION OF THE BOARD OF DIRECTORS

7.1. The Medical Staff Coordinator will forward the credentials application to the Board of Directors at its next meeting.

7.2. The time period from the receipt of the completed application to action by the Board of Directors should not take longer than a period of 90 days.

7.3. The Board of Directors will act on the application by approving or disapproving the ECMS's recommendation. The Chairman of the Board of Directors, or designate, will sign the Recommendation for Initial Appointment form and will return the credentials application to the Medical Staff Coordinator.

7.4. All appointments to the Medical Staff will be provisional for a period of one year.

7.5. If the Board of Director's decision is adverse to the applicant in respect to either appointment or clinical privileges, the applicant shall be so notified of such adverse decision by Certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his/her rights to a hearing and appellate review, under Article VII of the Medical Staff Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

7.6. At its next regular meeting after all of the applicant's rights under Article VII have been exhausted or waived, the Board of Directors or its duly authorized committee shall act on the matter. The Board of Director's decision shall be conclusive, except that the Board of Directors may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons thereof, shall set a time limit within which a subsequent recommendation to the Board of Directors shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. At its next regular meeting, after receipt of such subsequent recommendation and new evidence in the matter, if any, the Board of Directors shall make a decision either to provisionally appoint the applicant to the staff or to reject him/her for staff membership. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.

7.7. Whenever the Board of Directors' decision will be contrary to the recommendation of the Executive Committee of the Medical Staff, the Board of Directors shall submit the matter to the Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.
7.8. When the Board of Directors' decision is final, it shall send notice of such decision through the Executive Director to the Medical Staff Coordinator, to the Chairman of the Executive Committee and of the department concerned, and by certified mail, return receipt requested, to the applicant.

8.0 APPLICATIONS TO ALLIED HEALTH PROFESSIONAL STAFF

8.1. Applications for the Allied Health Professional Staff will be processed in the manner as described in Policy MS 024.

9.0. APPOINTMENTS OF CONSULTANTS

There are two categories of consultants:

9.1. A Department Chair who wishes to invite an expert practitioner to come to the hospital for one day to provide patient care or to perform surgery will write a letter of request to the Chief Executive Officer and follow the procedure for Temporary Privileges (see MS-026, Temporary Privileges). They will not have admitting privileges.

9.2. A Department Chair who wishes to invite a New York State licensed physician/dentist to join his/her staff as a consultant to examine and treat patients will subject the applicant to the same verification process required by other staff applicants. They will not have admitting privileges.

10.0 PROCEDURE FOR PROCESSING PROVISIONAL TO ACTIVE STAFF APPOINTMENTS

10.1. One month prior to the anniversary date of a provisional appointment, Medical Staff Services is responsible for:

10.1.1. Informing the specific Department Chair that the provisional appointment of a staff or adjunct member needs revision and
10.1.2. Providing the Department Chair with the practitioner’s complete Quality Management Profile, the NPDB report and State license verification.

10.2. The Department Chair will recommend either continuation of provisional status, change to active staff or termination. If the option is continued provisional status or termination, the Department Chair must indicate the reasons thereof.

10.3. The Department Chair will then forward the candidate's initial application, complete Quality Management Profile NPDB report, State license verification and signed recommendation to the Medical Staff Coordinator for further
prompt processing by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors.

10.4. The initial application will be available in Medical Staff Services for review by members of Credentials Committee prior to the meeting. The initial application, Quality Management Physician Profile and the Department Chair's recommendation must be available at the time of review by the Credentials Committee, the Executive Committee of the Medical Staff and the Board of Directors.
NASSAU UNIVERSITY MEDICAL CENTER
EAST MEADOW, NEW YORK 11554

SECTION: MEDICAL STAFF

POLICY\PROCEDURE

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1.0 POLICY

1.1 At least five months prior to the two-year anniversary date of appointment or reappointment, Medical Staff Services will:

1.1.1 Forward a reappointment application package to the medical staff practitioner

1.1.2 Notify the specific Department Chair that the reappointment process has been initiated

1.2 No earlier than 120 days prior to the Credentials Committee meeting date during which the applicant will be discussed, Medical Staff Services will:

1.2.1 Query the National Practitioner Data Bank

1.2.2 Query Medical Staff Services in all hospitals where the applicant has privileges to verify relevant data contained in the application

1.2.3 Query the New York State Office of Professional Medical Conduct (OPMC), National Technical Information Services (DEA verification), General Services Administration (GSA), and Federation of State Medical Boards (FSMB), New York State Department of Health Medicaid Exclusion List (DOH) and if employed, query the Medicare “Opt-Out” program listing

1.2.4 Prepare the Credentialing Outcome Form by collecting stipulated components from various departments prior to forwarding to Department Chair

1.2.5 The OPMC, DOH and Medicare “Opt-Out” queries will be conducted on a monthly basis and housed in the Medical Staff Office. The OIG Excluded Parties Listing will be available as it is published and maintained in the Medical Staff Office

2.0 PROCEDURE

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Bylaws of the Medical Staff – FINAL – 1-28-08
2.1. The applicant will review and/or amend the pre-printed "Reappointment Application", include with it all information requested in the "Directions for Completing the Reappointment Application," and return it to Medical Staff Services within one month.

2.2. The application must be filled out completely. If there are any unanswered questions or missing documents, the application will not be processed and will be returned to the applicant for completion. The completed reappointment application must include:

2.2.1. The applicant’s license from the New York State Department of Education
2.2.2. Signed current registration certificate from the New York State Department of Education
2.2.3. Current DEA certificate, if applicable
2.2.4. Current Curriculum Vitae that includes a work history for the ten (10) years prior to application by month and year
2.2.5. Name of malpractice insurance company, policy number, dates of coverage and amount of coverage, if required. (Declaration page should be attached)
2.2.6. Malpractice claims history for the ten (10) years prior to application
2.2.7. Completed Annual Health Assessment form
2.2.8. Certificate evidencing completion of an infection control training course from a New York State certified infection control provider
2.2.9. Signed Attestation Form (original) evidencing completion of at least thirty (30) hours of AMA/ADA Category 1 continuing medical education in the two-year period prior to application for reappointment
2.2.10. Fellowship certificate, if applicable
2.2.11. Board certification, if applicable
2.2.12. Licenses from jurisdictions other than New York, if applicable

2.4. Medical Staff Services will forward to the appropriate Department Chair all relevant documentation, after receiving the following:

2.4.1. Completed application for reappointment
2.4.2. Applicant's complete Credentialing Outcome Profile
2.4.3. Results of all queries and verifications from Medical Staff Services and the chairs of the pertinent departments in the hospitals or facilities where the applicant has privileges
2.4.4. Will make at least three attempts to obtain a verification from another hospital or facility with or at which a practitioner had or has an association, employment, privileges or practice, relevant to the requested privileges. The applicant will be made aware of and held accountable for any non-response. If the Corporation receives satisfactory verifications of experience from other hospitals or facilities, the process will continue.
2.5. The Department Chair will conduct a review of each candidate at the time of reappointment and/or renewal/revision of clinical privileges. This includes confirmation of adherence to Medical Staff membership requirements as stated in departmental policies.

The Department Chair will review the Credentialing Outcome Profile and the reappointment file in its entirety. This review will cover the full scope of privileges requested and clinical practice. The Department Chair will also review the queries conducted by the Medical Staff Office. The Department Chair will recommend privileges and category rank. The Department Chair will indicate whether there has been an increase, decrease or termination of privileges.

2.6. The Medical Director, in accordance with Section 2.5 above, conducts the reappointment of Department Chairs. The Medical Director will then forward all applications, documentation and recommendations to Medical Staff Services for further processing by the Credentials Committee.

2.7. The applicant will be notified of any information obtained during the credentialing process that varies from the information that was provided on the application. The applicant has the right to review the information submitted in support of their credentialing application and correct erroneous information for correction prior to the Credentials Committee member review. In advance of the Credentials Committee meeting, a member of the Credentials Committee will review each credential folder including the Credentialing Outcome Profile and the Department Chair's recommendations. The Credentials Committee member reviewing the file and presenting the findings to the Credentials Committee must be someone who is not a member of the applicant's department. A member of the committee may present any adverse findings in a narrative fashion as described in the Appointment Procedure (MS-010) and the secretary will record this for the minutes. (A checklist will be used for this narrative). The applicant has the right to be informed of the credentialing process upon his or her inquiry.

2.8. If the applicant has not provided the Medical Staff Office with all appropriate documentation to complete the application and after thirty days or three attempts have been made to collect the necessary documents, the application shall be deemed withdrawn.

2.9. If the Credentials Committee recommends the practitioner’s reappointment, the Chair of the Credentials Committee, or designate, will sign the Recommendation for Reappointment form, and it will be sent together with pertinent reappointment documentation to the Executive Committee of the Medical Staff for review and further recommendation. The Credentials
Committee may hold the application for further review and investigation if circumstances warrant such action.

2.10. If the Executive Committee agrees with the recommendation for reappointment, the signed Recommendation for Reappointment Form will be forwarded to the Board of Directors, or its designee, for review. If approved by the Board of Directors, or its designee, the Recommendation for Reappointment Form will be signed and returned to Medical Staff Services.

2.11. Medical Staff Services will advise the applicant within 60 days of reappointment and forward a copy of the approved delineation of privileges to the practitioner and post these privileges on ITWeb, NHCC’s intranet system.
SECTION: MEDICAL STAFF
POLICY/PROCEDURE

TITLE:
MS 024 - CREDENTIALING IN THE EVENT OF A DISASTER

Approved:
Julie Mirkin, Sr VP patient care services; Steven Walerstein, MD, Sr VP medical affairs;

Cross References:
None

1.0 POLICY

1.1 It is the policy of the medical staff of Nassau Health Care Corporation to allow volunteer Licensed Independent Practitioners to provide care and treatment to patients seeking treatment at Nassau University Medical Center in the event of an emergency occurrence (known by the term “disaster”), when the Emergency Management Plan has been activated.

1.1.1. To ensure that Licensed Independent Practitioners, who do not possess medical staff or practice privileges, may be accepted to work in the facility in the event of an emergency occurrence (known by the term “disaster”), when the Emergency Management Plan has been activated.

2.0 PROCEDURE

2.1 The Sr. Vice President for Medical Affairs shall determine that Nassau University Medical Center requires additional practitioners to handle its immediate patient care needs. The Sr. Vice President for Medical Affairs shall appoint a Credentialing Officer (CO) who alone will have the authority to grant disaster privileges. All Volunteering Professionals (VP) shall report to the CO.

2.2 Individuals holding a valid license to practice medicine may volunteer to provide services during a disaster. The scope of services provided must be within the individual’s scope of practice as outlined by their appropriate state board, and the individual must have a valid, current license on file with their appropriate state board. The term “individual” applies to all Licensed Independent Practitioners (LIP).

2.3 The CO will grant privileges to VP’s based on a judgment of having sufficient information to determine with reasonable confidence as to the identity and qualifications of the VP. The nature of the Disaster and the acuity of the need
for additional medical professionals will be considered in this process. Data
to be collected and used in the decision making process may include:

2.3.1 Current license to practice;
2.3.2 Current picture hospital ID;
2.3.3 An ID indicating that the volunteer is a member of a state or federal
disaster medical assistance team;
2.3.4 An ID from a municipal, state, or federal entity granting authority to
administer patient care in emergency circumstances;
2.3.5 Verification of the volunteer practitioner’s identify by a current
hospital or medical staff member (good faith vouching);
2.3.6 Government issued photo ID; or
2.3.7 Internet confirmation of VP’s status

2.4 Upon presentation of appropriate identification, the privilege to provide
patient care during the disaster may be granted by the designated point person
for coordinating volunteer practitioners. The determination to grant
temporary privileges to a LIP will be made on a case-by-case basis, dependent
upon the needs of the patient population and the facility during the time of the
disaster.

2.5 The volunteer LIP’s name, title and license number (if immediately available)
will be documented by the designated point person for coordinating volunteer
practitioners with this information forwarded to the medical staff office.

2.6 Upon receipt, as time permits pursuant to the disaster, the medical staff
coordinator or designated member(s) of the medical staff office, will verify
the LIP’s licensure with his/her appropriate state board.

2.6.1 The medical staff office will keep the name, title and license number
of the VP LIP on file for future reference if needed
2.6.2 A folder will be created containing information stated in 2.6.1. and the
date and time of the VP’s arrivals and departures throughout the crisis.
2.6.3 The folder will contain a copy of the core specialty privileges for the
VP.
2.6.4 If applicable, the folder will contain a signature attesting that the VP is
known to a named NUMC-affiliated practitioner.
2.6.5 The folder will contain the name of any hospital or medical staff
member who has vouched for the VP.
2.6.6 The folder will contain the name of the practitioner with whom the
volunteer was paired.

2.7 The VP granted disaster privileges must be paired with a credentialed
practitioner on staff who has similar specialty.
2.8 A VP privileges, granted under this emergency situation, may be terminated at
any time without any reason or cause.
2.9 Termination of these privileges will not give rise to a hearing or review.
2.10 A temporary badge will be issued.
2.11 The VP will be assigned to a Department (and a Division if appropriate) and
will work under the direction of the Department Chair and Division Chief, if
applicable.

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3.0 Form and badge
3.1. Credentialing Form
3.2. Temporary badge (hand created)
NASSAU HEALTH CARE CORPORATION

DISASTER PRIVILEGES FORM

I, ____________________________, certify that I am licensed/certified as a
____________________________ in the state of ____________________________, license
#__________________________

I certify that I have the training, knowledge, and experience to practice in the specialty of
____________________________.

I hereby volunteer my medical services to NASSAU UNIVERSITY MEDICAL CENTER
during this emergency/disaster and agree to practice under the direction of the Chairman of
the Department or the Director of the Division to which I am assigned.

I also acknowledge that my privileges at this hospital shall immediately terminate once the
emergency has ended, as notified by the hospital.

_______________________________ Date
Signature of practitioner

_______________________________ Date
Signature of Credentialing Officer

The information as provided by the practitioner has been reviewed and verified, as possible,
by Medical Staff Services. On this basis, this practitioner is hereby granted emergency
privileges to treat patients presenting to NASSAU UNIVERSITY MEDICAL CENTER
during this disaster.

The Volunteering Professional is known to ____________________________.
NUMC-affiliated practitioner

_______________________________ Date
Signature of Credentialing Officer
NASSAU HEALTH CARE CORPORATION
EAST MEADOW, NEW YORK 11554

SECTION: MEDICAL STAFF
POLICY/PROCEDURE

TITLE:
MS 024 - ALLIED HEALTH PROFESSIONAL CREDENTIALING & PRIVILEGING

Approved:
Julie Mirkin, Sr VP patient care services; Steven Walenstein, MD, Sr VP medical affairs;

Cross References:
None

1.0 POLICY

1.1 The Medical Staff is organized under Section 405.4 of the New York State Health Code and consists of two categories of membership. Article 131 of Title 8 of the State Education Law defines Category I, and Section 405.4 (b)(3) of the health code defines Category II. Category II professionals shall be listed herein as Allied Health Professionals (AHPs) Licensed Independent Practitioners (LIPs) to include but are not limited to Certified Registered Nurse Anesthetists, Physician Assistants, Nurse Practitioners and Nurse Midwives.

1.2 Allied Health Professionals (AHPs) Licensed Independent Practitioners (LIPs) shall not be deemed members of the Medical Staff, which is limited to physicians, dentists, and podiatrists, but shall be organized solely for administrative purposes.

1.3 An application for specified services by any AHP\LIP shall be submitted and processed in the same manner provided in MS-010. Terms of appointment and reappointment of AHPs\LIPS shall not exceed two years. Reappointment shall be subject to the same reappointment process as is specified in MS-020.

2.0 PROCEDURE

2.1 An AHP\LIP holding a license, certificate, or other legal credential as required by New York State Law submits his/her application to the appropriate Department Chairman.

2.2 The Chairman determines eligibility and qualifications and, upon acceptance, recommends the candidate to the Medical Staff. Nurse Practitioners require a collaborative agreement with a physician member of the medical staff.
2.3 Following completion of the application process, the Credentials Committee of the Medical Staff reviews and approves the application and makes recommendations about delineated clinical privileges to the Executive Committee of the Medical Staff.

2.4 The Executive Committee of the Medical Staff approves the application and privileges, and makes recommendations to the Board of Directors.

2.5 Final authority to grant approval for appointment to the AHP/LIP staff and to grant privileges rests with the governing body, i.e. Board of Directors.

2.6 In the event of adverse recommendations and/or actions regarding the medical staff appointment and/or privileges, candidates are not entitled to the right of hearing and appellate review as the members of the Medical Staff.
NASSAU HEALTH CARE CORPORATION
EAST MEADOW, NEW YORK 11554

SECTION: MEDICAL STAFF
POLICY/PROCEDURE

TITLE:
MS 026 - TEMPORARY PROFESSIONAL PRIVILEGES

Approved:
Julie Mirkin, Sr VP patient care services; Steven Walsterstein, MD, Sr VP medical affairs;

Cross References:
None

1.0 POLICY:
1.1 Pre-appointment Privileges: A practitioner seeking staff appointment will be granted temporary privileges when:

1.1.1 The practitioner is engaged to fill a specific, essential position and service which must be available or provided on a certain date, and whose appointment or employment is delayed;

1.1.2 Documentation of prior education and experience does not contain negative or questionable information nor lack significant entries.

1.1.3 Temporary privileges may be granted when the applicant for medical staff membership or privileges has been recommended by the Credentials Committee and is waiting for a review and recommendation by the Executive Committee of the Medical Staff for approval by the Board of Directors.

1.2 Restricted Temporary Privileges. In cases of hospitalized patients, their families or whose physician-of-record requests a visit, or second opinion, a procedure or other professional interaction, temporary privileges limited to the purpose identified will be granted pending reasonable ascertainment of the health care professional’s credentials and appropriateness of the request.

1.2.1 All such requests must originate with the Attending Physician of Record and be approved by the Department Chair.

1.2.2 The Physician of Record assumes responsibility for the actions of the visitor

1.2.3 The practitioner must be licensed in New York State, submit a copy of his/her registration prior to or at the time of the patient encounter and be prepared to offer photo identification at the time of the visit.

2.0 PROCEDURE
2.1. **Pre-appointment Privileges.**

2.1.1 When appropriate, the Chief Executive Officer or his/her designee may grant temporary clinical privileges for a limited period of time on the recommendation of the chairman of the applicable clinical department, when available, or the President of the Medical Staff in all other circumstances.

2.1.2 When temporary privileges are requested, the Chair will recommend that to the Medical Director. Medical Staff Services will review the application and perform verification in order to assure the Medical Director of the following:

2.1.2.1. There is verification (which may be accomplished through a telephone call) of

- Current licensure,
- Relevant training or experience,
- Current competence,
- Ability to perform the privileges requested.
- Other criteria required by Medical Staff Bylaws

2.1.2.2. The results of the National Practitioner Data Bank and OPMC queries have been obtained and evaluated; and

2.1.2.3. The applicant has

- a complete application,
- no current or previously successful challenge of licensure or registration,
- not been subject to involuntary termination of medical staff membership at another organization, and
- not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

2.1.3 The Chairman’s memorandum and Temporary Privilege Worksheet (attached) will be hand delivered to Medical Staff Services with a copy of the original license, a copy of the registration and a copy of the delineation of privileges signed by the department chair. The NPDB and OPMC will be queried. The Medical Staff Coordinator will have the memorandum with all attachments hand delivered to the Senior Vice President for Medical Affairs/Medical Director.

2.1.4 The Chief Executive Officer, after approval, addresses a letter to the candidate notifying him/her of the granted temporary admitting and clinical privileges while his/her application for provisional appointment is being processed, and forwards it and the Temporary Privilege Worksheet to the Department Chair.

2.1.5 The Department Chair makes copies of the letter from the Chief Executive Officer and forwards the original to the candidate. One copy is kept in the department’s files, and one copy and original Temporary Privileges Worksheet are forwarded to the Medical Staff Coordinator. A copy of the letter is forwarded to the Credentials Committee, the operating room if applicable, Human Resources if
applicable, and Medical Records. A copy of the letter and original worksheet are filed in the applicant’s folder.

2.1.6 All temporary pre-appointments are time limited for a period not to exceed 90 days. In certain circumstances, if there has been satisfactory clinical performance in the first 90 days, and with full written justification temporary privileges may be extended by the Executive Committee of the Medical Staff beyond the 90 days for a period not to exceed another 90 days.

2.2 Restricted Temporary Privileges (RTP)

2.2.1 When appropriate, the Chief Executive Officer or his/her designee may grant temporary clinical privileges for a limited period of time on the recommendation of the chairman of the applicable clinical department, when available, or the President of the Medical Staff in all other circumstances.

2.2.2 All requests for RTP must be generated by the Physician of Record as an order on the chart.

2.2.3 The Department Chair is apprised of the reason for obtaining non-staff consultation. If in agreement, and the need is urgent, the Chair requests temporary privileges for the consultant specific for the procedure or evaluation and notifies the Information Desk of the expected visit during normal business hours, or Security during off hours. When the consultant is to perform surgery, the operating room is also notified.

2.2.4 Practitioner verification:

2.2.4.1 Medical Staff Services will complete primary source verification of current licensure

2.2.4.2 Department Chair will verify current competence for privileges requested

2.2.5 The consultant will write a report on the medical record. A more detailed report may be submitted on the consultant’s letterhead for inclusion in the medical record.

2.2.6 Practitioners on Restricted Temporary Privileges may not write orders.

2.2.7 RTPs are valid only for the duration of hospitalization for which the consultation was requested.
NASSAU HEALTH CARE CORPORATION

TEMPORARY PRIVILEGES WORKSHEET

Applicant’s Name: _________________________________
Date of Request: ________________

The Corporation must have the following items BEFORE temporary privileges can be granted to an applicant:

1. ______ Application completed by practitioner
2. ______ Signed Waiver
3. ______ CV
4. ______ Signed Delineation of Privileges
5. ______ Copy of Original License
6. ______ Copy of Registration
7. ______ ER Physicians = Proof of ACLS, ATLS, PALS
8. ______ Response from Data Bank
9. ______ OPMC Listing Checked

Contacts – VERIFYING ABILITY TO PERFORM REQUESTED PRIVILEGES

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<tr>
<th>Date</th>
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TEMPORARY PRIVILEGE FORM SIGNED BY:

➢ Department Chairman [  ]
➢ Medical Director [  ]
➢ CEO/President [  ]

NOTIFICATION LETTER GENERATED AND SIGNED BY:

➢ CEO/President [  ]