

**BYLAWS OF THE PROFESSIONAL STAFF OF
THE UNIVERSITY OF UTAH NEUROPSYCHIATRIC INSTITUTE**

DEFINITIONS

1. **HOSPITAL BOARD** means the UNI Advisory Board.
2. **GOVERNING BODY** means the University of Utah Hospitals and Clinics Boards.
3. **EXECUTIVE DIRECTOR** means the individual appointed by the Governing Body to act on its behalf in the overall administrative management of the hospital.
4. **MEDICAL DIRECTOR** means the physician appointed by the Governing Body to act on its behalf to insure the clinical excellence of the hospital's programs, activities, and systems.
5. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical or other clinical services in this hospital.
6. **EX OFFICIO** means service as a member of a committee by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.
7. **HOSPITAL** means The University of Utah Neuropsychiatric Institute of Salt Lake City, Utah and includes related services and programs.
8. **PROVIDER** means the individual member of the Professional Staff.
9. **EXECUTIVE COMMITTEE** means the Executive Committee of the Professional Staff, unless otherwise stated.
10. **PROFESSIONAL STAFF or STAFF** means the formal organization of all licensed physicians, psychologists, dentists, and independently licensed Mental Health Practitioners and podiatrists who are members and exercise clinical privileges in this hospital.
11. **SPECIAL NOTICE** means written notification sent by certified or registered mail, return receipt requested.
12. **CLINICAL DIRECTOR** means the Medical Director, psychology or social work supervisor (appointed by the Executive Director) who insures the clinical excellence of the appropriate programs.

NOTE: The masculine pronoun shall be used throughout these bylaws to denote professional staff of either sex.

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PREAMBLE

WHEREAS, The University of Utah Neuropsychiatric Institute is organized under the laws of the State of Utah; and

WHEREAS, its purpose is to serve as a psychiatric and neuropsychiatric institute providing patient care, education and research; and

WHEREAS, it is recognized that one of the aims and goals of the Professional Staff is to strive to provide patient care of professionally recognized quality, that the Professional Staff must work with and is subject to the ultimate authority of the hospital Governing Body, and that the cooperative efforts of the Professional Staff, the University of Utah Department of Psychiatry, the Executive Director, and the Governing Body are necessary to fulfill the hospital's obligations to its patients;

THEREFORE, the professionals practicing in this hospital are recognized as a Professional Staff in conformity with these bylaws.

ARTICLE I: NAME

Appointees to the professional staff shall be known collectively as the Professional Staff of The University of Utah Neuropsychiatric Institute.

ARTICLE II: PURPOSES

The purposes of the Professional Staff are:

1. To be the formal organizational structure through which;
 - (a) the benefits of appointment to the staff may be obtained by individual practitioners; and
 - (b) the obligations of staff appointment may be fulfilled.
2. To serve as the primary means for accountability to the Governing Body for the appropriateness of the professional performance and ethical conduct of staff appointees and to foster the policy that the pattern of patient care in the hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.
3. To provide a means whereby policies and procedures relating to the quality of medical care, and whereby issues concerning the Professional Staff and the hospital may be discussed by the Professional Staff with the Governing Body.

ARTICLE III: RESPONSIBILITIES

The responsibilities of the Professional Staff are:

1. To account for the quality and appropriateness of patient care rendered by all practitioners authorized to practice in the hospital through the following measures:
 - (a) A credentialing procedure, including mechanisms for appointment and reappointment and the delineation of clinical privileges;
 - (b) A continuing medical education program fashioned at least in part on the needs demonstrated through patient care evaluation and other quality improvement programs;
 - (c) A Utilization Review program based on the requirements of the hospital's Continuum of Care Plan;
 - (d) An organizational structure that allows for continuous monitoring of patient care practices;
 - (e) Evaluation of the quality of patient care and the reporting of results to the UNI Advisory Board;

- (f) Initiation and pursuit of corrective actions with respect to practitioners when warranted;
 - (g) Development, administration and compliance with these bylaws and the rules and regulation of the Professional Staff, and other medical care-related hospital policies;
 - (h) The exercise of authority granted by these bylaws to adequately fulfill the foregoing responsibilities.
2. To provide patients with continuous care at a generally recognized professional level of quality and efficiency;
 3. To abide by the current Professional Staff Bylaws, by all other lawful standards, and by current policies and rules of the hospital;
 4. To discharge such staff, committee, and hospital functions for which the Professional Staff is responsible by appointment, election, or otherwise;
 5. To prepare and complete in a timely fashion the medical and other required records for all patients admitted to, or in any way provided care in the hospital; and
 6. To abide by the lawful and ethical principles of the profession.

ARTICLE IV: PROFESSIONAL STAFF APPOINTMENT

SECTION I: Nature of Professional Staff Appointment

Appointment to the Professional Staff of The University of Utah Neuropsychiatric Institute is a privilege which shall be extended only to professionally competent, qualified providers with training and current experience in providing services in a hospital setting who continuously meet the qualification, standards and requirements set forth in these bylaws. Appointment shall also be based on the hospital's need and ability to accommodate additional appointees to the staff.

SECTION II: Qualifications for Appointment

- (a) Only providers licensed in the State of Utah who can document their background, training and experience, who can demonstrate competence, adherence to the ethics of their profession, and their good capability - based on current attitude and evidence of performance - to work with and relate to other staff appointees, to professionals in other health disciplines, to hospital management and employees, to visitors and the community in general in a cooperative professional manner that is essential for maintaining a hospital environment appropriate to quality and efficiency of patient care with sufficient adequacy to assure the professional Staff and the Governing Body that any patient treated by them in the hospital will be given professional care within recognized standards, shall be

qualified for appointment to the Professional Staff. No provider shall be automatically entitled to appointment to the Professional Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or in any other State, or because he is a member of any professional organization, or because he is certified by any clinical board, or because he had, or presently has, staff appointment at this hospital or another healthcare facility or in another practice setting. Qualifications for appointment include a willingness and capability, also based on current attitude and evidence of performance, to discharge the basic obligations of staff appointment and to participate equitably in the discharge of staff obligations specific to Professional Staff category. Applicants for appointment to the Professional Staff are to be free of or have under adequate control any significant physical or behavioral impairment and to be free of any difficulty in communicating verbally or in writing in the English language that interferes with or presents a substantial probability of interfering with the quality and efficiency of patient care.

- (b) The applicant must provide certification by his insurance carrier of having professional liability insurance in the amount of at least \$1,000,000/\$3,000,000 on a per occurrence or claims made basis as part of his application or reapplication for appointment. In the event that the applicant is insured under a claims made policy, he shall continue to purchase such coverage for a minimum of two years following the discharge of the last patient he treats at this facility. The applicant shall give immediate notice to the credentialing service office if the policy is ever canceled, altered or replaced. Proof of present and continued employment by a Utah governmental entity, as defined by Utah's Governmental Immunity Act, Utah Code Ann. Sections 63-30d-101 et seq. (as amended), such as the University of Utah, satisfies this requirement of proof of professional liability insurance.
- (c) Professional Staff privileges are offered to all professionally qualified providers without regard to age, race, religion, disability, color, gender, or national origin.

SECTION III: Conditions and Duration of Appointment

- (a) By applying for appointment to the Professional Staff each applicant thereby signifies his willingness to appear for interviews in regard to his application, authorizes the hospital to consult with members of professional staffs of other hospitals with which the applicant has been associated and to consult with others who may have information regarding the applicant's competence, character and ethical qualifications. In addition, the applicant consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence to carry out the clinical privileges requested. The applicant also releases from any liability all representatives of the hospital and its Professional Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment.
- (b) Initial appointment and reappointment to the Professional Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments or revocation of

appointments within a reasonable amount of time after there has been a recommendation from the Executive Committee as provided in these bylaws; provided that in the event of unwarranted delay on the part of the Executive Committee, that is, failure by that Committee to act within 45 days of receipt of the Credentials Committee report, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff appointee's professional and ethical qualifications obtained from reliable sources other than the Professional Staff.

- (c) Initial appointments to the Professional Staff shall be for a maximum period of twenty-four (24) months. Reappointments shall be for a period of not more than two Professional Staff years.
- (d) Appointment to the Professional Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body in accordance with these bylaws.
- (e) For physicians and psychologists, appointment to the Professional Staff is contingent upon receiving a faculty appointment with the University of Utah School of Medicine; however, physicians who are on the Associate Professional Staff need not have faculty appointments at the School of Medicine.

ARTICLE V: UNI PROFESSIONAL STAFF CATEGORIES

The Active Professional Staff

The Active Professional Staff shall consist of (1) physicians who shall have met all the prerequisites for application for examination to the American Board of Psychiatry and Neurology and (2) psychologists licensed in the State of Utah. In addition, physicians who have met all the prerequisites for application for board certification in a related field (e.g., Family Medicine, Internal Medicine, Pediatrics, Neurology, or Anesthesiology) may also be appointed to the Active Professional Staff when by additional training, clinical experience, and/or subspecialty certification they have acquired skills that fulfill an identified teaching and clinical need within the hospital, as determined by the Medical Director. Examples of such need could include, but should not be limited to, the treatment of patients with addictions, eating disorders, or chronic pain. Such providers will be required to seek consultation from a psychiatrist member of the Active Professional Staff if a patient under his/her care suffers from a secondary mental disorder (outside the provider's particular area of expertise) that by itself would warrant inpatient treatment. In addition, physicians on the Active Professional Staff who are not eligible for examination by the American Board of Psychiatry and Neurology must have a faculty appointment through the Department of Psychiatry, University of Utah School of Medicine.

The Active Professional Staff shall deliver the preponderance of professional services within the hospital and/or be willing to be actively involved in all the functions and responsibilities of appointment to the Active Professional Staff, including, where appropriate, emergency service care and consultation assignments. Appointees to the Active Professional Staff shall be eligible to vote, to hold an office and to serve on professional staff committees. They are encouraged to attend Professional Staff meetings, participate in assigned peer review activities, shall be expected to teach in the hospital's clinical training programs, and must provide services for at least (6) patients (either inpatients or partial hospital patients) per year in order to maintain Active Professional Staff status. The Chairman of the University of Utah Department of Psychiatry and Director of the University of Utah Division of Child and

Adolescent Psychiatry shall automatically receive Active Professional Staff status, and shall be exempt from the requirements of meeting attendance and minimum patient care numbers.

- **The Courtesy Professional Staff**

The Courtesy Professional Staff shall consist of those providers who have met all the prerequisites for application for examination by the American Board of Psychiatry and Neurology and providers who are licensed in the State of Utah, who are known personally or by reputation within the local psychiatric community. These professionals, because of the nature of their practice, are unable to meet all of the responsibilities for Active Professional Staff appointment and admit less than six (6) patients per year. They must, however, submit appropriate peer review data from other JCAHO accredited institutions, as determined by the UNI Credentials Committee. Any provider holding Attending privileges at the University Medical Center may automatically hold Courtesy Staff privileges at UNI. Appointees may occasionally be asked to assume teaching responsibility in the hospital's medical and non-medical training programs. Appointees to the Courtesy Staff may neither vote nor hold office.

- **The Associate Professional Staff**

The Associate Professional Staff shall consist of licensed physicians. These staff appointees are privileged to admit patients to the hospital, however, if the physician is a resident in training, he can admit patients only after the prior approval of the Medical Director or his designee. It is expected that each member of the Associate Professional Staff will participate in the care of at least six (6) patients per year. Associate Staff appointees may be asked to teach in the hospital's medical and non-medical training programs. These staff appointees are neither eligible to vote at Professional Staff Meetings nor hold elected office.

- **The Consulting Professional Staff**

There shall be a Consulting Professional Staff consisting of providers of recognized professional ability who have signified a willingness to accept such appointment and who are given privileges to consult on patients admitted to the hospital. Any provider holding Attending privileges at the University Medical Center may automatically hold Staff privileges at UNI. Appointees to the Consulting Staff may neither vote, hold office, nor admit patients.

- **The Honorary Professional Staff**

There shall be an Honorary Professional Staff consisting of former staff members retired or Emeritus, and other providers of outstanding reputation whom it is desired to honor. Appointees to the Honorary Professional Staff may neither vote nor hold office. They may have admitting privileges if they meet the requirements of the Courtesy Professional Staff.

ARTICLE VI: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

SECTION I: General Description

The appointment/reappointment process is provided through the Medical Staff Office of the University of Utah Hospitals and Clinics if the provider will have privileges at both the University of Utah Hospital and UNI. The appointment / reappointment process is provided through UNI Credentialing Services if the provider will have

privileges at UNI only. Full authority has been given to administer the collection, assembly, processing and authentication of credentials for all Professional Staff. The Professional Staff, through its designated committees and officers, shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff appointment status and shall adopt and transmit recommendations thereon to the Governing Body, which shall be the final authority on granting, extension, termination, or reduction of Professional Staff privileges. The Institute does not offer temporary privileges to practice without completion of an appointment to the Professional Staff.

SECTION II: Application for Appointment

- (a) All applications for appointment to the Professional Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Executive Committee. The applicant's request for application will be reviewed by the Clinical Director or his designee. The application shall require detailed information concerning the applicant's professional qualifications, shall require the applicant to provide the names of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character, shall request information as to whether the applicant's appointment status and/or clinical privileges have ever been denied, voluntarily relinquished, revoked, suspended, reduced or not renewed at any other hospital or institution, as to whether his membership in local, state or national medical societies or his license to practice any profession in any jurisdiction has ever been suspended or terminated, and whether any investigatory or disciplinary actions (including DEA) are currently pending, and shall require documentation of the applicant's past and current history of any professional liability actions including any settlement awards.
- (b) The applicant shall specifically request the staff category and clinical privileges for which he wishes to be considered.
- (c) The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Any misrepresentation or omission of a material fact shall result in a denial of appointment. In demonstrating satisfaction of the foregoing qualifications, a provider may, when suspicion or knowledge of a problem exists based on physical or behavioral manifestations on the job, on recent events or performance, or as follow-up to or concurrent monitoring as part of participation in a treatment program, be required to provide such information or to submit to such examination or tests as may be reasonably requested by any two of the following: Professional Staff President, Clinical Director, or Executive Director.
- (d) The applicant must show evidence of current licensure, relevant training and/or experience, current competence, and current health status.
- (e) The applicant shall be interviewed by the Clinical Director, by his designee or by the director of the program for which the applicant seeks privileges.

- (f) Every application for staff appointment shall contain the applicant's specific acknowledgment of every Professional Staff appointee's obligations to provide continuous care and supervision of his patients, to abide by the Professional Staff Bylaws, Rules and Regulations, to accept committee assignments and to accept consultation assignments.
- (g) The application form shall include a statement that the applicant has received and read the bylaws of the hospital Governing Body and the Bylaws, Rules and Regulations of the Professional Staff and that he agrees to be bound by the terms thereof if he is granted appointment and/or clinical privileges in all matters relating to consideration of his application.
- (h) The hospital must query the federal National Practitioner Data Bank for each health care provider who applies for appointment to the Professional Staff and for each provider who applies for clinical privileges.
- (i) The completed application shall be submitted to the Credentialing Coordinator. After collecting the references and other materials deemed pertinent, but in any event within 90 days of receiving the application, he shall transmit the application and all supporting materials to the Credentials Committee for evaluation.
- (j) Any provider holding Attending privileges at the University Medical Center may automatically hold Staff privileges at UNI. These provider applications are reviewed at UNI in the credentials and executive committee meetings after they have received Hospital Board Approval at the University Medical Center.
- (k) As a condition of consideration of an application for appointment or reappointment, and as a condition of continued appointment, if granted, every applicant and member specifically agrees to report to his or her relevant department chair and to the UNI Credentials Committee, any events relative to the following:
 - (1) Loss of license or other penalties imposed by state licensing agencies;
 - (2) Loss of Drug Enforcement Administration (DEA) certificate or other penalties placed on it;
 - (3) Any investigation initiated regarding reductions in privileges or other penalties placed on provider by facilities at which appointments are currently held;
 - (4) Reductions in privileges or other penalties placed on provider by facilities at which appointments are currently held;
 - (5) Any investigation initiated regarding participation in Medicare/Medicaid;
 - (6) Any sanction or exclusion imposed restricting participation with Medicare/Medicaid;
 - (7) Any charge of a misdemeanor or felony related to the practice of medicine or crimes against children, or any members of vulnerable populations;
 - (8) Any action, whether voluntary or involuntary, to enter a substance abuse treatment program;

- (9) Any other significant professional problem;
- (10) Any malpractice claim and/or any private negotiation or settlement of a claim alleging professional malpractice;

Failure to report may be grounds for automatic and permanent revocation of staff membership.

SECTION III: Appointment Process

- (a) Upon receipt of the application for appointment, the Credentials Committee shall determine whether the application is complete, shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in the references given by the applicant and from other sources available to the committee, whether he has established and meets all of the necessary qualifications for the category of staff appointment and the clinical privileges requested by him.
- (b) The Credentials Committee shall act on an application within 45 days of receipt. Upon deeming the application complete and upon completion of its review of the application and related materials, the Credentials Committee shall make a recommendation as to whether the applicant is to be appointed, rejected, or deferred for further consideration to the Executive Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted which may, where appropriate, be qualified by probationary conditions. The Credentials Committee shall transmit to the Executive Committee the completed application and all other documentation considered in arriving at its recommendation.
- (c) The Executive Committee shall review the recommendations of the Credentials Committee and all supporting documentation and shall make its recommendation within 45 days after receiving the Credentials Committee's report.
- (d) When the recommendation of the Executive Committee is favorable to the provider, the information shall be forwarded to the Governing Body for approval.
- (e) When the recommendation to the Executive Committee is adverse to the applicant either in respect to appointment or in granting of clinical privileges, the applicant will be notified as soon as possible. No such adverse recommendation need be forwarded to the Governing Body until after the applicant has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Plan, described in Appendix II of these Bylaws.
- (f) Assuming that the applicant requests and is granted a hearing, the Executive Committee will consider the report and recommendation of the Hearing Committee and the hearing record. If the Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph d. of this Section III. If such recommendation continues to be adverse, the applicant will be notified as soon as possible. The information shall also be forwarded to the Governing Body but the Governing Body shall not take any action thereon until

after the provider has exercised or has been deemed to have waived his right to an appellate review as provided in the Fair Hearing Plan.

- (g) At its next regular meeting after receipt of a favorable recommendation, the Governing Body or its Executive Committee shall act in the matter. If the Governing Body's decision is adverse to the applicant in respect to either appointment or clinical privileges, the applicant will be notified as soon as possible and such adverse decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his rights under the Fair Hearing Plan of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.
- (h) At its next regular meeting after all of the applicant's rights under the Fair Hearing Plan have been exhausted or waived, the Governing Body or its duly authorized committee shall act on the matter. The Governing Body's decision shall be conclusive except that the Governing Body may defer final determination by referring the matter back for further recommendation. Any such referral back shall state the reasons therefore, shall set the time limit within which a subsequent recommendation of the Governing Body 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 recommendations and of any new evidence in the matter, the Governing Body shall make a decision either to appoint the applicant to the staff or to reject him for staff appointment. All decisions to appoint shall include a delineation of the clinical privileges which the applicant may exercise.
- (i) When the Governing Body's decision is final, it shall send notice of such decision to the Chairman of the Executive Committee, and by certified mail, return receipt requested, to the applicant.

SECTION IV: **Fast Tracking Appointment Process**

1. If recommended by the Medical Director or Director of Psychology, applications for initial appointment may be processed as set forth in this Section so long as they meet the following conditions:
 - a. the applicant has successfully completed a residency, or is in the process of completing a residency, in the specialty for which privileges are requested, with no disciplinary action or conditions during residency training;
 - b. the applicant has not changed practice locations more than three times in the past 10 years;
 - c. all reference evaluations are completed and received within reasonable time of the initial request;
 - d. all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;
 - e. the applicant's claims activity (including past malpractice claims, settlements or judgments) is reasonable in light of his or her specialty; and
 - f. there are no pending or past restrictions, investigations or disciplinary actions from any hospital or licensing agency.
2. The Medical Director or Director of Psychology, acting for the Committee as a whole, shall review all relevant information and sign approval of a recommendation on appointment and clinical privileges. The application shall be forwarded to the President of the Executive Committee.
3. The President of the Executive Committee, acting on behalf of the Executive Committee, shall review the application and recommendation made by the Chair of the Credentials Committee. If the President of the Executive Committee concurs with the recommendation, the application shall be forwarded to the Chief Executive Officer or his or her designee.
4. The Chief Executive Officer or his or her designee, acting on behalf of the Hospital Board, may grant the individual an interim appointment and interim clinical privileges.
5. In the event that the Medical Director or Director of Psychology, Chair of the Credentials Committee, the President of the Executive Committee, or the Chief Executive Officer has any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.
6. Information regarding all applicants who are granted interim appointment and privileges shall be forwarded to the Credentials Committee for its information and to the Executive Committee for review and confirmation, and to the Hospital Board or designated Hospital Board Committee, at its next meeting, for final action.

SECTION V: Emergency Privileges

In the case of emergency, any provider or appointee, to the degree permitted by his 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 of any consultation necessary or desirable. When an emergency situation no longer exists, such provider must request the privileges necessary to continue to treat the patient. In the event that such privileges are denied or he does not desire to request privileges, the patient shall be assigned to an appropriate appointee to the Professional Staff. For the purpose of this Section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient, in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

SECTION VI: Disaster Privileges

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - a. A volunteer's identity may be verified through valid government-issued photo identification (i.e. Driver's license or passport).
 - b. A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice and/or proof of membership and good standing in a relevant professional organization; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.
- (3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners.

SECTION VII: Reappointment Process

Description:

Every other year, all members of the Professional Staff shall apply for reappointment and renewal. The reappointment process shall be based on a review of current licensure, health status, professional performance, judgment, clinical/technical skills (as indicated by results of quality assurance and other continuing medical activities) peer recommendation, and specifically:

1. Demonstrated professional competence in the treatment of patients in terms of both ethics and conduct;
2. Participation in staff affairs, including attendance at Professional Staff and appointed committee meetings;
3. Compliance with the Bylaws and Rules and Regulations of the Professional Staff and the Governing Body Bylaws;
4. Pertinent data from Quality Assurance/Utilization Review. The hospital must query the National Practitioner Data Bank for all members of the professional staff with clinical privileges who are seeking reappointment. By federal law, querying is required at a minimum every two years for a provider who is on the Professional Staff or who has clinical privileges. Reappointment will not be approved until the Executive Committee has received and reviewed a Data Bank report in response to a query made within the past two years or less.
5. Participation in staff development and professional growth and development activities.
6. Professional Staff members shall have the responsibility to forward to the Credentials Committee documentation of insurance, license renewals, professional liability actions and any legal professional judgments or settlements which occur during the calendar year.

Process:

1. The Credentials Coordinator shall, at least 90 days prior to the expiration date of the present staff appointment year, request staff appointees to reapply for appointment and to request the privileges for which they wish to be considered. He shall mail the reappointment application form to each current Professional Staff appointee. Each appointee who desires reappointment shall return his reapplication to the Credentials Coordinator in a timely manner. Failure by the Professional Staff appointee to submit an application at least sixty (60) days prior to the expiration of the Professional Staff appointee's current term may result in expiration of appointment and clinical privileges at the end of the then current term of appointment. The individual shall not practice until an application is

processed and approved by the required bodies. The Credentials Coordinator shall forward the completed form to the Credentials Committee.

2. The appropriate Clinical Director shall review the completed form and the appointee's file of professional staff activities and make a recommendation to the Credentials Committee that appointment be reviewed, renewed with modifications, or terminated.
3. The Executive Committee shall review all pertinent information available on each appointee scheduled for periodic appraisal for the purpose of determining its recommendations for reappointments to the Professional Staff and for the granting of clinical privileges for the ensuing period, and shall forward its recommendations to the Governing Body before the current privilege dates of the provider expire. Where the non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented by the Executive Committee.
4. Each recommendation concerning reappointment and the clinical privileges to be granted upon reappointment shall be based upon review of documentation of the appointee's professional competence and clinical judgment in the treatment of patients, of current licensure, of his ethics and conduct, attendance at Professional Staff meetings and participation in continuing education and other Staff activities, compliance with the hospital and Professional Staff Bylaws, Rules and Regulations, demonstration of proof of current malpractice insurance coverage in the prescribed amount, use of the hospital's facilities for his patients, relation with other providers and current health status and such other factors as the Executive Committee deems relevant. An applicant for reappointment is required to submit reasonable evidence of current health status if requested to do so by the Credentials or Executive Committee.
5. Thereafter, the procedure provided in the subsection d. et seq of Section III of Article VI relating to recommendations on applications for initial appointment shall be followed.

SECTION VIII: Change in Staff Category

Description:

An appointee to the Professional Staff may request a change in Staff category. For descriptions of each category, see Article V.

Procedure:

1. Request:
All members desiring a change in Staff category shall submit a written request/explanation to the appropriate Clinical Director / or designee.
2. Verification:
Upon receipt of the written request for change in Staff category, the Clinical Director / or designee,

shall review it, verify the necessary data and forward request to the Credentials Committee for their review and approval or denial. The Credentials Coordinator will forward the information to the Executive Committee for their review and approval or denial.

3. Process:
 - a. Approval:
The applicant shall be notified within ninety (90) days of the request for change in Staff category.
 - b. Denial:
If the request for change has been denied, the applicant shall be informed of the reason for the denial.
4. Appeal:
Individuals denied a request for change in Staff category do not have the right to an appeal process as defined in the Fair Hearing Plan.
5. Clinical Supervision:
The Executive Committee shall establish parameters for supervision on an individual basis for providers with any change in professional staff category.

ARTICLE VII: CLINICAL PRIVILEGES

SECTION I: Exercise of Privileges

- (a) Every practitioner or other professional providing direct clinical services at this hospital by virtue of Professional Staff appointment or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Governing Body, except as provided in Sections III and IV of this Article. In every case, a licensed physician will be responsible for all medical care rendered to patients at this facility.
- (b) Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, performance, experience, demonstrated competence, references, demonstrated ability and judgment in accordance with the criteria established in Section II(b) within this article, and other relevant information, including an appraisal by the service in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges he requests.
- (c) Biennial re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of the Professional Staff which document the evaluation of the appointee's participation in and the delivery of medical care.

SECTION II: Delineation of Privileges

(a) **Basis for Privilege Determination:**

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, performance, experience, demonstrated competence, demonstrated ability, references and judgment in accordance with the criteria established in Section (b) following. Determination of privileges made in connection with reappointment shall also include review of clinical performance, records of the Professional Staff, and the result of patient care evaluation and other quality management activities. Clinical privileges granted on initial appointment shall be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where the practitioner exercises or exercised clinical privileges. This information shall be added to and maintained in the credentials file established for a staff appointee. The applicant shall have the burden of establishing his qualifications and competencies relating to the clinical privileges requested.

(b) **Areas of Privileging and Criteria:**

Specific areas of privileging shall be defined by the Medical Director and the Credentials Committee of the Professional Staff. Areas of privileging shall be specific as to program, patient group, age group, and special procedures and shall include:

- (1) specific privilege to be granted;
- (2) nature of privilege;
- (3) criteria required for granting of privilege;
- (4) supervision required.

All privileges defined in this manner shall be approved by the Executive Committee and the Governing Body and shall form Appendix III to these Bylaws. Privilege delineation shall be reviewed, revised, and approved annually by the Executive Committee and the Governing Body.

(c) **Supervision**

All new appointees to the Professional Staff may be assigned a mentor whose responsibilities may include supervision and case review monthly for the first six (6) months of practice in the hospital. Peer supervision for any practitioner is optional, as recommended by the Credentials Committee. All Professional Staff appointees are subject to routine review and supervision through the Professional Staff and hospital quality assurance program and through supervision as deemed appropriate by the Medical Director.

(d) **Modification of Privileges**

- (1) Any appointee of the Professional Staff may request additional privileges at any time by

completing an Application for Privileges form stating privileges requested and providing documentation as required in subsection b.3. above.

(2) Procedure for reviewing and granting privileges shall follow the same procedure as for reappointment, stated in Article VI, Section IV.

(e) **Denial of Privileges**

If a request for specific privileges is denied, the applicant shall be informed in writing by the Executive Director of the reason for such denial. Notification shall be sent within one hundred and twenty (120) days of receipt of the completed application and supporting documents. Individuals denied exercise of specific privileges have the right to an appeal process as defined in the Fair Hearing Plan.

(f) **National Practitioner Data Bank**

The hospital must report to the National Practitioner Data Bank in conformity with the hospital's National Practitioner Data Bank policies and procedures, when the hospital accepts the voluntary surrender or voluntary restriction of the clinical privileges of a physician or dentist in return for the hospital not conducting an investigation or proceeding relating to possible incompetence or improper professional conduct. The hospital must also report to the National Practitioner Data Bank the voluntary surrender or voluntary restriction of clinical privileges of a physician or dentist while the physician or dentist is under an investigation by the hospital relating to possible incompetence or improper professional conduct.

ARTICLE VIII: ALLIED MENTAL HEALTH PROFESSIONALS

SECTION I: Definition

Allied Mental Health Professionals shall consist of licensed individuals other than those eligible for Professional Staff appointment under Article V who, by virtue of their professional credentials and documented current competence, are privileged to provide patient assessment and care services. Appointment shall be based on the hospital's need and ability to accommodate additional appointees to the staff. These Professionals shall consist of Licensed Clinical Social Workers, Advanced Practice Registered Nurses (including nurse practitioners and clinical nurse specialists), and Physician's Assistants. Such Professionals are licensed to practice with varying levels of supervision, including those who are licensed to practice without supervision. Appointment to the Allied Mental Health Professional Staff shall confer on the appointee only such privileges and prerogatives as are specifically granted by the Governing Body in accordance with these Bylaws.

SECTION II: Qualifications

Only those Allied Mental Health Professionals currently licensed to practice in the State of Utah who:

- (1) Document their experience, background, and training and who can demonstrate competence and adherence to the ethics of their profession with sufficient adequacy to assure the Professional Staff and the Governing Body that any patient treated by them will receive care of a generally recognized professional standard; and who
- (2) Demonstrate capability of working cooperatively with others and who are willing to participate in the discharge of staff responsibilities; shall be qualified for appointment as an Allied Mental Health Professional.
- (3) Independently licensed Allied Mental Health Professionals are required to carry, as a minimum, professional liability insurance in the amounts stipulated in Article IV, Section II.b. (\$1,000,000/\$3,000,000). Proof of present and continued employment by a Utah governmental entity as defined by Utah's Governmental Immunity Act Utah Code Ann. Sections 63-30d-101 et seq. (as amended), such as the University of Utah, satisfies this requirement of proof of professional liability insurance.

SECTION III: Prerogatives

Allied Mental Health Professionals shall:

- (1) Participate directly in the assessment and care of patients under the direction of, or in collaboration with, an active or courtesy appointee of the Professional Staff;
- (2) Record pertinent information in progress notes on the patient's records;
- (3) Be permitted only those practices delimited under Utah State Law and compatible with the Institute's mission and standards;
- (4) Advanced Practice Registered Nurses are permitted to practice independently in the Institute's outpatient behavioral health clinics;
- (5) Not independently admit or discharge patients at the hospital.

SECTION IV: Responsibilities

Each Allied Licensed Mental Health Professional shall:

- (1) Meet the basic responsibilities set forth in Article III;
- (2) Seek consultation whenever necessary;
- (3) Strive to attend the quarterly meetings of the Professional Staff as a non-voting member;
- (4) Attend department meetings as assigned;
- (5) Participate as requested in hospital education and training programs;
- (6) Complete all medical records in accordance with the requirements established by the hospital's policies and procedures.

SECTION V: Procedures

Procedures for application, appointment, and reappointment to the Allied Mental Health Professionals shall follow those specified for the Professional Staff in Article VI. The appeal and hearing rights for Allied Mental Health Professional Staff are as defined in the Fair Hearing Plan. The hospital must query the Data Bank for each Allied Mental Health professional who applies for privileges and the hospital must also query the Data Bank every two years for each health professional who presently possesses clinical privileges.

ARTICLE IX: **CORRECTIVE ACTION**

SECTION I: Routine Corrective Action - Procedure

- (a) Whenever the activities or professional conduct of any practitioner and/or Allied Mental Health Professional with clinical privileges are considered to be lower than the standards or aims of the Professional Staff or be disruptive to the operations of the hospital, corrective action against such practitioner and/or Allied Mental Health Professional may be requested by an officer of the Professional Staff, by the chairman of any standing committee of the Professional Staff, by the hospital Executive Director, by the Medical Director, or by the Governing Body. All requests for corrective action shall be in writing, shall be submitted to the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.
- (b) Whenever the corrective action could be a reduction or suspension of clinical privileges, the Executive Committee shall immediately appoint an ad hoc committee to investigate the matter. Within fourteen (14) days after the receipt of the request to investigate, the committee shall forward

a written report of the investigation to the Executive Committee.

- (c) Within ten (10) days of receipt of the report from the ad hoc committee, the Executive Committee shall take action.
- (f) The action of the Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the practitioner's staff appointment be suspended or revoked.
- (g) Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Professional Staff shall entitle the affected practitioner and/or Allied Mental Health Professional to the procedural rights provided in the Fair Hearing Plan of these Bylaws. The Chairman of the Executive Committee shall promptly notify the Medical Director and hospital Executive Director in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Medical Director and hospital Executive Director fully informed of all action taken in connection therewith. After the Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Article VI, Section III, subsection (e) et seq and in the Fair Hearing Plan, if applicable, of these Bylaws.

SECTION II: Summary Suspension

- (a) Any one of the following: the Chairman of the Executive Committee, the President of the Professional Staff, the Medical Director or his designee, a director of a clinical program, the Executive Committee, or the Governing Body, shall each have the authority, whenever action must be taken immediately in the best interests of patient care in the hospital or whenever a practitioner and/or Allied Mental Health Professional poses a threat to the viability of the institution, or willfully disregards these Bylaws or other hospital policies or whenever his conduct may require that immediate action be taken to protect the life of any patient(s) or to reduce the likelihood of immediate injury or damage to the health or safety of any employee or other person in the hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner and/or Allied Mental Health Professional, and such summary suspension shall become effective immediately upon imposition. The Medical Director shall promptly give special notice of the suspension to the practitioner.
- (b) A physician or dentist whose clinical privileges have been summarily suspended shall be entitled to request that the Executive Committee hold a hearing on the matter within such reasonable time period not to exceed seven days thereafter as the Executive Committee may be convened in accordance with the Fair Hearing Plan of these Bylaws.
- (c) The Executive Committee may recommend modification, continuancy or termination of terms of the

summary suspension. If, as a result of such hearing, the committee does not recommend immediate termination of the summary suspension, the affected physician or dentist shall, also in accordance with the Fair Hearing Plan, be entitled to request an appellate review by the Governing Body, but the terms of the summary suspension as sustained or as modified by the committee shall remain in effect pending a final decision thereon by the Governing Body.

- (d) Immediately upon the imposition of a summary suspension, the chairman of the Executive Committee or the Medical Director shall have authority to provide alternative medical coverage for the patients of the suspended physician or dentist still in the hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternate practitioner.

SECTION III: Automatic Suspension

(a) **License**

Action by the State of Utah that revokes, suspends or modifies the license or certificate or other legal credentials authorizing the practice of an appointee of the Professional Staff or Licensed Mental Health Professional Staff shall immediately result in the suspension of the practitioner or Allied Mental Health Professional from the staff. As soon as possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the license was revoked or suspended. The Committee may then take such further corrective action as is appropriate in view of the facts disclosed in its investigation.

(b) **Drug Enforcement Administration (DEA) Number**

A practitioner whose DEA number is revoked or suspended shall immediately and automatically be divested of his right to prescribe medications covered by such number. As soon as possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The committee may then take such further corrective action as is appropriate in view of the facts disclosed in its investigation.

(c) **Medical Records**

A suspension of a practitioner's admitting privileges may, after warning of delinquency, be imposed for failure to complete medical records in a timely fashion, as established by hospital policy. Such suspension may continue until such records are completed unless the practitioner satisfies the Executive Director and the Medical Director that he has a justifiable excuse for such omissions.

(d) **Enforcement**

It shall be the duty of the Medical Director to cooperate with the Executive Director in enforcing all automatic suspensions. The Medical Director shall notify the practitioner and/or Allied Mental Health Professional regarding automatic suspension of privileges.

ARTICLE X : OFFICERS

SECTION I: Officers of the Professional Staff

- (a) President
- (b) President Elect

SECTION II: Qualifications of Officers

- (a) Officers must be members of the Active Professional Staff at the time of nomination and election and must remain so, in good standing, during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- (b) Officers must have a record of clinical competence, committee service and continuing education.
- (c) Officers cannot have a corrective action pending or in force.
- (d) The President of the Professional Staff shall be a medical doctor.

SECTION III: Election of Officers

- (a) Officers are elected as needed at a meeting of the Professional Staff. Only appointees to the Active Professional Staff shall be eligible to vote. The candidate receiving a majority of votes from those eligible to vote shall be elected. In the event that there are more than two candidates and no single candidate receives a majority, the candidate receiving the least number of votes will be eliminated and a second vote taken. If no single candidate receives a majority in the second vote taken, the above procedure will be used for all successive ballots until a candidate receives a majority.
- (b) The Executive Committee shall act as the nominating committee. This committee shall offer one or more nominees for the elected offices. Nominations may also be made from the floor.

SECTION IV: Term of Office

The Officer's term of office shall be a minimum of two years. Officers shall take office on the first day of the Professional Staff Year.

SECTION V: Vacancies in Office

The Executive Committee shall make appointments to fill vacancies in office during the Professional Staff Year.

SECTION VI: Duties of Officers

- (a) President: The President shall serve as the Chief Administrative Officer of the Professional Staff to (1) Represent the views, policies, needs and grievances of the Professional Staff to the Governing Body and Executive Director; (2) Act in coordination and cooperation with the Medical Director and hospital Executive Director in all matters of mutual concern within the hospital; (3) Call, preside at, and be responsible for the agenda of all general meetings of the Professional Staff; (4) Serve as chairman of the Professional Staff and its Executive Committee; (5) Be responsible for the enforcement of the Professional Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner; (6) Appoint committee members to all standing and special staff committees except the Executive Committee; (7) Receive and interpret the policies of the Governing Body on the performance and maintenance of quality with respect to the Professional Staff's delegated responsibility to provide medical care; and
- (b) President Elect: In the absence of the President, he shall assume all the duties of and have the authority of the President.

SECTION VII: Removal of Officers

Except as otherwise provided, recall of an officer may be initiated by the Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the Professional Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Professional Staff members eligible to vote for Professional Staff officers who actually cast votes at the special meeting in person or by mail ballot. Permissible conditions for removal of a staff officer include, without limitations:

- (1) failure to perform the duties of the position in a timely and appropriate manner;
- (2) failure to continuously satisfy the qualifications for the position;
- (3) having a conflict of interest with the Hospital;
- (4) conduct or statements inimical or damaging to the best interests of the Professional Staff or the Hospital or to their goals, programs or public image; and
- (5) physical or mental infirmity that renders the officer incapable of fulfilling official duties.

ARTICLE XI: PROFESSIONAL STAFF COMMITTEES

SECTION I: Professional Staff Committees

(a) Committee Structure

The Professional Staff Committees are as follows

- Executive
- Quality / Patient Safety Council
- Credentials
- Medical Records Standards
- Utilization Review
- Pharmacy and Therapeutics
- Environment of Care Safety
- Clinical Practice Standards
- Ethics
- Infection Control

(b) Membership

- (1) The President of the Professional Staff, in consultation with the Executive Director, shall appoint membership to all Professional Staff committees except as expressly required by these Bylaws.
- (2) Appointments to committees shall take place at a Professional Staff meeting and shall consist of one year, renewable terms.
- (3) Chairpersons of committees shall be appointed by the Medical Director in consultation with the Executive Director unless stipulated otherwise in the Bylaws.

(c) Minutes and Meeting Frequency

Minutes shall be the official records of committee proceedings. Meeting frequency shall be not less than quarterly, and will be determined by the Executive Committee

SECTION II: Executive Committee

(a) Membership

The Executive Committee shall consist of the President of the Professional Staff, President Elect, the Medical Director, Quality/ Information Coordinator, the Executive Director (ex officio without vote), one nursing / clinical care coordinator, one physician Unit Director, and one additional Professional Staff member appointed by the President of the Professional Staff. A majority of the Executive Committee shall at all times be composed of medical doctors.

(b) **Duties and Responsibilities**

- (1) Represent and act on behalf of the Professional Staff, subject to such limitations as may be imposed by these Bylaws.
- (2) Receive and act upon reports and recommendations from clinical programs/departments/services/and the following Professional Staff committees: Credentials Committee, and Quality / Patient Safety Council.
- (3) Provide liaison between Professional Staff and the Executive Director and the Governing Body, fulfilling the Professional Staff's accountability to the Governing Body for medical care rendered to patients.
- (4) Implement Professional Staff Bylaws, Rules and Regulations by establishing a monitoring system to assess the quality and appropriateness of Professional Staff activities, to evaluate the system annually, and to revise as needed.
- (5) May make recommendations on hospital management matters regarding long range planning to the Governing Body.
- (6) Recommend action to the Governing Body on matters of a medical-administrative nature.
- (7) Review recommendations from the Credentials Committee for reappointments and renewal or changes in clinical privileges. Report actions (approve / disprove) to the Governing Body.
- (8) Take all reasonable steps to promote ethical conduct and competent clinical performance on the part of all appointees of the Professional Staff, including the initiation of and/or participation in Professional Staff corrective or review measures when warranted.
- (9) Inform the Professional Staff of accreditation requirements and status and that areas of non-compliance are identified and recommendations for appropriate action made to the Executive Director and the Governing Body.
- (10) Report at each Professional Staff meeting.
- (11) Perform other related duties as requested by the Governing Body.

SECTION III: Quality / Patient Safety Council

(a) **Membership**

The Quality / Patient Safety Council shall consist of at least one (1) physician member plus a member of hospital administration, adult services care coordinator, youth services coordinator, the Quality/Information Coordinator, and other members of the clinical Staff as appointed. A physician member shall serve as Council Chairperson.

(c) **Duties and Responsibilities**

- 1) Review key quality characteristics in medical, nursing, diagnostic and therapeutic services provided to patients in the hospital.
- 2) Monitor the progress of Cross-Functional Teams quarterly.
- 3) Evaluate the appropriateness of care rendered to patients and shall promote and maintain professionally accepted levels of care through review and evaluation of clinical practice.
- 4) Receive and act upon reports and recommendations from the following Professional Staff Committees: Medical Records Standards, Utilization Review, Environment of Care Safety, Pharmacy and Therapeutics, and Ethics.
- 5) Develop, implement, and oversee the patient safety program.
- 6) Measure and assess performance and safety improvement activities.
- 7) Oversee the Infection Control Program.
- 8) Other monitoring activities as outlined in the Quality/Patient Safety Management Plan.

SECTION IV: Credentials Committee

(a) **Membership**

The Credentials Committee shall consist of at least two representatives of the Professional Staff (including at least one physician and at least one psychologist), the Executive Director or her/his designee, an Advanced Practice Nurse, social worker, marriage and family therapist, and all others as invited.

(b) **Duties and Responsibilities**

- (1) Review and evaluate the qualifications, competence, and performance of each applicant for initial appointment, reappointment, or modification of appointment and for clinical privileges and make appropriate recommendations.

- (2) Submit recommendations, in accordance with Articles IV through VII, to the Governing Body with respect to appointment, Staff category, clinical privileges, and special conditions attached thereto.
- (3) Investigate, review and report on matters, including the clinical or ethical conduct of any practitioner referred to it by: (a) the President of the Professional Staff; (b) the Governing Board; or (c) the Medical Director.
- (4) Serve as an advisory body to the Executive Committee.
- (5) Establish a confidentiality policy for the handling of credentials records.

SECTION V: Medical Records Standards Committee

(a) **Membership**

The Medical Records Standards Committee shall consist of at least two physician members, the Lead Worker of Medical Records Department, the Information Systems Coordinator, and members of the nursing and social service Staff.

(b) **Duties and Responsibilities**

- (1) Conduct quarterly reviews of currently maintained medical records to determine whether they accurately reflect the patient's condition and response to treatment and are sufficiently complete to meet the criterion of medical comprehensiveness in the event of transfer of physician responsibility for patient care.
- (2) Review and approve content and format of all forms prior to placement in the medical record.
- (3) Monitor the timeliness and clinical pertinence of medical record documentation.

SECTION VI: Utilization Review Committee

(a) **Membership**

The Utilization Review Committee shall consist of one physician and one social worker from each of the adult and youth inpatient services, a psychologist, the managers of Teenscope, Kidstar, and Recovery Works, one utilization review nurse, the Hospital Administrator and the Hospital Associate Administrator (chairperson of the committee), the manager of the Business Office, the Billing Supervisor, the manager of the Clinical Assessment Center, and the supervisor of the Patient Access staff (secretary for the committee).

(b) **Duties and Responsibilities**

- (1) Evaluate patterns and trends indicating over- or under-utilization.

- (2) Evaluate denied days and readmission rates and the contributing factors to each.
- (3) Make recommendations to the Quality / Patient Safety Council regarding Performance Improvement Teams needed to improve systems and processes associated with inefficient or inappropriate delivery of care and services.

SECTION VII: Pharmacy and Therapeutics Committee

(a) **Membership**

The Pharmacy and Therapeutics Committee shall consist of at least one physician, the hospital pharmacist, and at least one representative from the nursing Staff.

(b) **Duties and Responsibilities**

- (1) Develop and monitor all drug utilization policies and practices to determine whether professionally recognized clinical standards are being met.
- (2) Assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, dispensing, distribution, administration, and all other matters relating to medication use.
- (3) Serve as an advisory group to the hospital's Professional Staff, Nursing, Pharmacy, and other health care providers on matters pertaining to the use of medications. Provide all needed education to medical, nursing, and pharmacy personnel and other health care providers.
- (4) Approve all medications to be stocked on patient care areas.
- (5) Develop and approve a formulary or drug list for use in the hospital.
- (6) Develop and review at least biannually a medications list for floor stock, emergency, and crash cart medications.
- (7) Evaluate clinical data and approve use of new medications requested for use in the hospital.
- (8) Identify, monitor, and make recommendations for use of high risk medications at UNI.
- (9) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
- (10) Establish therapeutic substitution policy for UNI.
- (11) Participate in the hospital's overall quality management program by conducting studies to assess drug utilization and effectiveness. Review all drug utilization Policy and Procedures to assure optimal clinical results.

- (12) Monitor and report all adverse drug reactions. Make recommendations to prevent future adverse drug reactions.
- (13) Monitor, report, and make recommendations about preventing medication errors.
- (14) Review all medication management safety precautions.
- (15) Monitor and report unusual off-label medication use.

SECTION VIII: Environment of Care Safety Committee

(a) **Membership**

Safety Officer, a nursing representative from Adult and Youth Services, and a representative from Dietary, Housekeeping, Maintenance, Rehabilitation Services & Administration.

(b) **Duties and Responsibilities**

- (1) Establish, monitor and review the facility's environmental safety policies, procedures, and plans.
- (2) Evaluate the results of routine Hazardous Surveillance activities to assess adherence to good safety practices and develop corrective actions as needed.
- (3) Plan, direct and evaluate all fire and disaster drills as outlined in the hospital's fire and disaster plans.
- (4) Review and assess all environment of care-related incident reports and make recommendations to the Quality Council to reduce the potential for future incidents.
- (5) Review safety plan monitory data and approve corrective action as needed.

SECTION IX: Clinical Practice Standards Committee (AD HOC)

(a) **Membership**

The Clinical Practice Standards Committee shall consist of the Medical Director, Executive Director and the Unit Clinical Director from each hospital program.

(b) **Duties and Responsibilities**

The Executive Committee may convene this subcommittee when needed to:

- (1) Review and make recommendations regarding unproven or questionable clinical practices.
- (2) Assist in the formulation of policies which foster excellent clinical practice standards.

- (3) Review and make recommendations regarding extraordinary cases or those of unusual complexity.
- (4) Call consultants from allied mental health fields to report and provide testimony on practices or practitioners from other disciplines.

SECTION X: Ethics Committee

(a) **Membership**

The Ethics Committee shall consist of at least one representative from nursing, social work, psychology, rehabilitation therapies and physicians. A representative from the Social Sciences or Humanities faculty at the University of Utah also will be included as a core member of the Ethics Committee.

(b) **Duties and Responsibilities**

- (1) Function in an advisory capacity, and serve as a resource, with regard to ethical issues facing patients, their families, staff and clinicians.
- (2) Enhance the milieu and the delivery of care by promoting education regarding ethical issues.
- (3) Provide review of policies, guidelines and practices that impact patient and staff rights and responsibilities. Referrals for review by the Ethics Committee may come from concerned staff, clinicians, patients and/or their families.
- (4) Hold regular meetings and be available for “crisis consults” if and when such requests for immediate consults may be made.
- (5) Keep minutes for all meetings, and prepare a record of each case the Ethics Committee reviews. Records of a case will contain a summary of the facts pertinent to the case, areas of expertise brought to bear, a summary of alternatives considered in forming recommendations, and final recommendations.
- (6) Maintain the confidentiality of patients, their families, staff, and clinicians when processing ethical concerns.
- (7) Commit to the virtues of civility, empathy, mutual respect and rational discourse in the reception and processing of all matters addressed by the Ethics Committee.

SECTION XI: Infection Control Committee

(a) **Membership**

The Infection Control Committee shall consist of at least the UNI Infection Control Coordinator, the UUH&C Infection Control liaison, and a representative from housekeeping, dietary, maintenance.

(b) **Duties and Responsibilities**

- (1) Serve as an advisory group to the Professional Staff on matters pertaining to Infection Control.
- (2) Assess antibiotic utilization and coordinate with the Medical Staff on action relative to the findings.
- (3) Review all infection control reports to determine proper management and epidemic potential.
- (5) Monitor hospital infection control practices.
- (6) Educate staff on infection control issues.
- (7) Make recommendations to the Quality Council and Medical Staff regarding policies and procedures relating to Infection Control.

ARTICLE XII: PROFESSIONAL STAFF MEETINGS

SECTION I: Regular Meetings

Professional Staff meetings shall be held quarterly. The Executive Committee shall, by standing resolution, designate the time and place for all regular Staff meetings. At each meeting of the Professional Staff a report will be given on the ongoing monitoring and evaluation of the quality and appropriateness of care provided to patients. A record that includes the resultant conclusions, recommendations, and actions taken shall be maintained.

SECTION II: Special Meetings

Special meetings of the Professional Staff may be called at any time by the Governing Body, the President of the Professional Staff, the Executive Committee or not less than one quarter of the appointees to the Professional Staff.

SECTION III: Notice of Special Meetings

Written or printed notice stating the place, day and hours of any special meeting of the Professional Staff shall be delivered, either personally or by mail, to each appointee of the Active Professional Staff not less than seven days nor more than fourteen days before the date of such 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 appointee at his address as it appears on the records of the hospital. The attendance of the appointees of the Professional 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 IV: Attendance Requirements

- (a) Each appointee of the Active Professional Staff should strive to attend at least fifty percent of all regularly scheduled Professional Staff meetings in each year.
- (b) Quorum: Presence of fifty percent of the total number of appointees of the Active Professional Staff at any regular or special meeting shall constitute a quorum for the purposes of amendment of these Bylaws, Rules and Regulations, and the presence of twenty-five percent of such appointees is a quorum for all other actions.

SECTION V: Minutes

Minutes of each regular and special meeting of the Professional Staff shall be maintained and shall include a record of the attendance of members and the vote taken on each matter. A permanent file shall be kept of the minutes of each such meeting.

ARTICLE XIII: COMMITTEE MEETINGS

SECTION I: Regular Meetings.

Committees may, by resolution, provide the time for holding regular meeting without notice other than such resolution.

SECTION II: Special Meetings

A special meeting of any committee may be called by or at the request of the chairman thereof, by the President of the Professional Staff, or by one-third of the group's then members, but not less than two.

SECTION III: Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than seven days before the time of such meeting by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a committee member at a meeting shall constitute a waiver of notice of such meeting.

SECTION IV: Quorum

Fifty percent of a committee shall constitute a quorum at any meeting.

SECTION V: Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or service. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereon.

SECTION VI: Rights of Ex Officio Members

Persons serving under these Bylaws as ex officio members of committees, unless otherwise indicated, shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum.

SECTION VII: Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the Executive Committee. Each committee and service shall maintain a permanent file of the minutes of each meeting.

SECTION VIII: Attendance Requirements

Each committee member shall strive to attend not fewer than sixty-six percent of all meetings of his committees in each year. The reasons provided for any absences and the action of the committee chairman thereon shall be shown in the minutes.

ARTICLE XIV: IMMUNITY FROM LIABILITY

- (a) The following shall be express conditions to any individual's application for, or exercise of, clinical privileges at this hospital:
- (1) First, that any act, communication, report, recommendation, or disclosure, with respect to any such individual, 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 patient care of professionally recognized quality in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
 - (2) Second, that such privileges shall extend to appointees of the hospital's Professional Staff and of its Governing Body, its other appointees, its Executive Director and his 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 XIV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Professional Staff.
 - (3) 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.
 - (4) 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 institution's activities related, but not limited to: (a) applications for appointment or clinical privileges, (b) periodic reappraisals for reappointment or clinical privileges (c) corrective action including summary suspension, (d) hearings and appellate reviews, (e) medical care evaluations, (f) utilization reviews, and (g) other hospital, service or committee activities related to the assessment of patient care and intra-professional conduct.
 - (5) Fifth, that the acts, communications, reports, recommendations, and disclosures referred to in this Article XIV may relate to an individual'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.
 - (6) Sixth, that in furtherance of the foregoing, each individual shall, upon request of the hospital, execute releases in accordance with the tenor and import of this Article XIV 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.
 - (7) Seventh, that the individual releases from any liability all representatives of the hospital and its Professional Staff for their acts performed in good faith and without malice in connection

with evaluating the individual and his credentials and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the individual's competence, ethics, character and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information.

ARTICLE XV: RULES AND REGULATIONS

The Professional Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Professional Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting after proper notice, by a two-thirds vote of those present of the Active Professional Staff. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVI: AMENDMENTS

These Bylaws, Rules and Regulations may be amended after submission of the proposed amendment at any regular or special meeting of the Professional Staff. A proposed amendment shall be referred to the Executive Committee which shall report on it at the next regular meeting of the Professional Staff or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of the Active Professional Staff present at a regular or special meeting of the Professional Staff provided that at least ten days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action. Amendments so made shall be effective when approved by the Governing Body. These Bylaws, Rules and Regulations shall be amended as necessary to reflect the facility's current practices regarding Professional Staff organization and functions. Neither the Professional Staff nor the Governing Board may amend these Bylaws unilaterally.

ARTICLE XVII: REVIEW

These Bylaws shall be reviewed periodically by the Executive Committee or by an ad hoc committee appointed by the President of the Professional Staff.

ARTICLE XVIII ADOPTION

These Bylaws together with the appended Fair Hearing Plan and Rules and Regulations, shall be adopted at any regular or special meeting of the Active Professional Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Body of the hospital.