



**Mount  
Sinai  
Hospital**

# **The Bylaws of The Hospital Staff**

## **RECORD OF REVISION APPROVALS**

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## ARTICLE I

### CODE OF CONDUCT OF THE MEDICAL STAFF

To encourage a culture of safety and quality, the Medical Staff of The Mount Sinai Hospital has adopted this Code of Conduct. The purpose of this Code of Conduct is to set the expectation that all members of the medical staff and employees will demonstrate the following qualities:

1. **Integrity** in our dealings with and on behalf of the Medical Center;
2. **Respectful behavior** whereby all are treated with civility, confidentiality is respected, learners are understood to have lower levels of competency and criticism of performance and/or competency is delivered constructively in appropriately private locations, and aimed at performance improvement
3. **Trustworthy conduct**, including dependability, availability, loyalty and honesty in communications and actions;
4. **Accountability** in assuming personal responsibility for one's actions and decisions and maintaining clinical competence;
5. **Fair and just actions** in utilizing equitable processes in decision-making;
6. **Managing responsibly**, including prudent use of Medical Center resources in a fiscally responsible manner;
7. **Compassion** in caring for others, both within and apart from the Medical Center community, and providing the highest quality service to patients and humanity;
8. **Good citizenship** including a commitment to quality improvement and protection of those who report unsafe conditions or unacceptable behavior; and
9. **Achieving excellence** in our work.

## ARTICLE II

### MEDICAL STAFF

#### CATEGORIES OF STAFF AND CRITERIA FOR APPOINTMENT

##### **A. GENERAL**

The membership of the Hospital Staff shall consist of all medical and osteopathic physicians, dentists, podiatrists, and other independent health care professionals who are appointed to the Hospital Staff pursuant to these Bylaws. Acceptance of membership on the Hospital Staff shall constitute that Staff Member's agreement to strictly abide by these Bylaws, the Rules and Regulations of the Hospital, relevant Principles of Medical Ethics and Behavior and other applicable Hospital policies and procedures as may from time to time be in effect.

Membership on the Medical Staff grants to the Staff Member only those rights and privileges expressly set forth in these Bylaws and in the Rules and Regulations of the Hospital Staff. Members of the Medical Staff shall have representation and participate in any Hospital deliberation affecting the discharge of Medical Staff responsibilities. Neither these Bylaws nor the Rules and Regulations of the Medical Staff relate, pertain to or govern the employment status of Staff Members, whether salaried Hospital employees or School of Medicine faculty or otherwise holding Hospital or School administrative appointments, including but not limited to, appointments such as Department Chairs.

##### **B. CATEGORIES OF STAFF**

There shall be five categories of Hospital Staff:

1. Medical Staff
2. Visiting Medical Staff
  - a. Alliance physicians
  - b. Non-Alliance physicians such as community physicians
3. Teach Only Staff
4. Professional Staff
5. Honorary Staff

##### **C. MEDICAL STAFF**

1. **Appointments to the Medical Staff** shall be made at the following titles:
  - a. Attending
  - b. Staff Fellow
2. **General Requirements** -- Each applicant for membership on the Medical Staff must:
  - a. Be a graduate of an LCME or AOA accredited medical school, a medical school recognized by the World Health Directory, and approved college of osteopathy, ADA accredited dental school, or CPME accredited podiatric school of medicine.  
(amendment:10/16/08 Med Bd; approved 10/27/08 Bds of Trustees)
  - b. Have completed a residency in an approved ACGME, AOA, Osteopathic, Podiatric, Dental training program or a program acceptable to the Chair of the Department.
  - c. Be licensed to practice medicine, dentistry or podiatry in accordance with the requirements of the State of New York.

- d. Be certified by ECFMG if a foreign graduate
- e. Be Board Certified; if not Board Certified obtain certification within 5 years of appointment and maintain certification in the appropriate Board for the duration of Medical Staff affiliation. Exceptions may be made on a case-by-case basis depending on the experience of the applicant and recommendation by the Department Chair

**3. Additional Criteria** -- Decisions as to appointment and reappointment to the Medical Staff shall be based upon the following:

- a. Demonstrated professional competence, expertise, skill, current practice, and clinical qualifications in the treatment of patients;
- b. Education and training;
- c. Character, ethics, conduct, and professionalism, and, for current members of the staff, also good citizenship on the Hospital Staff and the faculty of the School of Medicine;
- d. Adherence, or in the case of new applicants, willingness to adhere to these Bylaws, the Rules and Regulations of the Medical Staff and the Hospital, regulations of the Hospital's Office of Compliance, and City, State and Federal laws;
- e. Contributions to patient care in accordance with policies established by the Medical Board with respect thereto, including a commitment to provide for continuous care to his/her patients;
- f. If DHL is Mount Sinai-Manhattan: (a) qualifications to teach and instruct medical students and House Staff; (b) contributions to teaching and research; and (c) membership on the Faculty of the School of Medicine unless such requirement is waived by the Medical Board, the Board of Trustees, and the Dean, or (d) if the application is for appointment to the Medical Staff by a Staff Member who does not meet the qualifications set forth in this paragraph, s/he, may be credentialed in accordance with the procedures in Article III, Section D. 2 (a);
- g. If DHL is Mount Sinai-Queens: a title in the School of Medicine of Associate Physician, Dentist, or Podiatrist;
- h. With respect to new applicants for privileges at any DHL, the DHL's further need for Staff Members with these qualifications and/or the availability of more qualified candidates for appointment;
- i. Agreement to cooperate with all quality assurance investigations, including but not limited to those of the Physician Wellness Committee;
- j. Compliance, or in the case of new applicant, agreement to comply with Conditions of Appointment, if any;
- k. Designation by applicant of Mount Sinai-Manhattan, Mount Sinai-Queens or both as the DHL, as appropriate;
- l. Documentation of the applicant's health status and successful completion of a medical examination and toxicology screen as may be required by applicable law and/or Medical Center regulations;
- m. Maintenance of medical malpractice insurance of such form and amount as required by the Board of Trustees;
- n. Evaluation and verification of the information provided by the applicant, including but not limited to: information relating to challenges to licensure or registration or the voluntary relinquishment of licensure or registration; termination of medical staff membership, or limitation or loss of clinical privileges at another hospital, whether

- voluntary or involuntary; any and all final judgments or settlements or currently pending professional liability or criminal actions; and other information relevant to the applicant's qualifications submitted in connection with the application for privileges;
- o. A review of qualifications and competencies that shall include at least: current work practice; special training; quality of specific work; patient outcomes; utilization review; education; maintenance of continuing education; good citizenship; adherence to Medical Staff rules and compliance with licensure requirements; relevant practitioner-specific data as compared to aggregate data (when available); morbidity and mortality data (when available); "Focused Professional Practice Review"; and evidence of sufficient patient care encounters to enable review; and
  - p. Continuing medical education (CME) of at least 50 hours annually. At least 25 hours per year must occur at Mount Sinai Medical Center, and may include departmental conferences or committee work that is so designated by the department director, even if not ACCME-certified. The above does not exempt the medical staff member from obtaining sufficient ACCME-certified CME credits for maintenance of specialty certification(s). (amendment 5/8/2010 Med Bd; approved 5/25/2010 Board of Trustees)
  - q. Relevant information that may be obtained from low volume providers, including but not limited to, details of 25 patient encounters as defined by their respective specialties or departments; and
  - r. Any other relevant information.
- 4. All members of the Medical Staff** shall have appointments, as more specifically set forth below:
- a. Privileges at Hospital Locations: A member of the Medical Staff shall be entitled to that level of privileges at his/her DHL as specifically set forth in his/her delineation of privileges form. All members of the Medical Staff may visit their patients and write comments in their medical records at either hospital location.
  - b. Staff Fellow – Additional Criteria: In addition to the requirements and criteria set forth in section C(2) and (3) above, a Staff Fellow must be an employee of the Hospital. When that employment terminates for any reason, the appointment to the Medical Staff shall automatically terminate and shall not be subject to the procedures provided in Article VIII, Section A of these Bylaws.
- 5. Visiting Medical Staff** are divided into two categories. Neither category requires a title or appointment in the Mount Sinai School of Medicine to be appointed to the Visiting Medical Staff
- a. The Alliance Staff are employed by healthcare entities that are affiliated with The Mount Sinai Hospital. They are allowed to see their patients, but have no admitting or other privileges.
  - b. Non-Alliance Staff are physicians who are appointed from the community-at-large and are allowed to see their patients but have no admitting or other privileges. They may also be called "community physicians" who refer and follow the care of their patients provided by the Medical Staff.
  - c. Members of the Visiting Medical Staff will be referred to as Visiting Attendings.
  - d. Requirements:
    - (i) Each applicant for membership on the Visiting Medical Staff must be a graduate of a LCME, AOA accredited medical school, a medical school recognized by the World

Health Directory, School of Osteopathy, ADA accredited dental school, or CPME accredited podiatric school of medicine, and must be licensed to practice medicine, dentistry or podiatry in the State of New York.

- (ii) Additional Criteria: Decisions as to appointments and reappointment to the Visiting Medical Staff shall be based on the following additional criteria:
- membership on the medical staff of a facility, or membership in a practice that is affiliated/allied with the Mount Sinai Health System and participation in and contribution to the Mount Sinai Health System.
  - the recommendation of a community practitioner, the department chair, chief executive officer or equivalent of the Mount Sinai – Manhattan.
  - the criteria set forth in subparagraphs C (2) above.
- (iii) Termination: upon termination of any member of the Visiting Medical Staff from the member of the Mount Sinai Health System with whom s/he is affiliated, his/her membership on the Visiting Medical Staff shall automatically terminate. Such termination shall not be subject to the notice and hearing provisions of these Bylaws. In addition, upon the termination of any alliance or affiliation arrangement between Mount Sinai and an alliance hospital or practice, membership on the Visiting Medical Staff of those physicians whose membership on the Visiting Medical Staff is by virtue of their relationship with the terminated hospital or practice shall automatically terminate. Non-alliance staff appointments shall be terminated if the practitioner has retired, resigned, or otherwise indicated s/he no longer wishes to participate on the Medical Staff, or based on a peer review action, which shall be non-appealable.
- (iv) Rights and Restrictions: Members of the Visiting Medical Staff may visit their patients, review their patients' medical information, and advise the patient's attending physician, but may not have admitting privileges, write orders or notes, instruct house staff, or render direct patient care.

## 6. Teach Only Staff:

- a. Teach-Only Staff are physicians who are on the Hospital Attending Medical Staff and have faculty appointments in the Medical School. As the name implies they may only teach.
- b. Members of the Teach Only Staff will be referred to as Teach Only Attendings.
- c. Requirements: Each applicant to the Teach Only Staff must meet the requirements of Article II, Section C.2 and such Additional Criteria as set out in Article II, Section C.3 as appropriate.
- d. Additional Criteria: Each candidate for the Teach Only Staff must have demonstrated competence in the field in which the individual will be teaching.
- e. Rights and Restrictions: Members of the Teach Only Staff can examine patients only within the scope of their teaching duties. They may not admit, (or) otherwise treat patients, (or) write orders or bill, and they must have a current New York State license.

## 7. Honorary Staff Titles: Members of the Honorary Staff are referred to as Emeritus Attending.

- a. Requirements: Appointees to this category are Medical Staff Members who have both served at least twenty (20) years and otherwise distinguished themselves as outstanding practitioners, educators, researchers or administrators.



- b. Additional Criteria:
  - (i) Members of this category have no required duties
  - (ii) Are eligible to sit in an ex-officio capacity on Medical Staff Committees; and
  - (iii) Are not required to carry professional malpractice insurance coverage.
- c. Rights and Restrictions: Members of this category will not have clinical privileges to treat, to admit patients, or to assist in surgery, and may not write in patient records or serve on the Medical Board. They may, however, also be Teach Only Staff.

#### D. PROFESSIONAL STAFF TITLES:

1. **Appointment.** Members of the Professional Staff shall receive an appointment in the Hospital consistent with their faculty title (e.g., “Attending Psychologist”). Members of the Professional Staff who do not have faculty appointments shall be identified by their profession (e.g., “Nurse Practitioner”).
2. **Professional Staff Requirements:**
  - a. Each applicant to the Professional Staff must be engaged in a health care profession other than medicine, dentistry, or podiatry. If the applicant’s practice is a profession for which a license is required by the State of New York, each applicant must be licensed to practice that profession. Applicants to the Professional Staff may be on the Faculty of the School of Medicine. Members of the Professional Staff fall into two categories: a) those that have both Hospital and Medical School appointments and are designated by their rank (e.g., Attending Psychologist or Attending Physicist) and b) those that have no school appointment and are identified by their profession e.g., Nurse Practitioner or Nurse Midwife.
  - b. Additional Criteria: Decisions as to appointment and reappointment to the Professional Staff shall be based on all of the same criteria as set forth in Section C.3.
  - c. Rights and Restrictions: Members of the Professional Staff shall not admit patients, except for midwives, who may admit patients if granted specific privileges to do so. When involved in the delivery of direct patient care, Professional Staff will practice within the clinical parameters established by the Medical Board. If appropriate, a member of the Medical Staff in the same department will supervise the Professional Staff member and will have ultimate responsibility for the Professional Staff member’s delivery of patient care.
  - d. Supervision:
    - (i) **Professional Staff in General**  
Except as more specifically set forth below, members of the Hospital-based Professional Staff shall at all times be under the direct supervision of a physician on the medical staff of the Department in which the member of the Professional Staff is appointed or privileged. Members of the Physician-employed Professional Staff who are not employed by the School in the Faculty Practice Associates shall at all times be under the direct supervision of the employing Medical Staff Member. Physician-employed Professional Staff who are employed by the School in the Faculty Practice Associates shall at all times be under the direct supervision of his/her supervising physician in the Faculty Practice Associates.
    - (ii) **Physician Assistants**  
A physician assistant may provide medical services to Hospital inpatients when under the supervision of a physician; however, such supervision shall not necessarily

require the physical presence of the supervising physician at the time and place where the services are performed. The attending physician of record for any given patient will be the supervising physician for the physician assistant caring for that patient. No physician may supervise more than six registered physician assistants employed by the Hospital. The supervising physician shall remain medically responsible for the medical services provided by the registered physician assistant whom the physician supervises.

## ARTICLE III

### APPLICATION FOR APPOINTMENT AND REAPPOINTMENT

#### A. RECRUITMENT AND APPLICATION

When physician recruitment is initiated by the Department Chair or a member of School or Hospital administration, the Chair, Dean, and Hospital President must be informed as soon as the applicant is identified and updated throughout the recruitment process, including appointment and non-appointment. Similarly, the Chair, Dean and Hospital President must inform one another whenever an application for appointment to the Medical Staff has been received.

#### B. PROCEDURE FOR APPOINTMENT TO HOSPITAL STAFF

The applicant shall have the burden of producing adequate information for a proper evaluation of competency, character, ethics, professionalism, mental and physical health, and other qualifications and for resolving any doubts about such qualifications. By applying for appointment, each candidate signifies willingness to appear for interviews and authorizes the Department Chair and his/her designee and the Credentials Committee in writing to consult with persons who have information relevant to the applicant's qualifications.

All applicants for appointments and reappointment to the Hospital Staff shall submit in writing and sign a completely accurate and timely application containing the following and will provide:

1. **A curriculum vitae** to include appropriate professional biographical data
2. **Application for privileges** including any application fee or late fee as may be established by the Medical Board. Such application shall include an election of the applicant's DHL
3. **Evidence of current New York State licensure**, Infection Control Certificate, and evidence of a current DEA registration
4. **A pledge that the applicant will:**
  - a. Practice his/her profession in accordance with highest ethical standards;
  - b. read and uphold these Bylaws and Rules and Regulations of the Hospital and such rules, regulations and policies of the staff that may be in effect from time to time;
  - c. Maintain malpractice insurance coverage that meets the requirements established from time to time by the Board of Trustees including, but not limited to, requirements relating to insurer solvency and the amount and extent of coverage. *(rev. 11/13/08 MB; appvd Bd of Trustees 11/24/08)*
  - d. Execute a release, in a form provided by the Hospital, of the Hospital, its Board of Trustees, officers, agents and employees, and all other individuals and entities, from civil liability relating to the review and verification of information relating to credentialing, staff membership and privileges; and
  - e. Provide for continuous care of patients
5. **Proof of Board Certification** or eligibility status where applicable
6. **Personal malpractice history** including pending, final judgments or settlements
7. **Information regarding any previously successful or currently pending discipline** including, but not limited to, challenges to any licensure or registration or the voluntary or involuntary relinquishment of licensure or registration in any state

- 8. Information regarding voluntary or involuntary termination** of medical staff membership or any voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital;
- 9. Documentation of the applicant's health status** and successful completion of a medical examination and toxicology screen as may be required by applicable law and/or Hospital regulations
- 10. Criminal convictions**, pending hearings and settlements
- 11. All other information** that the Medical Board may require or that may be required by the New York Public Health Law, including §2805-k
- 12. An agreement to inform the Hospital immediately** of any proceedings pending and/or disciplinary actions taken by New York State, another state, or any health facility with which the Staff Member is/was affiliated or any other information required by Article II.C.3
- 13. An agreement to cooperate fully with any quality assurance**, Physician Wellness Committee, risk management or peer review investigation undertaken by the Hospital
- 14. At least two peer recommendations**
- 15. All appointments to the Medical Staff** will be reviewed by the Credentials Committee and approved by the President of the Hospital and the Board of Trustees.

#### **C. PROCESSING**

Processing of Appointments and Reappointments to the Medical Staff will be pursuant to the Appointment and Reappointment Manual, and Medical Staff Credentialing Policies and Procedures, incorporated by reference as appendices in these Bylaws.

#### **D. TERM OF INITIAL APPOINTMENT**

Each Staff Member shall be given an appointment of up to two years as necessary to synchronize the Staff Member's appointment cycle with his/her Department as more fully set forth below. All initial applicants will go through a professional practice review period during the first six (6) months and if deemed necessary, extendable to twelve (12) months of their appointment. When appropriate, a limited appointment may be granted for up to one year and in this circumstance the individual's activities will be evaluated by his/her Department, which shall determine whether the staff member should be eligible for full appointment status.

#### **E. APPLICATIONS BY MEMBERS OF THE FULL-TIME STAFF TO THE VOLUNTARY STAFF**

- 1. Application:** Except as provided in Paragraph B below, any Staff Member who is a member of the full-time staff and has applied for appointment to the voluntary staff must follow the Procedures for Appointment for a new applicant set forth in this Article. Such application shall be processed consistent with Section 5, except that the Department Chairs must respond in writing within 30 days of receipt of such application advising the applicant whether the Department Chair intends to recommend the Staff Member's appointment to the voluntary staff. If the Department Chair decides not to recommend the Staff Member's application for appointment or decides to recommend it, but with Conditions of Appointment or limitations on privileges which the staff member finds unacceptable, the Staff Member may request a hearing under Article VIII, Section F.1 and 2, in which case, s/he must resign from the full-time staff effective no later than one year from the date a hearing is requested. In the alternative, the

Staff Member may elect to appeal the Department Chair's decision pursuant to the expedited appeals procedure set forth in Article VIII, Section F. The Staff Member's election of either appeals procedure set forth in Article VIII precludes an appeal pursuant to the other procedure.

## **2. Exceptions**

- a.** Members of the full-time staff who joined the staff prior to May 6, 1981 are exempt from the provisions of this Section and are subject to the requirements contained in the May 17, 1982 "Report of the Ad Hoc Committee on Clinical Practice." References in Article VI.B.2 of that Report to the Joint Conference Committee shall be deemed to refer to the ad hoc committee described in Article VI, Section B.6 of these Bylaws.
- b.** Department Chairs, in consultation with the Hospital Administration, may permit a new member of the full-time Faculty to convert to voluntary status during the first three years of that Faculty member's appointment. To be effective, there must be a written agreement which sets forth the nature of the right to convert and any restrictions on that right. The agreement must be signed by the applicant and the applicant's Chair and may require that the Faculty member give up to one year's written notice of his/her intentions to convert. A copy of the agreement must be provided along with the applicant's initial application for appointment to the full-time staff.

## **3. Procedure for Reappointment to Hospital Staff**

Except as otherwise provided, the term of each reappointment shall be for a maximum of two years (24 months) expiring on December 31.

## **4. Criteria for Reappointment Decisions**

Reappointment of a Staff Member shall be based upon the same criteria as the initial appointment, evaluation of the Staff Member's continuing education, and a re-evaluation of the Staff Member's physical and mental capabilities. The criteria for reappointment are those set forth in this Article. Non-reappointment to the faculty or termination by the School of Medicine shall disqualify the Staff Member from reappointment to the Medical or Professional Staff unless such requirement is waived by the Medical Board, the Board of Trustees and the Dean.

## **5. Processing**

Reappointments to the Medical Staff will be pursuant to the Appointment and Reappointment Manual and Medical Staff Credentialing Policies and Procedures, incorporated by reference in these Bylaws.

## ARTICLE IV

### LEAVES OF ABSENCE

**Members of the Hospital Staff may request a Leave of Absence** if they will not be practicing their profession at the Hospital for a period of three (3) or more months. A request is to be made in writing to the Department Chair and must state the reason and expected duration of the leave of absence. The Chair will respond in writing with copy to the Medical Staff Services department. During the period of the leave of absence, a Staff Member does not have admitting privileges and is not required to maintain malpractice insurance.

**A leave of absence from the Faculty** shall automatically result in the Staff Member being placed on a leave of absence from the Medical Staff.

**A leave of absence may not exceed one year** with the exception of medical or military leave. To reestablish clinical privileges upon return from a leave of absence, the Staff Member must notify the Department Chair and request in writing reinstatement of privileges to the Hospital Staff. However, if the term of appointment has expired during the leave of absence, the Staff Member must reapply for reappointment and privileges. The Staff Member will supply documentation as to activity during the leave of absence and supply any documents that have expired during the leave of absence. In the interim, the Department Chair may request that temporary privileges be granted pursuant to Article VI, Section C. 2(a).

**In the event of a medical leave of absence**, privileges cannot be reinstated without medical clearance acceptable to the Department Chair. The Department Chair and the Physician's Wellness Committee may also recommend to the Credentials Committee a specific member of the Medical Staff to serve as an evaluator and or monitor. Other requirements may be established to ensure a high level of professional performance.

## **ARTICLE V**

### **RESIGNATION**

Notwithstanding any other provision of these Bylaws, upon resignation and/or termination of any Member of the Hospital Staff's (i) School Faculty position (ii) Non Faculty School Title (as defined in the Faculty Handbook), or (iii) appointment to the medical staff of an alliance hospital, such Hospital Staff Member's appointment to the Hospital Staff shall automatically terminate and s/he shall not be entitled to any of the rights or procedures contained in these Bylaws. Upon the resignation of any member of the Allied Health Staff from their employment or clinical position, such Member's appointment shall automatically terminate and the Member shall not be entitled to any of the rights or procedures contained in these Bylaws. Upon resignation Medical Staff Services and Human Resources must also be notified; the practitioner's access to the Hospital computer systems will be terminated. Any subsequent application to the Hospital Staff shall be treated as a new appointment.

## ARTICLE VI

### DETERMINATION OF PRIVILEGES

#### A. ADMITTING PRIVILEGES

Only members of the Medical Staff, **including Staff Fellows**, shall be eligible for privileges to admit patients to the Hospital in accordance with the rules of the Hospital as from time to time are in effect. Honorary Staff and Teach Only Staff have no admitting privileges.

#### B. CLINICAL PRIVILEGES

1. **Criteria for Privileges:** Each member of the Hospital Staff shall be granted privileges within one or more clinical department(s) at one or both DHL(s). Each Department shall develop criteria for privileges that shall be consistent with these Bylaws and the policies of the Medical Board and the Board of Trustees. The candidate shall have the burden of establishing his/her qualifications and competency for the requested privileges at the DHL.
2. **Processing:** Evaluation and processing of requests for privileges will be pursuant to the Appointment and Reappointment Manual and Medical Staff Credentialing Policies and Procedures, incorporated by reference in these Bylaws.
3. **Queens DHL:** A Medical Staff Member with privileges at the Queens DHL who is not a member of the faculty of the School of Medicine may seek privileges at the Manhattan campus in accordance with the procedures set forth in Article II, Section C.3 (g).
4. **Change in Privileges:** Members of the Hospital Staff may request a change in privileges at any time. The process for delineating additional privileges shall be the same as that outlined in this Section.
5. **Evaluation:** Members of the Hospital Staff will have their Hospital activities evaluated after their initial appointment for a period of six months, extendable to twelve [12] months, if deemed necessary (“Focused Professional Practice Review”).
6. **Disputes:** Departmental criteria concerning all medical and professional staff privileges must be applied fairly to the full-time and voluntary staffs. If a dispute arises in this regard, an attempt shall be made to resolve the dispute within the Department. If the Department is unable to resolve the matter, it shall be referred to an Ad Hoc Committee of three members of the Medical Staff who are not on the Medical Board. The Committee shall include one member selected by the Dean, one member selected by the President of the AAS, and one agreed to by the Dean, the President of the AAS, and the physician at issue. The decision of this Ad Hoc Committee may be appealed in accordance with the procedures in Article VIII.

#### C. EMERGENCY AND TEMPORARY PRIVILEGES

##### a. Emergency Privileges:

- i. In the case of an emergency, any Staff Member, regardless of his/her Department or staff status shall be permitted to do everything possible within the scope of his/her license, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. For the purposes of this subsection, “emergency” shall mean a condition in which serious permanent harm would result to a patient or in which the life or health of a patient is in immediate danger and any delay in administering treatment would increase the danger.



- ii. In the event that the Emergency Preparedness Plan is activated and the organization is unable to handle the immediate patient needs, the CEO or President of the Medical Staff or their designee(s) may grant emergency privileges to any licensed healthcare professionals for the period that they deem necessary to meet immediate patient care needs upon the presentation of two of the following:
  1. A current hospital photo ID that clearly identifies professional designation
  2. Current state picture driver's license or current passport
  3. A current medical license with valid photo ID issued by a state, federal, or regulatory agency
  4. An ID that certifies that the licensed independent practitioner is a member of a state or federal disaster medical assistance team (DMAT)
  5. ID that certifies that the licensed independent practitioner has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
  6. Presentation by current hospital medical staff member with personal knowledge regarding the practitioner's identity
- iii. Verification of the credentials of those individuals who have been granted Emergency Privileges will be consistent with the Medical Staff policy on Granting of Emergency Privileges on Activation of the Emergency Management Plan, incorporated by reference in these Bylaws. The Hospital will verify the licenses of all volunteers within 72 hours following the implementation of the Emergency Preparedness Plan. In the extraordinary circumstance that primary source verification cannot be completed within that time frame, it is expected that it be done as soon as possible. (See Disaster Privileges Policy in Credentialing Appendix)

**b. Temporary Privileges:**

- i. Temporary privileges may be granted for a period of up to 120 days to an applicant whose Department Chair (or at the DHL Queens, the Chief of Service) demonstrates an urgent patient care need as defined in this section. There are two circumstances under which temporary privileges may be granted:
  1. After primary source verification of a practitioner's completed application has raised no concerns, has been presented to the Credentials Committee, and is awaiting the review and approval of the Medical Board and the Hospital's governing body; or,
  2. To fulfill an important patient care, treatment, and service need (e.g., the practitioner has special skills or qualifications not available within the Hospital's Medical Staff).
- ii. **Processing:** Evaluation and processing of requests for temporary privileges will be pursuant to the Appointment and Reappointment Manual and Medical Staff Credentialing Policies and Procedures, incorporated by reference in these Bylaws.

**D. MEDICAL RECORDKEEPING**

**1. General Guidelines**

- (a) The physician of record is responsible for the preparation of a complete and legible medical record on each of his/her patients. This record should include identification data, complaint, personal and family history, history of present illness, physical

examination and special reports such as consultation, laboratory, x-ray, etc. Pregnancy status must be documented on all patients of childbearing potential within 24 hours of admission and prior to any diagnostic or therapeutic procedures. Refusal of pregnancy testing must be documented as applicable. A physical examination and medical history must be performed within 30 days before admission or surgical procedure. A physical examination and medical history must also be performed by the attending physician within 24 hours after admission and must also be documented in the medical record within 24 hours of admission. Surgical cases must be documented prior to anesthesia. The admission history and physical examination, which must be signed by the Attending of record (or, when at Mount Sinai Queens, by the House physician) shall include a screening uterine cytology smear on women 21 years and over unless such test is medically contraindicated or has been performed within the previous 3 years. Also, palpation of the breasts, unless medically contraindicated, shall be performed and noted for all women over 21 years of age. All entries by the responsible physician must include:

- Printed name and signature
- Date and time of entry
- Dictation Code

**Note -- Abbreviations may no longer be used in the medical record except when they have been approved by the medical staff.\_**

- (1) All entries documented on an electronic system must be authenticated by the provider through the use of a unique electronic signature and password. The password must be kept confidential and may not be shared with anyone. (See Administrative Policy GPP-412)
  - (2) Access to the entries is restricted to those who have a need, reason or permission to review the entry.
  - (3) Providers are responsible for the accuracy, completeness and timeliness of their documentation in the electronic health record. By authenticating entries in the electronic record, the provider indicates that he/she has verified that the documentation is accurate and complete whether the information is original, or imported as part of a template note, or copied and pasted. The providers documenting in the electronic health record must appropriately use the "copy/paste" functionality and review the documentation carefully to update changes in the patient's status prior to authentication. (See Health Information Policy GE-18)
- (b) No portion of a medical record may be deleted, erased or otherwise made illegible. Corrections or amendments must be made by sequential entries rather than by interlineations or marginal notes. All corrections must be made so the original entry is not obscured, by drawing a single line through the text that is being corrected. Where appropriate, the reasons for the changed or subsequent entry should be stated. All corrections and amendments must be dated and timed at the actual date and time of the correction.
- (1) If there is any question concerning this policy, an appropriate administrative official should be contacted immediately.

- (2) Any action inconsistent with this policy shall be the subject of immediate appropriate discipline, including suspension or termination of staff privileges.
- (c) Medical records are the property of the Hospital and shall not be removed without administrative permission. Nothing belonging in the patient's record is to be removed from the chart.

  - All medical student notes in the medical record must be reviewed and signed by a member of the housestaff or an attending physician.
  - Attending physicians may utilize any portion of a medical student note as part of attending medical record documentation, but may not make linking statements to notes written by medical students.
- (d) In the case of a readmission, the patient's previous record, regardless of the prior physician or dentist, is available upon request to the admitting physician under the unit record system. In the case of referral to the Ambulatory Care service, the hospital record shall be available as needed for all visits to the Ambulatory Care service.
- (e) Medical records must accompany the patient from the O.R. to the PACU or to any procedure area.
- (f) The admission history and physical on ambulatory surgery or day of admissions patients must be signed before surgery by the attending surgeon. Any changes in the patient's condition must be documented by the surgeon and placed within the patient's medical record within 24 hours of admission or registration or prior to surgery or a procedure requiring anesthesia services, whichever comes first. If there has been no change in the patient's condition, this too must be documented within this timeframe.
- (g) Transfer of responsibility for the care of a patient from one member of the staff to another or from one service to another is to be indicated on the medical record by signed, dated and timed notes certifying the concurrence of both the transferring and receiving physicians.
- (h) A medical record will be made available upon request to qualified professional members of the Medical Staff when:

  - (1) They have an existing professional relationship with the patient.
  - (2) They have participated in the management and/or the treatment of the patient.
  - (3) They require the record for an authorized research project.
  - (4) The patient, the patient's family or a member of the health care team has requested that a Mount Sinai-employed chaplain provide religious or spiritual counseling.
- (i) All phase of care medical orders will expire upon discharge from that area to home, patient floors, or ICU's.

All members of the Hospital Staff and their respective employees and agents, shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the Hospital, or by business associates of the Hospital, in accordance with any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected health information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the Hospital and HIPAA.

Members of the Hospital Staff and their respective employees and agents, shall cooperate with Hospital personnel in obtaining and maintaining in the medical record any and all patient authorizations required under any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to HIPAA.

## 2. Content

- (a) Daily progress notes shall be written in the record describing all important changes in the patient's condition that occur. These are to be signed by the full name of the Physician responsible for them, followed by the dictation code number, as well as date and time of entry.
- (b) A brief operative/procedure note must be entered into the medical record immediately upon completion of the procedure and/or prior to transfer to the next level of care. This dated and timed note shall include the name(s) of the primary surgeon(s)/proceduralist(s) and his/her assistants, pre-operative and post-operative diagnosis, procedure performed and a description of procedural findings. The note must also describe estimated blood loss and fluids replaced (except in operations involving cardiopulmonary bypass and other complex procedures in which EBL cannot be reasonably documented), specimens removed, any complications of the procedure and the general condition of the patient.
- (c) A full operative/procedural report must be generated immediately after surgery. This note shall include the name(s) of the primary surgeon(s)/proceduralist(s) and his/her assistants, date, time, pre-operative and post-operative diagnosis, procedure(s) performed, description of the technique(s) utilized and a description of each procedural finding. The operative note should also describe estimated blood loss (except in operations involving cardiopulmonary bypass and other complex procedures in which EBL cannot be reasonably documented), fluids replaced, tissues/specimens removed or altered, implants utilized, any complications of the procedure, and the general condition of the patient. This full operative/procedural report must be placed in the medical record within 24 hours and signed by the attending physician within seven days.
- (d) **Anesthesiology Pre-Operative Notes:** A credentialed PGY-2 (or higher) resident, or a credentialed CRNA, may place a pre-operative note in the medical record prior to entry to the OR with an attending co-signature and attestation placed in the medical record after entry into the operating room stating that the patient was seen and the note agreed with prior to entry into the operating room.
- (e) **Anesthesiology Post-Operative Notes:** A credentialed PGY-2 (or higher) resident, or a credentialed CRNA, may place a post-operative note in the medical record without the need for co-signature.

A post-operative examination and assessment must be performed by the Attending Surgeon of Record. A post-operative examination and assessment by an Attending Surgeon must be performed no less frequently than daily until discharge, with an accompanying progress note by the attending which documents each such visit.

### **3. Completeness**

- (a)** The Director of each Department is responsible for the quality and completeness of the medical records on his/her service. When a House Officer rotates to another institution from Mount Sinai or when the House Officer leaves Mount Sinai after the completion of his/her residency, the House Officer must notify the Medical Records Department of the name of the Physician who will be responsible for the completion of charts for patients whose hospitalization period extends beyond the House Officer's last day at Mount Sinai.
- (b)** Responsibility for chart completion lies with the Physician or Dentist of Record. The responsibility of completing a medical record becomes that of the surgeon once surgery is involved or the Physician of Record at the time of discharge.
- (c)** Chart completeness is the responsibility of the medical staff member. Although he/she may delegate the actual tasks to a House Officer, such delegation does not relieve the Staff Member of his/her primary responsibility.
- (d)** The Physician of Record shall edit, correct or amend and countersign the history, physical examination and summary written by a member of the House Staff, Physician Assistant, Nurse Practitioner, or by a Nurse Mid-wife.
- (e)** The Physician who newly diagnoses cancer in his/her inpatient, in ambulatory surgery or day of admission surgery, or who initially treats a patient with cancer diagnosed elsewhere must personally document, in the eOutcomes AJCC-TNM staging data base, the diagnosis and staging of the cancer. This documentation must be completed within 30 days of notification of the Physician by the eOutcomes Data Base. Failure to do so in the time allowed will lead to discipline for incomplete medical records. Patients with cancer but admitted for other illnesses, or admitted for subsequent treatments do not require such entries.

### **4. Promptness of Record Completion**

- (a)** Records of patients discharged are to be completed within 30 days following discharge, regardless of whether all test results have been completed and/or reported. Final notes of the mortality records are to be done by the attending physician of record or the resident in charge of the case within 15 days of death.
- (b)** Attending Physicians:
  - (1)** The medical record may be filed as incomplete if the Physician or Dentist of Record is deceased or has resigned.
- (c)** Compliance:
  - (1)** The responsible physician will be notified by the Hospital Administration via e-mail, when a chart remains incomplete beyond the allowed time frame.
  - (2)** There will be a seven day grace period from midnight of the day of notification during which the responsible physician can complete the medical record after which a delinquency notice will be issued.
  - (3)** If the chart is not completed within sixty (60) days of discharge the responsible Physician will be notified in writing via overnight mail that his/her clinical privileges will be administratively suspended. This will entail a temporary suspension of admitting, surgical and consultation privileges consistent with Article IX, Section B of the Bylaws.
    - (i)** When incomplete records are completed, the Physician will be immediately reinstated without penalty.

(ii) Suspension will remain in effect until all delinquent records are completed.

(iii) To avoid these penalties, the responsible physician must show good cause as to why the charts cannot be completed in the allocated time.

(d) House Officers:

(1) The completion of a patient's medical record by a House Officer shall be considered a medical matter rather than an administrative matter as medical records are an integral part of patient care.

(2) If the House Officer has not completed his/her medical records at the time of the patient's discharge, the House Officer's Chief of Service will be notified via e-mail by the Director of Medical Records (copies to all concerned). Any reassignment of the medical record must be made by the Chief Resident at the time the first notice is received.

#### **E. MEDICAL SCREENING EXAMINATION**

Qualified medical personnel are authorized to perform a medical screening examination and provide treatment necessary to stabilize an individual presenting to the Emergency Department with an emergency medical condition. Qualified medical personnel are defined as a physician who is a member of the medical staff or a nurse practitioner who is a member of the professional staff.

## ARTICLE VII

### DISCIPLINARY ACTION

#### A. MEDICAL STAFF DISCIPLINARY ACTION

1. **General:** The Department Chair, Chief Medical Officer, or Hospital President, and at Mount Sinai Queens, the Chief of the Service, the Medical Director-Mount Sinai Queens or the Executive Director, may recommend disciplinary action, including censure, formal written warning, limitation on clinical privileges, probation for a definite period not to exceed one year, suspension, dismissal, or such other action as may be appropriate, against any Staff Member who:
  - a. Fails to demonstrate an acceptable level of professional competence or clinical judgment in the treatment of patients; or
  - b. Commits an act which constitutes professional misconduct under the New York State Education Law or engages in unprofessional or unethical behavior,
  - c. Fails to abide by a material provision of these Bylaws, the Rules and Regulations of the Medical Staff or any other policies or rules of the Medical Staff or Hospital; or
  - d. Fails to meet a Condition of Appointment; or
  - e. Engages in any activity which is a threat to the welfare or safety of patients, employees, other Staff Members, or the Hospital.
  
2. **Notice:** The individual who recommends the disciplinary action must send the Staff Member notice in writing:
  - a. Of the proposed disciplinary action;
  - b. Of the reason for the decision;
  - c. That the Staff Member has the right to request a hearing on the decision in the manner provided by Article VIII, Section B within thirty (30) days of the Staff Member's receipt of notice of the decision; and
  - d. Of the Staff Member's rights under Article VIII.
  
3. **Finality of Disciplinary Action:**

The disciplinary action shall not become final until either (a) the time to request a hearing or appeal regarding such action has lapsed; (b) the resolution of all hearing and appeal procedures provided in Article VIII; or (c) the physician is deemed to have forfeited the right to a hearing as set forth below.

#### B. SUMMARY SUSPENSION

1. **General:** The President of the Hospital, Chief Medical Officer, or the President of the Medical Board, and at Mount Sinai Queens, the Executive Director may summarily suspend some or all of the admitting and/or clinical privileges, of any Staff Member where (1) the failure to take such action may, in the opinion of the individual taking this action, result in an imminent danger to the health of any individual or to the Hospital, or (2) the Staff Member failed to cooperate with the Physician Wellness Committee or other quality improvement investigation.

2. **Notice:** If a Staff Member's privileges are summarily suspended as provided in B.1, the Staff Member shall be notified thereafter in writing by the individual taking the action:
  - a. Of the summary suspension;
  - b. Of the reason for the decision;
  - c. That the staff member has the right to request a hearing on the decision in the manner provided by Article VIII, Section B, within thirty (30) days of receipt by the Staff Member of notice of the decision; and
  - d. Of the staff member's rights under Article VIII.

3. **Finality of Disciplinary Action:**

If the Staff Member does not request a hearing within thirty (30) days of receipt of notice, the terms of the summary suspension shall become final. If a hearing is requested, the terms of such suspension shall remain in effect until a final determination under Article VIII or forfeiture as set forth below.

### C. SUMMARY SUSPENSION PENDING INVESTIGATION

The President of the Hospital, Chief Medical Officer, or the President of the Medical Board, and at Mount Sinai Queens, The Executive Director may summarily suspend some or all of the admitting and/or clinical privileges of any Medical Staff member pending investigation up to 14 days. Such a suspension shall not be subject to the notice and hearing provisions set forth in these Bylaws with regard to summary suspensions. The suspended physician must, however, receive written notice of the suspension and the reasons therefore. (*amended-apprvd. Med Bd12/10/09; apprvd. Bd of Trustees 12/14/09*)

### D. AUTOMATIC ADMINISTRATIVE SUSPENSION OR TERMINATION

1. **Automatic Termination:** A Staff Member whose license to practice his/her profession has been revoked or suspended; who has failed to renew his/her New York State license to practice his/her profession; or whose appointment to the School of Medicine has been terminated for cause or due to non-reappointment to the faculty, shall be automatically terminated from the Hospital Staff and such termination shall not be subject to the procedures set forth in Articles VII and VIII.

2. **Administrative Suspension:**

- a. A temporary Administrative Suspension of clinical privileges may be imposed by the Hospital President, Chief Medical Officer, or the President of the Medical Board, and for a Staff Member at Mount Sinai Queens, the Executive Director, in the event that the Staff Member fails to maintain malpractice insurance that meets the requirements established from time to time by the Board of Trustees; fails to provide documentation of the completion of the New York State mandated Infection Control Course or a completed health assessment; or violates the policy of the Medical Board regarding incomplete medical records. Failure to obtain malpractice insurance that meets the requirements established by the Board of Trustees shall be grounds for Administrative Suspension and no prior notice shall be required. Advance notice shall, however, be given that failure to provide documentation of the completed Infection Control Course or completed health assessment, or to comply with the policy of the Medical Board regarding incomplete medical records, will lead to automatic suspension.



Administrative Suspensions are not subject to the procedures set forth in Articles VII and VIII. Administrative Suspension under this section shall be in addition to, not in lieu of, any disciplinary action that may be recommended pursuant to Section A. *(rev. 11/13/08 MB; approved 11/24/08 Bd of Trustees)*

- b. Length of Administrative Suspension:** The temporary Administrative Suspension will be for a period of (30) days. If the required document(s) are received within the thirty (30) day suspension period, the suspension will be lifted. Failure, without good cause, to obtain malpractice insurance in accordance with the requirements established by the Board of Trustees; to renew the New York State professional license; to provide documentation of completion of the New York State mandated Infection Control Course or a completed health assessment; or to comply fully with Medical Board policy regarding medical records, within the thirty (30) day suspension time frame, will be deemed a voluntary resignation from the Medical Staff.

## ARTICLE VIII

### HEARING AND APPEALS PROCESS

#### **A. RIGHT TO HEARING**

Except as otherwise provided in these Bylaws, any Staff Member who has received notice of a non-reappointment, curtailment of privileges, disciplinary action, or summary suspension, or whose application for any privilege has been denied, is entitled to a hearing pursuant to the procedure set forth in this Article.

#### **B. REQUEST FOR HEARING**

A request for a hearing shall be sent in writing to the President of the Medical Board by certified mail, return receipt requested, within thirty (30) days of the receipt by the Staff Member or applicant of notice of the adverse action. If no such request is made, the adverse action shall become final.

#### **C. NOTICE OF HEARING**

If a hearing is requested on a timely basis, the staff member or applicant will be given notice in writing within a reasonable time after the request for the hearing is received, setting forth:

1. The place, time, and date of the hearing, which date, unless otherwise agreed to by the parties, shall be no later than thirty (30) days from the date of the notice. However, where the hearing has been requested in connection with a summary suspension, the Staff Member may request an expedited hearing. Upon receipt of a proper and timely request for an expedited hearing on a summary suspension, the date of the hearing shall be no later than fifteen (15) days from the date the request for hearing is received.
2. The names of the witnesses, if any, expected to testify at the hearing.

#### **D. HEARING**

##### **1. Hearing Committee Composition:**

The hearing shall be held before a "Hearing Committee" of the Medical Board comprised of at least five (5) members of the Medical Board. In lieu of the foregoing, if the staff member practices or applied to practice at Mount Sinai Queens, at the discretion of the President of the Medical Board, the Hearing Committee may be comprised of at least one member of the Medical Board whose DHL is Manhattan and members of the Clinical Operations Committee (aka "Medical Board Mount Sinai Queens"), including at least two voluntary physicians. At no hearing, however, shall the President of the Hospital, President of The Medical Board, and the Dean constitute a majority of the hearing body. The President of the Medical Board or, in his absence, the Vice President of the Medical Board, shall appoint one member of the hearing body (the "Hearing Committee") to act as Chair (the "Chair"). The Medical Staff member or applicant may challenge for cause the appearance of any member of the Medical Board, who in the staff member's or applicant's opinion, would not be able to render an impartial decision. It shall be at the sole discretion of the Chair whether to excuse any member of the Hearing Committee so challenged. Any member of the Medical Board who is in direct economic competition with the staff member or applicant requesting the hearing will be precluded from hearing the appeal of such staff member or applicant.

## **2. Written Submissions:**

If requested by the Chair of the Hearing Committee, each party shall submit to the Chair, no later than ten days prior to the scheduled date of the hearing, or such other time as may be determined by the Chair, eight copies of: (1) all documents the party wishes to be considered by the Hearing Committee; (2) a written statement setting forth the party's position; (3) a list of names of witnesses that will be called by that party to testify at the hearing together with copies of the curriculum vitae and report of any witness being called as an expert. As required by HIPAA, all PHI shall be redacted. Furthermore, to preserve the integrity and confidentiality of patients and their families, neither the Department nor Staff Member may call a patient or their family as a witness in a hearing. In the event that the Staff Member or Department believes that such testimony is critical to its case, they may make a special application to the Committee Chair or his/her designee for an in camera interview. The Chair shall have discretion to grant this request and then interview the witness prior to the Hearing. The Department and Staff Member shall provide the Chair with written questions for such an interview. The Chair shall provide a summary or a transcript of the interview to both parties.

Upon receipt of material from both parties, the Chair shall provide one copy of all submitted material to the other party. Two copies of any supplemental documentation, including but not limited to written rebuttal statements and names of additional witnesses expected to be called to testify at the hearing, shall be submitted by the parties to the Chair no later than three days, or such other time as may be determined by the Chair, prior to the scheduled date of the hearing. Upon receipt of rebuttal material, if any, from both parties, the Chair of the Hearing Committee shall provide one copy of all submitted material to the other party. Additional witnesses and documentary evidence may be permitted at the hearing at the discretion of the Committee. The Staff Member shall have the right to make a written submission at the close of hearing. All documents shall be treated as strictly confidential.

## **3. Hearing Procedure:**

- a.** The Medical Staff Member or applicant shall be entitled to be present at the hearing, to present relevant evidence and witnesses on his or her behalf and to question witnesses appearing in support of the adverse action. The rules of evidence shall not apply. At the hearing, the Staff Member or applicant may be represented by an attorney or other person of his or her choice. The role of this representative or the department's attorney shall be limited to: (1) providing advice and counsel to the Staff Member or applicant; and addressing the members of the Hearing Committee. The role of the representative shall not include the presentation of evidence or the examination or cross examination of witnesses. However, the Hearing Committee may, at its discretion, further define, expand or limit the role of any such representative.
- b.** All testimony at the hearing shall be under oath and a transcript of the hearing be made. At the close of the hearing, each party may present an oral, closing statement, the length of which shall be at the discretion of the Hearing Committee or, at the discretion Hearing Committee, submit a written statement.
- c.** The scope of the hearing shall be limited to determining whether there is sufficient evidence to demonstrate that the adverse action taken was not arbitrary and capricious. The Hearing Committee shall make any rules it deems necessary to assure prompt, fair and expeditious handling of the matter.

4. The right to a hearing may be forfeited if the physician fails, without good cause, to appear. Requests for postponement without good cause, as determined by the Committee, shall constitute forfeiture.

#### **E. APPEAL TO BOARD OF TRUSTEES**

1. **Generally.** The decision of the Hearing Committee may be appealed to the Board of Trustees by the Medical Staff Member, applicant, or individual who initiated the disciplinary action.
2. **Procedure**
  - a. A request for an appeal shall be sent in writing to the Chair of the Board of Trustees by certified mail, return receipt requested, no later than fifteen (15) days after receipt of the decision of the Hearing Committee. The person requesting the appeal shall forward a copy of the transcript of the proceedings before the Hearing Committee to the Chair of the Board of Trustees. If no request for an appeal is made, the decision of the Hearing Committee shall become final.
  - b. The Chair of the Board of Trustees may, at his or her discretion, refer the appeal to the entire Board of Trustees, a standing committee thereof or an ad hoc committee thereof consisting of at least three persons appointed for such purpose. The person bringing the appeal and the person opposing the appeal shall be entitled to appear before the body hearing the appeal and to make a statement. The appeal shall be limited to the record of the proceedings before the Hearing Committee and the scope of review shall be limited to determining whether there is a reasonable basis on which to support the findings and conclusions of the Hearing Committee. The body hearing the appeal may at its discretion ask one or more members of the Hearing Committee of the Medical Board to appear before it to advise as to the basis for its decision and to answer any questions. The body hearing the appeal shall at any time make such additional rules as it deems necessary to assure prompt, fair and expeditious handling of the appeal.
3. **Decision.** Within thirty (30) days after the conclusion of the appellate review, the body hearing the appeal shall send notice of its decision and a statement of the basis for its decision to the Staff Member or applicant, the individual who initiated the disciplinary action, the President of the Medical Board, the Department Chair, the Dean of the School of Medicine, the President of the Hospital, and the Chair of the Board of Trustees. The decision of the body hearing the appeal shall be final.
  - a. Whenever the body hearing the appeal does not concur with the Medical Board's recommendation regarding Hospital Staff appointment, reappointment, change of privileges or disciplinary action, the matter shall be referred to an ad hoc committee consisting of three members of the Liaison Committee to the Board of Trustees, appointed by the President of the Medical Board, and three members of the Executive Committee of the Board of Trustees, appointed by the Chair of the Board for a recommendation prior to the final decision by the body hearing the appeal.
4. **The right to an appeal** to the Board of Trustees may be forfeited if the physician fails, without good cause, to pursue the appeal. Requests for postponement without good cause, as determined by the Committee of the Board of Trustees shall constitute forfeiture.

## **F. EXPEDITED APPEALS PROCEDURE FOR CONVERSION TO VOLUNTARY STATUS**

### **1. Right to a Hearing**

A request for a hearing pursuant to this expedited Appeals Procedure may be made only by full-time Staff Members who have applied for an appointment to the voluntary staff pursuant to Article III, Section D.

### **2. Request for a Hearing**

- a.** A request for a hearing pursuant to this Section shall be sent in writing to the Dean by certified mail, return receipt requested, postmarked within ten (10) days of the receipt by the Staff Member of the Department Chair's written denial of the request for conversion or granting of that request with Conditions of Appointment or limitations on privileges which the Staff Member finds unacceptable. If no such request is made within the time-frame specified, the Department Chair's decision with respect to this application shall become final.
- b.** If a hearing is requested on a timely basis, the Staff Member will be given notice in writing within a reasonable time after the request for the hearing is received, setting forth (i) the place, time and date of the hearing, which date shall be no sooner than three (3) months and no later than six (6) months after the Staff Member's request; (ii) the composition of the hearing panel considering the appeal; and (iii) the names of the witnesses (if any) expected to testify at the hearing. The delay in scheduling the appeal is designed to encourage the Department Chair and Staff Member to reach a compromise without resorting to this appeal process.
- c.** The hearing will be held before a hearing panel selected from the Expedited Appeals Committee for Conversion from Full-Time to Voluntary Status as established in Article V of the Faculty Handbook of the Mount Sinai School of Medicine. The hearing panel will consist of five members selected by the Dean: One trustee, two full-time Staff Members, including a Department Chair who will chair the hearing panel, and two voluntary Staff Members. No member of the hearing panel shall be from the department in which the applicant seeks voluntary privileges. The Staff Member or Department Chair may challenge for cause within five (5) business days of receipt of notice of the hearing the participation of any member of the hearing panel.

### **3. Hearing**

- a.** The Staff Member and Department Chair or other representative shall be entitled to be present at the hearing to present relevant evidence and witnesses on his or her behalf, and to question witnesses. The rules of evidence shall not apply, no party shall be represented by an attorney at the hearing, and no transcript shall be made. The decision of the hearing panel shall be based on preponderance of the evidence, shall be reached by a majority vote, and shall be communicated in writing to the Staff Member within fifteen (15) business days of the conclusion of the hearing. The hearing panel's decision is not subject to appeal. If the Staff Member is successful before the hearing panel s/he will be free to become a member of the voluntary staff one-year from the date of the decision of the hearing panel without any lapse of appointment. If the appeal is unsuccessful, s/he may resign from the full-time staff effective one year from the date of the hearing panel's decision or accept the hearing panel's decision. During

that one-year period, the Staff Member and Department Chair shall continue to make efforts to reach a compromise.

- b. The hearing panel shall make such additional rules as it deems necessary to assure prompt, fair and expeditious handling of the matter. The hearing panel may take whatever action consistent with these Bylaws it considers appropriate.

#### **G. QUEENS BASED PHYSICIANS WAIVER PROCESS**

Medical Staff members at either Mount Sinai DHL may apply for privileges at the other DHL based on the requirements of the DHL at which privileges are being sought. A faculty title is required for privileges at DHL-Queens, and a faculty appointment or waiver for privileges at DHL-Manhattan.

#### **H. DEPARTMENT CHAIRS; SALARIED EMPLOYEES**

Notwithstanding the above, Chairs and the Medical Director serve at the pleasure of the Board of Trustees and the status of Department Chair shall not be governed by these rules. In addition, the procedures set forth in these Bylaws do not apply to matters relating to the employment or clinical positions of Staff Members who are salaried Hospital employees or otherwise hold Hospital administrative appointments.

#### **I. INTERPRETATION OF RULES**

The foregoing procedures are intended to establish fair and reasonable guidelines to be followed by the Medical Board and the Board of Trustees or their respective committees. Breaches of such rules shall be grounds for a new proceeding only if the breach is of a substantial and material nature.

## ARTICLE IX

### DEPARTMENTS

#### **A. DEPARTMENTS**

The Clinical Departments of the Hospital Staff shall be as follows:

- Anesthesiology
- Cardiovascular Surgery
- Dentistry
- Dermatology
- Emergency Medicine
- Geriatrics and Adult Development
- Family Medicine and Community Health
- Medical Genetics and Genomics
- Medicine
- Neurology
- Neurosurgery
- Obstetrics/Gynecology and Reproductive Science
- Ophthalmology
- Orthopaedics
- Otolaryngology
- Pathology
- Pediatrics
- Preventive Medicine
- Psychiatry
- Radiation Oncology
- Radiology
- Rehabilitation Medicine
- Surgery
- Thoracic Surgery
- Urology

**B. ORGANIZATION OF DEPARTMENTS:** Each Hospital Department shall be organized as a separate part of the Hospital Staff and shall have a Department Chair who shall report to the Hospital President and be responsible for the overall supervision of the Department.

#### **C. FUNCTIONS OF DEPARTMENT CHAIRS\_**

1. The Hospital shall require that, as part of his/her administrative responsibilities, each Department Chair shall, among other things:
  - a. Be accountable for all professional and administrative activities within the Department;
  - b. Be a member of the Medical Board;
  - c. Ensure continuing review of the professional performance of all Staff Members and other healthcare providers in the Department and report regularly thereon to the Medical Board as appropriate and determine the qualifications and competence of the Department personnel who are not LIP's and who provide patient care services (e.g. Physician Assistants);

- d. Ensure that the quality and appropriateness of patient care provided within the Department are monitored and evaluated. The Chair will use the six core competencies\* in assessing the clinical competence of each member of the medical staff seeking reappointment in his/her department. The metrics used within these core competencies may include, but will not be limited to, measures of clinical activity that can be monitored (such as admissions and consultations), adherence to defined standards of practice, length of stay of admitted patients, and clinical documentation. (\*The core competencies are: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning & Improvement, Interpersonal and Communication Skills, Professionalism and System-Based Practice.) (rev. 11/13/08 Medical Board; approved 11/24/08 Board of Trustees)
  - e. Enforce these Bylaws and the Rules and Regulations of the Hospital Staff and the Hospital within the Department;
  - f. implement actions taken by the Medical Board within the Department;
  - g. Be responsible for the recommendations concerning the appointment and reappointment of, and appropriate rank and delineation of clinical privileges for all members of and applicants to, the Hospital Staff in the Department;
  - h. Be responsible for all House Staff appointments within the Department;
  - i. Be responsible for the teaching, education and research programs in the Department;
  - j. Cooperate with the nursing service and the Hospital administration;
  - k. Assist in the preparation of such reports, including budgetary planning and resource allocation pertaining to the Department as may be required by the Medical Board, the Hospital President or the Board of Trustees;
  - l. Recommend to the Hospital President or his designee off-site sources for needed patient care services not provided by the Department or organization;
  - m. Facilitate the integration of the Department or service into primary functions of the organization and the coordination and integration of interdepartmental and intradepartmental services;
  - n. Ensure that orientation and continuing education are made available to all members of the Department; and
  - o. Recommend space and other resources needed by the Department or service.
2. The President of the Hospital and the Medical Director shall evaluate Department Chair performance annually.

#### **D. FUNCTIONS OF DEPARTMENTS**

1. Each member of the Hospital Staff assigned to a Department shall attend at least 10 Department or Division meetings each year or more, if required by Departmental policy. Each Department Chair shall ensure that minutes reflecting proceedings of these meetings are kept and that attendance is taken. Failure to meet the attendance requirements may constitute grounds for non-reappointment or dismissal.
2. Each Department shall establish its own written criteria, consistent with these Bylaws and with the policies of the Medical Board and the Board of Trustees, for the organization of the Department.



- 3.** Each Clinical Department shall be responsible for sharing pertinent clinical information at Departmental meetings that will contribute to the continuing education of every Staff Member and to the process of improving patient care. Information for such discussions may be gleaned from quality improvement activities and findings from any of the Committees of the Medical Board.
  
- 4.** Each Clinical Department shall meet at least 10 times each year to review and analyze, on a peer group basis, the clinical work of the Department.

## **ARTICLE X**

### **GOVERNANCE**

The Medical Board shall be the governing body of the Medical Staff and shall have the responsibility of carrying out its purposes. The Medical Board shall be responsible for the self-regulation of the Medical Staff and reports to the Board of Trustees.

#### **A. MEETINGS**

The Medical Board shall meet at least 10 times a year. Special meetings may be called at the discretion of the President of the Medical Board. Failure to attend 60% of meetings held, either in person or through a designee, without compelling reasons submitted to the Secretary in advance, will be reported to the Hospital President and may subject the member to removal from the Medical Board.

Department Chairs may appoint a designee to attend Medical Board. Such designee must be approved in advance by the Hospital's Chief Medical Officer and Medical Board President, and shall be permitted to attend meetings and to vote in accordance with Section C below.

#### **B. QUORUM**

A simple majority of the voting members of the Medical Board shall constitute a quorum for the transaction of business at any meetings, except as otherwise stated in these Bylaws. The Medical Board shall act by the vote of a majority of those eligible to vote who are present at meetings at which a quorum exists.

#### **C. VOTING AND OFFICE**

Except as otherwise provided herein, all members of the Medical Board shall be entitled to vote and to hold office throughout the period of their membership on the Medical Board. Chairs' designees appointed in accordance with section A above may vote on all matters, except the election of officers. Voting for officers will be by secret ballot. Any member may object to a "show of hands" and request a secret ballot for all other votes.

#### **D. DUTIES AND RESPONSIBILITIES**

It shall be the duty of the Medical Board to govern the Medical Staff and to advise the Board of Trustees on all matters relating to (1) the welfare of the Hospital; (2) the Medical Staff; (3) the medical care and treatment of patients in the Hospital; (4) the quality and the appropriateness of patient care; (5) the medical education and research programs conducted by the Hospital. The actions of the Medical Board are subject to review and approval by the Board of Trustees.

The Medical Board has the following responsibilities:

- 1.** Govern, direct and coordinate the Medical Staff and its various functions
- 2.** Monitor compliance with and direct review and revision of the Bylaws, Rules and Regulations, policies and procedures of the Medical Staff and Hospital
- 3.** Act on nominations for officers of the Medical Board
- 4.** Act as liaison with the Board of Trustees and Hospital administration
- 5.** Receive and act on recommendations from Committees of the Medical Board

6. Receive and review reports of the Credentials Committee and make recommendations to the Board of Trustees concerning Medical Staff membership and the delineation of clinical privileges
7. Participate in planning for and review of the provision of services required to meet the needs of Hospital patients and for Hospital growth and development
8. Review and approve outside sources (i.e. contractors) that provide patient care to assure timely and quality care that meets Hospital standards
9. Make recommendations to the Board of Trustees pertaining but not limited to the following subjects:
  - a. Structure of the Medical Staff
  - b. Guidelines for review of credentials for purposes of appointment and reappointment to the Medical Staff and for delineating individual clinical privileges
  - c. Termination of membership on the Medical Staff
  - d. Corrective action and fair hearing procedures
  - e. Quality of patient care

#### **E. RULES AND REGULATIONS**

The Medical Board shall adopt such policies, rules and regulations consistent with these Bylaws as it deems necessary for the governance of the Hospital Staff and the furtherance of its purposes. The Rules and Regulations may be amended at any regular meeting at which a quorum is present, without previous notice, by a majority vote of the Medical Board members present and shall not require the approval of the Board of Trustees.

#### **F. MEMBERSHIP OF THE MEDICAL BOARD**

- a. Members of the Medical Board shall include: Clinical Department Chairs
- b. President of the Hospital, if a physician
- c. Medical Director from Mount Sinai-Queens
- d. One (1) person elected by the Mount Sinai-Queens Clinical Operations Committee
- e. Six (6) delegates elected by the AAS
- f. Three (3) House Staff members elected by the House Staff Council
- g. Chief Executive Officer of the Medical Center
- h. Chief Nursing Officer
- i. Chief Operating Officer
- j. Dean of the Medical School
- k. Executive Director from Mount Sinai-Queens
- l. Medical Director of DHL-Manhattan
- m. Director, Department of Social Services.
- n. Chief Medical Information Officer

#### **G. OFFICERS**

The Officers of the Medical Board shall be President, Vice President and Secretary. The qualifications for office are:

1. A license to practice as a physician;
2. Medical Board membership in good standing
3. Demonstrated executive and administrative ability

- 4.** Recognized high level of clinical experience
- 5.** Ability to work cooperatively with other members of the Medical Staff.

## H. NOMINATING COMMITTEE

1. **Officers shall be elected** at the January meeting of the Medical Board. Only members of the Medical Board shall be eligible to vote.
2. **At least two (2) months prior to the January meeting**, the President of the Medical Board shall recommend to the Medical Board a Nominating Committee consisting of three (3) members, whose duty it shall be to nominate candidates for election as Officers. None of the members of the Nominating Committee shall be officers of the Medical Board, and not more than one shall be a member of the outgoing Nominating Committee. Their list of nominations shall be sent to each member of the Medical Board at least four (4) weeks prior to the January meeting.
3. **Nominations may also be made from the floor** at the time of the January meeting, or by petition signed by at least 5 members of the Medical Board and filed with the Medical Staff Services Department at least ten (10) days prior to the January meeting.
4. **For a nominee to be elected** to a Medical Board office s/he must receive a majority of the votes of those participating in the election.

## I. DURATION OF OFFICE

Officers of the Medical Board shall be elected for a one year period (one term). In addition, Officers are subject to a limit of two full terms (to which they have been elected), after which one year out of office is required before re-election to the same position.

## J. VACANCIES IN OFFICE

Except for the Medical Board President, vacancies in office during the year shall be filled by nomination and simple majority vote by the members of the Medical Board. If there is a vacancy in the Office of the President the Vice President shall serve out the remaining term.

## K. RESIGNATION AND REMOVAL FROM OFFICE

1. **An officer may resign at any time** by giving written notice to the President of the Medical Board. Any officer may be removed at any time by a majority vote of the members of the Medical Board.
2. **Grounds for removal include** but are not limited to:
  - a. Failure to perform the duties of the position in a timely and appropriate manner;
  - b. Failure to satisfy the qualifications of the position
  - c. Conduct or statements damaging to the best interests of the Staff or the Hospital or to its goals, programs or public image
  - d. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his or her office
  - e. Imposition of any disciplinary action pursuant to these Bylaws
3. **Mechanism to remove an officer:**
  - a. A petition signed by at least ten (10) members of the Medical Board shall be required to initiate removal of a Medical Board Officer and a vote of  $\frac{3}{4}$  of the members of the Medical Board shall be required for removal.
  - b. The Officer who is the subject of the removal action shall be given seven (7) days prior written notice of the meeting of the Medical Board at which the vote on removal is to be taken and of the grounds for removal and shall be afforded the opportunity to speak

on his or her own behalf before the Medical Board before the vote on his or her removal.

#### **L. DUTIES OF OFFICERS**

- 1. The President of the Medical Board** shall call and preside at all meetings and shall be an ex-officio member of the all Medical Board committees. The President's duties shall include:
  - a.** Preparing agendas in consultations with the members of the Administrative Committee of the Medical Board
  - b.** Serving, consulting and advising other committees as an ex-officio member;
  - c.** Appointing committee members and chairs as required by the Bylaws
  - d.** Advising the Medical Director on matters affecting the Medical Staff and the Departments
  - e.** Transmitting to the appropriate authority Medical Staff views, concerns and recommendations on matters affecting policy, planning, operations, governance and relationships with external agencies.
- 2. The Vice President** shall also perform such duties as are assigned by the President. The Vice President shall also be a member of the Quality Control Committee of the Board of Trustees. In the absence of the President the Vice President shall assume all of the duties and have the authority of the President.
- 3. The Secretary** shall assure that accurate and complete minutes are kept of all meetings, attend to correspondence and perform such other duties as ordinarily pertain to his or her office, or as may be assigned by the President of the Medical Board. In the absence of the President and Vice President of the Medical Board, the Secretary shall assume all of the duties and have the authority of the President.

#### **M. MEDICAL DIRECTOR, THE MOUNT SINAI HOSPITAL**

The Medical Director of The Mount Sinai Hospital, as a senior physician of the Medical Staff shall be the Chief Medical Officer of The Mount Sinai Hospital and Mount Sinai Medical School, and also head the Office for Excellence in Patient Care. S/he will (i) be selected by the Medical Center CEO; (ii) report to the Medical Center CEO; and (iii) be appointed by and sit at the pleasure of the Board of Trustees. The Medical Director shall be responsible for directing the Hospital Staff and the organization and conduct of the Medical Staff and in accordance with applicable law shall perform such other duties as may be required by law or specified by the Board of Trustees, Hospital President, or The Medical Center CEO. The Medical Director shall be a member of the Medical Board and shall serve as an ex-officio member of all other Committees of the Medical Board. The Medical Director may appoint one or more senior physicians as Associate Medical Directors with responsibilities for the Physician Wellness Committee, Medical Staff Services, Quality Assurance Committees, Risk Management, or other areas as the Medical Director may deem appropriate.

#### **N. LIAISON TO THE BOARD OF TRUSTEES**

The President of the Medical Board shall be an ex-officio member of the Board of Trustees representing the medical staff at the Board of Trustees meetings. The Vice President and Secretary shall be delegates to the Board of Trustees at the Board of Trustees meetings.

## ARTICLE XI

### COMMITTEES OF THE MEDICAL BOARD

**There shall be the following standing committees of the Medical Board:**

- |  |   |
|--|---|
| A. Administrative Executive Committee                  | L. Nutritional Care Committee   |
| B. Bylaws Committee                                    | M. Pain Management Committee  |
| C. Cancer Committee                                    | N. Pharmacy and Therapeutics Committee  |
| D. Credentials Committee                               | O. Performance Improvement Review & Oversight<br>Committee (PIROC) Manhattan Campus |
| E. Critical Care Committee                             | P. Performance Improvement Committee (PIC) Queens<br>Campus                         |
| F. Emergency Preparedness Committee                    | Q. Radiation Safety Committee   |
| G. Ethics Committee                                    | R. Surgery Committee  |
| H. Infection Control Committee                         | S. Transfusion Committee  |
| I. Laboratory Committee                                | T. Transplant Executive Committee   |
| J. Medical Records Committee                           | U. Novel Procedure Oversight Committee  |
| K. Mount Sinai Queens Clinical Operations<br>Committee | V. Utilization Review Committee   |

The Medical Board shall establish such ad hoc and special committees as it deems necessary and appropriate.

All committees of the Medical Board shall be advisory to the Medical Board and, unless otherwise authorized, shall only be empowered to make recommendations to the Medical Board. Immediately following election by the Medical Board, the President of the Medical Board shall appoint the committee chairs. Except as otherwise provided in this Article, each committee shall have a chair appointed for a term of one year. Further, and except as otherwise provided in this Article, committee chairs shall not be permitted to serve more than five (5) consecutive one-year terms. After the President of the Medical Board has appointed the committee chairs, he/she shall then solicit annual input from the appointed chairs as to committee composition, which input will be reviewed by the Executive Committee. The President of the Medical Board shall then make the final selection of committee members and then notify the members. Committee members shall be appointed for two year terms. There is no limit to the number of consecutive terms that committee members may serve. Each committee shall keep written minutes of its meetings and forward copies to the Medical Board. The time and place of the meetings shall be determined by the committee chair and members shall be notified in writing no less than three (3) days in advance.

The description, function, and membership of each committee are incorporated by reference in these Bylaws (Appendix 1).

## **ARTICLE XII**

### **IMMUNITY**

Each Staff Member and each applicant for membership to the Hospital Staff shall hold other Staff Members, the Hospital, School and The Mount Sinai Medical Center, their employees, faculty, officers and trustees, harmless and immune from any civil liability arising from any act, communication, report, recommendation or disclosure made in connection with Hospital activities related to:

- A.** Application for Medical Staff Membership;
- B.** Reappointment to Hospital Staff and reevaluation of privileges;
- C.** Any disciplinary action in connection with Medical Staff membership, including hearings and appellate review;
- D.** Medical evaluations;
- E.** Utilization and quality assurance reviews; and
- F.** Other Hospital, Departmental or Medical Board activities.



## **ARTICLE XIII**

### **AMENDMENTS**

Amendments to these Bylaws shall be adopted by the affirmative vote of two-thirds of the members of the Medical Board who are eligible to vote at any meeting of the Medical Board at which a quorum is present.

Voting shall be conducted by secret ballot and written proxies shall be valid for such purposes. Written notification of the proposed amendment shall be sent to all members of the Medical Board not less than seven (7) days before the meeting at which the amendment shall be discussed. The amendment shall be voted on at a meeting immediately following the one at which the amendment was discussed. Amendments shall become effective when approved by the Board of Trustees.

The Bylaws of the Medical Staff shall not conflict with the Bylaws of the Board of Trustees of The Mount Sinai Hospital. Neither the Medical Board nor the governing body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

## **ARTICLE XIV**

### **FREQUENCY OF BYLAWS REVIEW**

These Bylaws, as well as the Hospital Staff Rules and Regulations shall be reviewed in their entirety on a biennial basis.

Amendments may be made concurrently throughout the year as needed in accordance with the procedures set forth in Article XIII.

## ARTICLE XV

### DEFINITIONS

As used herein, the following terms have the subsequent definitions:

- A. AAS:** The “Association of the Attending Staff.” An association of the medical staff at The Mount Sinai Hospital; whose goal is to provide medical staff input to the leadership of the institution.
- B. Board of Trustees:** The Board of Trustees of the Hospital.
- C. Chief Executive Officer:** The President and Chief Executive Officer of The Mount Sinai Medical Center (also referred to as the “CEO”).
- D. Conditions of Appointment:** Those conditions of appointment specified in writing as determined by the Department Chair, approved by the Credentials Committee and agreed by the applicant to the Hospital Staff upon the applicant’s initial appointment to the Hospital Staff.
- E. Department Chair:** The chief of a department in the Hospital.
- F. Dean:** The Dean of the School of Medicine.
- G. Designated Hospital Location (“DHL”):** The location or locations of the Hospital (Manhattan or Queens) at which a Medical Staff member will use the privileges to admit patients or render direct patient care.
- H. Executive Director:** The Executive Director of Mount Sinai Queens.
- I. Faculty:** The faculty of the School of Medicine or a member thereof.
- J. Hospital:** The Mount Sinai Hospital, including its location at One Gustave L. Levy Place, New York, New York (“Mount Sinai-Manhattan”), and its location at 25-10 30<sup>th</sup> Avenue, Long Island City, New York (“Mount Sinai-Queens”).
- K. House Staff:** The Residents and Fellows of the Hospital.
- L. Medical Board:** The governing board of the Medical Staff as described in Article X.
- M. Medical Director:** The Medical Director of the Hospital.
- N. Medical Director – Mount Sinai Queens:** The Medical Director whose principle responsibility is at Mount Sinai Queens.
- O. Mount Sinai Manhattan:** The Manhattan campus of The Mount Sinai Hospital.
- P. Mount Sinai Queens:** The Queens campus of The Mount Sinai Hospital.
- Q. Professional Staff:** The Professional Staff receive an appointment in the Hospital consistent with their faculty title (e.g., Attending Psychologist). Those members who do not have faculty appointments shall be identified by their profession (e.g., Nurse Practitioner).
- R. School of Medicine:** Mount Sinai School.
- S. Staff Member:** Any member of the Medical Staff.
- T. Staff Fellow:** A Staff Fellow is an individual who is enrolled in any House Staff training program; (PGY 4 or above) who has applied for and been granted an Active Medical Staff appointment. (Their appointment must not be in any discipline/specialty for which they are currently being trained.)

**ADOPTION**

**Adopted by the Medical Board of The Mount Sinai Hospital:**

President of the Medical Board:



Signed: \_\_\_\_\_

Date: 7/9/2015

Andy Jagoda, MD

Secretary of the Medical Board:



Signed: \_\_\_\_\_

Date: 7/9/2015

Andrew Leibowitz, MD

**APPROVED BY THE BOARD OF TRUSTEES OF THE MOUNT SINAI HOSPITAL**

Chair of the Board of Trustees:



Signed: \_\_\_\_\_

Date: 7/20/2015

Peter W. May

## APPENDIX 1

### STANDING COMMITTEES OF THE MEDICAL BOARD --

#### THEIR STRUCTURE AND FUNCTIONS

- |  |   |
|--|---|
| A. Administrative Executive Committee                  | L. Nutritional Care Committee   |
| B. Bylaws Committee                                    | M. Pain Management Committee  |
| C. Cancer Committee                                    | N. Pharmacy and Therapeutics Committee  |
| D. Credentials Committee                               | O. Performance Improvement Review & Oversight<br>Committee (PIROC) Manhattan Campus |
| E. Critical Care Committee                             | P. Performance Improvement Committee (PIC) Queens<br>Campus                         |
| F. Emergency Preparedness Committee                    | Q. Radiation Safety Committee   |
| G. Ethics Committee                                    | R. Surgery Committee  |
| H. Infection Control Committee                         | S. Transfusion Committee  |
| I. Laboratory Committee                                | T. Transplant Executive Committee   |
| J. Medical Records Committee                           | U. Novel Procedure Oversight Committee  |
| K. Mount Sinai Queens Clinical Operations<br>Committee | V. Utilization Review Committee   |

The Medical Board shall establish such ad hoc and special committees as it deems necessary and appropriate.

All committees of the Medical Board shall be advisory to the Medical Board and, unless otherwise authorized, shall only be empowered to make recommendations to the Medical Board.

Immediately following election by the Medical Board, the President of the Medical Board shall appoint the committee chairs. Each committee shall have a chair appointed for a term of one (1) year. Committee chairs may serve consecutive terms.

After the President of the Medical Board has appointed the committee chairs, h/she shall then solicit annual input from the appointed chairs as to committee composition. The President of the Medical Board shall then make the final selection of committee members and then notify the members. Committee members shall be appointed for two year terms. Members may serve consecutive terms.

Each committee shall keep written minutes of its meetings. The time and place of the meetings shall be determined by the committee chair and members shall be notified in writing no less than three days in advance. A simple majority of the Active Attending Staff members, but not fewer than two members, shall constitute a quorum for all Standing Committees. The standing committees shall have the following memberships, duties and powers:

## **A. ADMINISTRATIVE EXECUTIVE COMMITTEE OF THE MEDICAL BOARD (AEC)**

Duties and Responsibilities: The Administrative Committee of the Medical Board (AEC) shall meet at least once a month. Its duties and responsibilities include, but are not limited to:

1. Preparing the agenda for the meetings of the Medical Board
2. Developing background material on important issues
3. Preparing solutions and alternatives to problems and recommending a course of action to the Medical Board
4. Following up as needed on actions taken by the Medical Board
5. Instructing standing committees, subcommittees and ad hoc committees, receiving their reports, and forwarding material to the Medical Board for information and/or action as appropriate
6. Review and forward to the Medical Board any issues identified by the Association of the Attending Staff (AAS)
7. Act on behalf of the Medical Board in the months the Medical Board does not meet
8. The organized medical staff are represented on the Medical Board by six (6) members elected from the members of the AAS, and on the AEC, by the President of the AAS.

Members shall include:

- a. President, Medical Board (*The President of the Medical Board or his/her designee shall Chair the AEC*)
  - b. Vice President, Medical Board
  - c. Secretary, Medical Board
  - d. Medical Director, Manhattan
  - e. Medical Director, Mount Sinai-Queens
  - f. Department Chair (elected by the Department Chairs)
  - g. Chair, Credentials Committee
  - h. Chair, Quality and Patient Safety Committee
  - i. President of AAS
  - j. Legal Department
  - k. Chief Resident representative
  - l. Immediate Past President of the Medical Board
9. Conflict Resolution:
- Any member of the organized medical staff may bring issues regarding Bylaws, Rules and Regulations, and relevant policies to the attention of the President of the Association of the Attending Staff (AAS), and the President of the Medical Board will facilitate conflict resolution processes that are appropriate to the issue(s) being raised.

## **B. BYLAWS COMMITTEE**

1. Membership shall include but is not limited to:
  - a. Medical Director or designee
  - b. Representative from the Legal Department
  - c. Representative of the Medical Staff
  - d. Secretary of the Medical Board
2. Duties and Responsibilities:
  - a. Conduct a biennial review of the Bylaws and recommend amendments as necessary
  - b. To reflect the Hospital's current practice with respect to the Medical Staff organization and functions
  - c. Consider proposed revisions to the Bylaws between the biennial reviews
  - d. Present proposed revisions and amendments to the Medical Board for review and approval
  - e. The Bylaws Committee shall meet as necessary.

## **C. CANCER COMMITTEE**

1. Membership. The Cancer Committee shall consist of the Cancer Center Director, who shall be the Chair, and at least one representative each from the Departments of Medicine, Pathology, Radiation Oncology, Surgery, Gynecologic Oncology, Pediatric Oncology, Hematology/Oncology, Administration, Nursing and Social Work Services. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities:
  - a. Review and make recommendations to the Medical Board on all aspects of cancer care and investigations conducted in the Hospital
  - b. Meet at least quarterly.

## **D. CREDENTIALS COMMITTEE**

1. Membership. Membership shall include, at a minimum, representatives of the Departments of Medicine, Ob/Gyn, Pediatrics, Surgery, Radiology and Emergency Medicine, but at a minimum be no less than 12 members. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Credentials Committee shall:
  - a. Be responsible for evaluating applications to the Hospital Staff for initial appointments, reappointments, privileges, promotions and terminations, and for issuing recommendations to the Medical Board
  - b. Develop procedures and guidelines to facilitate the credentialing system, to coordinate the Hospital and departmental components to the system and to maintain a consistently high level of competence across the institution
  - c. Meet at least ten times per year.

## **E. CRITICAL CARE COMMITTEE**

1. Membership. The Critical Care Committee shall consist of the Medical Director (or his/her designee) and the nurse manager of all adult, pediatric and neonatologic units at Mount Sinai. These units include: CCU, MICU, NICU, PACU, PICU and SICU. Due to the special nature of the

CSICU and NSICU, both a surgeon and a critical care specialist in addition to the nurse manager shall represent each of these two units. In addition, the representatives from Directors of Medicine, and Cardiovascular Services, Oncology, Neuroscience, Surgical Services and Maternal-Child Care Services, the Director of Infection Control, a representative of the Department of Pharmacy and a representative of Support Services shall be members. The Medical Board President, Medical Director and Chief Operating Officer shall be members ex-officio of this committee.

2. Duties and Responsibilities. The Critical Care Committee shall oversee the appropriateness and utilization of critical care services provided by Mount Sinai by:
  - a. Maintaining an overview of the quality and effectiveness of critical care delivery throughout the Hospital
  - b. Maintaining an overview of the utilization and coordination of critical care resources by the medical staff and recommending standards as appropriate to ensure consistency and cost-effectiveness in critical care practices throughout the Hospital
  - c. Maintaining an overview of the implementation of the 'Intensive Care Unit Bed Management Policy' of the Medical Board and appropriateness of the use of critical care and intermediate services
  - d. Proposing to the Medical Board changes in the scope of services, protocols, and standards, making recommendations regarding the acquisition of new technology in the field of critical care, and ensuring that credentialing criteria for physicians and other personnel providing critical care services are consistent with Joint Commission and other professional standards
  - e. Reviewing reports by the directors of the different critical care units on the state of their activities and responding to the needs of these directors for advice on the direction and operation of these different critical care units
3. Internal Organization. The Critical Care Committee shall elect among its members a team made of a critical care specialist and a nurse manager to function as co-chairs. Subcommittees and ad-hoc working groups shall be constituted from committee and non-committee members as appropriate to address specific tasks.
4. The Critical Care Committee shall meet once a month and at any other time when circumstances warrant such meetings. Minutes shall be kept of the committee meetings.

#### **F. EMERGENCY PREPAREDNESS COMMITTEE**

1. Membership. The Emergency Preparedness Committee shall consist of an Emergency Room physician, who shall be chair, and at least seven members of the Active Medical Staff and others from various departments, among whom shall be one representative from Engineering, Nursing and Security. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Emergency Preparedness Committee shall:
  - a. Develop and keep a current plan for the handling of disasters, both internal and external
  - b. Be responsible for carrying out drills periodically
  - c. Meet at least twice a year.

#### **G. ETHICS COMMITTEE**



1. Membership. The Ethics Committee shall consist of a Chair appointed by the Executive Committee of the Medical Board and at least 25 members: with at least one member from each of the Departments of Medicine, Obstetrics, Gynecology and Reproductive Sciences, Medical Genetics and Genomics, Pediatrics, Psychiatry and Surgery, five other physicians, and at least one nurse, one social worker, a patient representative, a member of the Legal Department and a medical ethicist. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Ethics Committee shall:
  - a. Review and make recommendations to the Medical Board on ethics-related policies and procedures
  - b. Conduct formal reviews of specific patient-related ethical issues at the request of healthcare providers. These reviews shall be conducted by a subcommittee of the Committee selected by the chair or the chair's designee and comprised of three or more members, at least three of whom must be Ethics Committee members, one of whom must be a physician
  - c. Provide consultations by one or more Committee members on ethics-related issues, as appropriate
  - d. Develop education and other programs on ethics-related issues
  - e. Meet as a full Committee no less than once a year, or as often as necessary.

#### **H. INFECTION CONTROL COMMITTEE**

1. Membership. The Infection Control Committee shall consist of a senior member of an Infectious Disease Service, who shall be the Chair, and at least six members of the Active Medical Staff, and one representative each from administration, Microbiology, Nursing and Pharmacy. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Infection Control Committee shall:
  - a. Devise and recommend to the Medical Board measures for reporting, analyzing, and controlling infections throughout the Hospital
  - b. Institute any appropriate control measure or studies when there is reasonably considered to be a danger to any patient or personnel
  - c. Establish appropriate mechanisms to monitor the incidence of infections as required by the Hospital's Quality Assurance Plan
  - d. Meet at least eight times per year.

#### **I. LABORATORY COMMITTEE**

1. Membership. The Chair of the Committee shall be appointed by the President of the Medical Board. The Laboratory Committee shall consist of at least one representative of the Departments of Medicine, Surgery, Pediatrics, Obstetrics & Gynecology; representatives of 2 other clinical departments; one representative from Hospital Ambulatory Care Services; and representatives from Nursing and House Staff. The Director of the Center for Clinical Laboratories, a representative of The Mount Sinai administration Pharmacy, and the Medical Board President and Medical Director shall each be ex-officio, nonvoting members. The Directors of the principal laboratories of The Mount Sinai Hospital shall be invited to meetings of the Laboratory Committee at the call of the Chair.

2. Duties and Responsibilities. The Laboratory Committee shall represent the views of the practicing professions of The Mount Sinai Hospital to the providers of Laboratory services in the institution by:
  - a. Maintaining an overview of the quality and effectiveness of the laboratory operations;
  - b. Maintaining an overview of the utilization of laboratories by the medical staff
  - c. Proposing to the Medical Board and the Center for Clinical Laboratories changes in the scope of services and menu of tests, turnaround times, specimen collection and transport, test reporting routines and all other activities which may impact the quality of care
  - d. Reviewing periodically reports by the Director of the Center for Clinical Laboratories on the state of laboratory operations and respond to the Director's needs for advice on the direction and operation of the laboratories
  - e. Meet four times a year.

#### **J. MEDICAL RECORDS COMMITTEE**

1. Membership. The Medical Records Committee shall consist of at least five members of the Active Medical Staff, the Director of Medical Records, and one representative each from Nursing, Quality Assurance, Risk Management, Regulatory Affairs, and Social Work Services. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Medical Records Committee shall:
  - a. Monitor and evaluate the quality and adequacy of the medical record
  - b. Develop and recommend criteria for the standardization and completion of medical records, consistent with enhancing patient care
  - c. Establish appropriate mechanisms to monitor the quality of the medical record
  - d. Develop education programs for House Staff and Attending staff specific to patient records and documentation requirements
  - e. Recommend to the Hospital President sanctions or suspensions of Medical Staff who fail to comply with established medical records rules and regulations
  - f. Develop and implement policies to protect patient confidentiality without compromising the institution's ability to provide quality, timely patient care
  - g. Meet at least nine times per year.

#### **K. MOUNT SINAI QUEENS CLINICAL OPERATIONS COMMITTEE**

1. Membership. The Mount Sinai Queens Clinical Operations Committee shall be comprised primarily of physicians whose DHL is Mount Sinai Queens. Members shall include the following: a Chair of the committee, who shall be appointed by the President of the Medical Board following nomination by the Mount Sinai Queens Clinical Operations Committee; the Mount Sinai Queens Representatives (as defined in Article X-F hereof); the Medical Director at the Mount Sinai Queens campus; the Chiefs of Service of the Departments of Medicine, Surgery, Laboratory and Pathology, Anesthesiology, Radiology, and Emergency Medicine at the Mount Sinai Queens campus; one additional representative of the Department of Surgery whose DHL is Mount Sinai Queens, who shall be appointed by the Chief of Service of the Department of Surgery at the Mount Sinai Queens campus (this appointment shall be for one year, at the end of which, the member may be reappointed); one additional representative of the Department of Medicine whose DHL is Mount Sinai Queens who shall be appointed by the Chief of Service of the Department of Medicine at the Mount Sinai Queens campus (this appointment shall be

for one year, at the end of which the member maybe reappointed); the Vice President of Nursing at the Mount Sinai Queens campus; up to 10 Members of the Medical Staff whose DHL is Mount Sinai Queens who shall be appointed by the Medical Director at the Mount Sinai Queens (these appointments shall be for one year, at the end of which, these members may be reappointed; the immediate past Chair of the Mount Sinai Queens Medical Board; the Executive Director of Mount Sinai Queens; and the Chief Operating Officer of Mount Sinai Queens. The Mount Sinai Queens Clinical Operations Committee Chairperson and the Mount Sinai Queens Medical Director shall each be ex-officio members of the MSH Medical Board.

2. Duties and Responsibilities. The Mount Sinai Queens Clinical Operations Committee shall:
  - a. Perform such duties and functions in connection with the clinical operations of the Mount Sinai Queens campus under the auspices of the Medical Board. In performing such duties and functions, the committee shall be under the authority of the Medical Board and must report back to the Medical Board
  - b. Hold a minimum of ten monthly meetings, special meetings may be called at any time by the Chair.

#### **L. NUTRITIONAL CARE COMMITTEE**

1. Membership. The Nutritional Care Committee shall consist of at least six members of the Active Medical Staff, the Director of Food Service, and one representative each from Administration, Nursing and Pharmacy. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Nutritional Care Committee shall:
  - a. Function as an interdisciplinary team to review nutritional services, including nutritional assessment, to various departments in the delivery of nutritional care
  - b. Review the care provided to patients on special nutritional therapy, particularly hyperalimentation, and make appropriate recommendations if necessary
  - c. Assist in the development of educational program for Medical Center personnel and for outside organizations
  - d. Establish appropriate mechanisms to monitor nutritional care as required by the Hospital's Quality Assessment and Improvement Plan
  - e. Meet at least six times per year.

#### **M. PAIN MANAGEMENT COMMITTEE**

1. Membership. Co-Chairs shall be the Director of the Department of Anesthesiology and the Chief Nursing Officer. Other members shall be from Nursing Surgical Units and Nursing Administration, Pediatrics, Geriatrics, Palliative Care, Anesthesiology Pain Management, Hospitalist Service, Surgery, Pharmacy, Information Technology, and Quality Assessment and Improvement. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Pain Management Committee shall:
  - a. Oversee all computerized physician order entry sets (e.g., TDS) for parenteral opioids
  - b. Achieve consistency in nursing practices for parenteral opioid administration on patient floors

- c. Create conditions to promote improved pain relief and related patient satisfaction as measured by standard methods
- d. Monitor pain treatment-related adverse events and intervene to decrease their incidence
- e. Develop pilot programs and introduce more effective pain management practices; and
- f. Promote ethnic and cultural sensitivity in pain management
- g. Create policies and procedures to implement the operational changes required to fulfill its responsibilities
- h. Provide recognition to individuals and units that excel in pain management.
- i. Meet 10 times per year

#### **N. PHARMACY AND THERAPEUTICS COMMITTEE**

1. Membership. The Pharmacy and Therapeutics Committee shall consist of at least ten members of the Active Medical Staff, the Director of Pharmacy, a representative from Administration, and a representative from Nursing. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Pharmacy and Therapeutics Committee shall:
  - a. Review and approve changes to the Hospital formulary;
  - b. Develop programs and assure appropriate utilization of pharmaceuticals and make recommendations to the Medical Board;
  - c. Establish appropriate mechanisms to monitor the quality of Pharmacy and Therapeutic services as required by the Hospital's Quality Assurance Plan;
  - d. Review all significant untoward drug reactions;
  - e. Review the appropriateness, safety and effectiveness of drugs used in the Hospital;
  - f. Meet at least eight times per year.

#### **O. PERFORMANCE IMPROVEMENT REVIEW & OVERSIGHT COMMITTEE (PIROC) MANHATTAN CAMPUS**

1. Membership. A senior member of the Attending Staff who is appointed by the Medical Board shall serve as Chair; at least 10 members of the Medical Staff who also serve as Departmental Representatives for clinical quality; Chairpersons of the multidisciplinary Quality Improvement Committee as well as appointees from hospital core and support departments.
2. Duties and Responsibilities. The Performance Improvement Review & Oversight Committee is the hospital-wide committee that oversees the quality improvement activities of the clinical, core, support departments and multidisciplinary committees. PIROC assures the ongoing monitoring, measurement and evaluation of high risk processes and the development and implementation of performance improvement strategies designed to enhance patient care and bring value to patient care processes. PIROC provides a venue for the enrichment of performance improvement strategies and uses trends to make recommendations to the Medical Board and the Quality Committee of the Board of Trustees and Clinical Departments regarding cross-functional performance improvement initiatives. Recommendations are made to the Medical Board as needed. The Committee shall:
  - a. Receive, review, and evaluate reports regarding the effectiveness of organization-wide performance improvement activities
  - b. Recommend prioritization of performance measurement and improvement teams

- c. Coordinate the re-prioritization of projects with Senior Administrative leadership in response to changes in the internal or external environment
- d. Recommend to Senior Administrative leadership the need to support required human and/or financial resources to accomplish the performance improvement function. If an opportunity for improvement involves a staff/provider competency issue, the resolution is addressed through appropriate Administrative or Medical Staff department channels
- e. Meet at least eight times per year.

**P. PERFORMANCE IMPROVEMENT COMMITTEE (PIC) QUEENS CAMPUS**

1. Membership. A chair of the Committee, who shall be appointed by the President of the Medical Board following nomination by the Mount Sinai Queens Performance Improvement Committee; at least 4 members of the Medical Staff who also serve as Departmental Representatives for clinical quality; Chairpersons of the multidisciplinary Quality Improvement Committee as well as appointees from hospital core and support departments.
2. Duties and Responsibilities. The Performance Improvement Committee is the hospital-wide committee that oversees the quality improvement activities of the clinical, core, support departments and multidisciplinary committees. PIC assures the ongoing monitoring, measurement and evaluation of high risk processes and the development and implementation of performance improvement strategies designed to enhance patient care and bring value to patient care processes. PIC provides a venue for the enrichment performance improvement strategies and uses trends to make recommendations to the Medical Board and the Quality Committee of the Board of Trustees and Clinical Departments regarding cross-functional performance improvement initiatives. Recommendations are made to the Medical Board as needed. The PIC Committee shall:
  - a. Receive, review, and evaluate reports regarding the effectiveness of organization-wide performance improvement activities
  - b. Recommend prioritization of performance measurement and improvement teams
  - c. Coordinate the re-prioritization of projects with Senior Administrative leadership in response to changes in the internal or external environment
  - d. Recommend to Senior Administrative leadership the need to support required human and/or financial resources to accomplish the performance improvement function. If an opportunity for improvement involves a staff/provider competency issue, the resolution is addressed through appropriate Administrative or Medical Staff department channels
  - e. Meet at least eight times per year.

**Q. RADIATION SAFETY COMMITTEE**

1. Membership. The Radioisotopes Authorization and Radiation Safety Committee shall consist of the Radiation Safety Hematology, Surgery, Laboratories, Dentistry, Institutional Safety, Security, Endocrinology and Administration. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Radiation Authorization and Radiation Safety Committee shall:
  - a. Review radiation protection problems in clinical and research work with all sources of ionizing radiation, and make appropriate recommendations
  - b. Perform all functions of a Medical Isotope Committee as required by the Atomic Energy Commission

- c. Meet at least twice per year.

## **R. SURGERY COMMITTEE**

1. Membership. The Surgery Committee shall consist of the Chairs of the Departments of Surgery and Anesthesiology, who shall be co-chairs, at least one member of all surgical departments and divisions, and at least one representative of Nursing Administration. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Surgery Committee shall consider all matters which are of common interest to General Surgery and the surgical specialties and make recommendations to the Medical Board. The Surgery Committee may use a committee structure to carry out its duties, and may form an Executive Committee and other committees as required. Responsibilities include:
  - a. Evaluate and standardize new products and equipment;
  - b. Evaluate new approaches to surgical and peri-operative care and make recommendations relative to efficacy and competency requirements
  - c. Determine, as appropriate, those procedures which may be performed in an ambulatory setting
  - d. Oversee the quality of efficiency of care provided in the peri-operative setting
  - e. Meet at least four times per year.

## **S. TRANSFUSION COMMITTEE**

1. Membership. The Transfusion Committee shall consist of the Director of the Blood Bank who shall be chair, the Director of the Hematology Laboratory and at least one representative each from Administration, Anesthesiology, Hematology, Medicine, Nursing, Pediatrics and Surgery. The Medical Board President and Medical Director shall each be ex-officio members.
2. Duties and Responsibilities. The Transfusion Committee shall:
  - a. Review the number of transfusions, including number and type of components transfused, number of compatibility tests, and number of units outdated or otherwise discarded
  - b. Review all adverse patient reactions attributed to transfusion of donor blood, blood components or blood derivatives, including suspected disease transmission
  - c. Review the results of proficiency testing, peer review and inspections by governmental or private accreditation agencies
  - d. Establish guidelines relative to antilugous transfusions and directed transfusions
  - e. Establish mechanisms to monitor the of blood utilization as required by the Hospital's Quality Assurance Plan
  - f. Establish guidelines for:
    - (i) Reservation (cross match) of blood for each elective surgical procedure which has been performed at the Hospital more than five times in the preceding calendar year and fix the number of hours that cross matched blood will be held on reserve;
    - (ii) Reservation and utilization of devascularized tissue for implantation
    - (iii) Proper receiving and storage of said tissue per State and Federal guidelines
    - (iv) Monitoring the appropriateness of tests performed on all tissue prior to implantation and reviewing all adverse patient reactions attributed to implantation of this tissue and suspected disease transmission.

- g.** Meet at least four times per year.

#### **T. TRANSPLANT EXECUTIVE COMMITTEE**

- 1.** Membership. The Transplant Executive Committee shall consist of one representative from each of the Departments of Medicine, Surgery, Cardiothoracic Surgery, Pediatrics, Radiology, Cardiology/Heart Hospital, Nursing, Hospital Operations, Hospital Finance, Hospital Administration, FPA Administration, Operating Room, Dean's Office, and the VP for Quality. The Medical Board President and Medical Director shall each be ex-officio members.
- 2.** Duties and Responsibilities. The Transplant Executive Committee shall oversee the appropriateness and quality of solid organ transplantation services provided in Mount Sinai:
  - a.** Maintain an overview of the quality and effectiveness of transplantation operations and services throughout the Medical Center
  - b.** Maintain an overview of the utilization of services by the medical staff and recommending standards as appropriate to ensure consistency and cost-effectiveness in practices
  - c.** Propose to the Medical Board changes in the scope of services; protocols and standards for specific types of services; recommendations regarding the acquisition of technology or resources; and ensuring that credentialing criteria for physicians and personnel performing procedures are consistent with Joint Commission, UNOS/OPTN, CMS, DOH and other professional standards
  - d.** Review reports by the Directors of the various organ transplant programs on the state of operations and responding to the Directors' needs for advice on the direction and operation of various services
  - e.** Meet at least four times per year.

#### **U. NOVEL PROCEDURE OVERSIGHT COMMITTEE**

- 1.** Membership. The Novel Procedure Oversight Committee shall consist of the following individuals or their designees:
  - a.** A chair of the committee to be appointed by the President of the Medical Board;
  - b.** A Hospital vice-president appointed by the Hospital President;
  - c.** A Hospital financial officer appointed by the Chief Financial Officer;
  - d.** A compliance expert appointed by the Chief Compliance Officer;
  - e.** The chairperson of the Institutional Review Board;
  - f.** The Chief Medical Officer;
  - g.** The Senior Director for Nursing Practice;
  - h.** The chairperson of Surgery;
  - i.** The director of the Catheterization Laboratory;
  - j.** The director of Gastrointestinal Endoscopy;
  - k.** The director of Interventional Radiology;
  - l.** The chairperson of Medicine; and
  - m.** The President of the Association of the Attending Staff.
- 2.** Powers and Duties. The Novel Procedure Oversight Committee shall:

- a. Review all new invasive procedures and techniques that involve novel equipment, innovative therapeutic approaches to existing procedures, and those being performed in new locations.
- b. Review and advise concerning training, education, and experience that will be required in the processes of credentialing and granting privileges.
- c. Review and advise regarding issues that are operational, financial, conflicts of interest, and regulatory compliance. (e.g., need for investigational device exemption)
- d. Review and advise related to matters of appropriate informed consent.
- e. Determine when novel procedures require review by the Institutional Review Board.
- f. Advise regarding the need to create educational/aftercare plans for Nursing and others.
- g. Meet on a regular basis and keep minutes for presentation at the next scheduled Medical Board meeting.

## **V. UTILIZATION REVIEW COMMITTEE**

1. Membership. The Medical Director of Utilization Management, Chief Physician Advisor shall serve as Chair. The UR Committee shall consist of at least two physician representatives from clinical departments and representation from the following departments: Medicine, Emergency Department, Nursing, Health Information Management, Finance, Hospital Administration, Compliance, Admitting, Case Management, Social Work, and Quality. Upon invitation from the Chair, other representatives of the Hospital or Medical Staff may sit in on the meetings.
2. Duties and Responsibilities. The Utilization Review Committee shall:
  - a. Reviews and makes recommendations relative to the appropriate utilization of the hospital's facilities, services and resources. The program is an integral part of the hospital's ongoing effort to promote and maintain quality patient care through analysis, review and evaluation of clinical practice. The Committee assures that the elements contained in the hospital's Utilization Management Plan are appropriately carried out. Referrals as appropriate are made to other bodies (e.g. Department Chair, Medical Board).
  - b. Meet at least 10 times per year.



## APPENDIX 2

### MEDICAL STAFF CREDENTIALING POLICY

Revision Approved by the Board of Trustees 3/16/2015

#### **CREDENTIALING POLICY OVERVIEW**

The Mount Sinai Hospital has established policy guidelines for credentialing and re-credentialing providers of patient care services at this institution. These guidelines ensure that physicians/dentists/podiatrists (MD, DO, DMD, DDS, DPM) and other health care practitioners (nurse practitioners, nurse midwives, psychologists, physician assistants, optometrists, and certified registered nurse anesthetists contracted to serve our patients) will meet uniform standards of education, specific training and experience, current competence and ability to perform the privileges assigned to them.

The policies and procedures delineated below have been established by the Medical Board in accordance with all applicable regulatory and accreditation standards, such as the Medical Staff Bylaws, the New York State Department of Health, and the Joint Commission. The Medical Board will review changes to this policy.

Healthcare practitioners will be recruited based on the need for their services in concert with the needs and objectives of the institution without regard to race, color, creed, religion, national origin, age, gender, marital status, military status, disability, citizenship, genetic predisposition, being a victim of spousal abuse, sexual preference, or any other characteristic protected by law.

#### **CREDENTIALING PROCEDURE**

Standards for Participation (see Article III (B) of the Medical Staff Bylaws)

- (a) All applicants shall submit a completed medical staff application form with appropriate documentation as requested on the application form. This includes signed statements and a release of information page.
- (b) All applicants shall allow for review of their records and medical record keeping practices, in their offices, as designated by the Bylaws and Rules and Regulations of the medical staff and the facility.
- (c) All applicants must be fully licensed and currently registered (or certified) in New York State.
- (d) All applicants should have a current unrestricted DEA registration, if applicable to their specialty and practice.
- (e) All applicants enrolled in Medicare and/or Medicaid must be free of any sanctions imposed by Medicare or Medicaid or other governmental health related program to remain on the Medical Staff.
- (f) All applicants will have at least the minimum professional malpractice insurance with limits as defined by the Mount Sinai Board of Trustees and any other hospital requirement.

- (g) All applicants will submit a complete work history (CV), chronologically outlined from graduation to the present, with any gaps in work/training explained
- (h) All applicants will provide, on their completed application, a full disclosure of all malpractice history, including any cases that have come or are coming before the applicable state board where the applicant has practiced, as well as disclosure of any outstanding claims.
- (i) All applicants agree to be interviewed by a sub-committee of the Credentials Committee as needed based on disclosed and/or non-disclosed information discovered during the application process.
- (j) Granting of Disaster Emergency Privileges: See *Mount Sinai Hospital Emergency Management Manual* and Medical Staff Services Policy *Granting of Emergency Privileges on Activation of the Emergency Management Plan*.

## **CREDENTIALING/RE-CREDENTIALING CRITERIA**

The following information will be reviewed/queried at the time of appointment or reappointment.

<b>Credential</b>	<b>Source</b>	<b>Method</b>	<b>Periodicity</b>
Licensure	NYS Education Dept	Query NYSDOH website	Upon application, reappointment, increase in privileges & date of expiration
DEA	DEA diversion website	Query DEA diversion website/copy of original	Upon application, reappointment & date of expiration
Education – graduate of medical/dental or other professional school	Medical/Dental professional school registrar/AMA physician profile/ECFMG	Direct query to school registrar/AMA or online to ECFMG	Upon application
Post-graduate training	Resident and/or fellowship program director	Direct query to institution/AMA	Upon application & reappointment if applicable
Board certification	Board certified doctors website  “Certifacts”	Internet query	Upon application, reappointment, increase in privileges & date of expiration
Malpractice Insurance	Approved Insurance company	Copy of insurance certificate/certificate holder status	Upon application, reappointment & date of expiration
Claims History	National Practitioner Databank (NPDB)	Electronic query	Upon application, reappointment, increase in privileges
Licensure Sanctions	NYS Office of Professional Medical Conduct	Internet query  (ongoing via e-mail with Office Of Professional Medical Conduct)	Upon application, reappointment & increase in privileges
Malpractice History	Application, NPDB, 2805k responses	NPDB/2805k letters/insurance carrier	Upon application, reappointment & increase in privileges
Hospital clinical privileges	Application & hospital	2805k letter query	Upon application & reappointment
Work history gaps	Application and/or CV	Direct query from source/explanation from applicant	Upon application
Attestation regarding health status	Health form with application	Maintained in PHI file	Upon application & yearly date of expiration
Medicare & Medicaid Sanctions	NPDB & OIG databases  & Internet Opt Out site	Electronic query	Upon application, reappointment, increase in privileges & quarterly
Infection Control Certification	NYS approved course certificate	Copy of certificate	Upon application & date of expiration
Criminal Background Check	Background check service	Internet query	Upon application
Ongoing Professional Practice Evaluation (OPPE)	Department Chairs or Designee	Data Reports, Peer or Benchmark Comparative Data	Every six months

All applications for medical staff privileges will be completed within 180 days of receipt of the application by Medical Staff Services. In rare cases, if the application is not completed within 180 days, the applicant will be asked to attest that nothing in their clinical practice has changed, or if there have been changes to indicate such changes. The applicant will review his/her request for privileges and indicate that there are no changes. All applicants must be willing to meet with the Credentials Committee when requested and must agree to utilize The Mount Sinai e-mail.

### **CONFLICTING INFORMATION/INFORMATION REVIEW BY PRACTITIONER**

The practitioner will be sent a letter or e-mail at the time the application is received in the Medical Staff Office advising him/her that the application has been received and what is missing. The aforementioned letter will also state that, upon request, the applicant will be advised of the status of their application by telephone or by e-mail. The practitioner can request to review the application, with the exception of protected material. This would include any peer review/reference letters or any document which has been submitted to the medical staff office as a result of a query and the National Practitioner Data Bank response.

The practitioner will be notified via mail, email or phone call if primary source verification data is not in agreement with information submitted in the appointment application package. The practitioner will have two weeks to correct this information with an explanation. All corrected information must be primary source verified. Corrected information shall be submitted in writing, via fax, email or mail, to the Medical Staff Services Department. The practitioner will be notified in writing, via fax, email or letter, when the corrected information has been received.

### **LEVELS OF REVIEW**

The Mount Sinai Hospital Medical Staff Bylaws ((Article X (D.6)) describe the credentialing review process. When the Medical Staff Services Department has determined that the application is complete, it will be forwarded to the departmental chair. The recommendation for appointment or non-appointment from the departmental chair or his/her designee is then forwarded to the Credentials Committee for review. The recommendations by the Credentials Committee will be submitted to the Medical Board for approval. Final approval will be granted by the Board of Trustees. Once the Board of Trustees grants approval, the applicant will be sent a letter of appointment. Within the first six months of initial appointment, the individual's activity is evaluated by the department chair or his/her designee (FPPE).

### **REAPPOINTMENT (Article III B (3,4))**

There is a process in place to reappoint each practitioner on the staff every **two** years. The practitioner receives notification of his/her reappointment. S/he is expected to sign off on the reappointment application that contains, among other things, a request for updated physical and mental health status, and a signature attesting to lack of impairment due to chemical dependency/substance abuse. The practitioner's file will first be reviewed in the Medical Staff Services Department for primary source verification (see table above). Additionally, education, training, experiences and competencies since the last appointment or reappointment are reviewed and, if applicable, primary source verification is

done. A checklist will be used to indicate the date information was received in the Medical Staff Services Department. Medical Staff Services will also utilize a checklist to indicate the date all required items were verified to be current and in good standing. A date stamp will be used on all incoming mail. Documents received via fax will automatically have a date and time printed on them from the fax machine. A reappointment file is only submitted to the Credentials Committee after quality assurance data, peer evaluations, OPPE and other materials relevant to the reappointment process are collected. Each Department is required to comply with the Ongoing Professional Practice Evaluation (OPPE) Policy of the hospital. The file then goes through the same levels of review as is described above for the appointment process. Once the governing body grants approval, the applicant will be sent a letter of reappointment.

### **REDUCING, SUSPENDING, TERMINATING PRIVILEGES**

The mechanism for reducing, suspending or terminating practitioner privileges is described in detail in the Medical Staff Bylaws. It describes the appeal process for use by the practitioner. The Mount Sinai Hospital reports the reduction, suspension or termination of practitioner privileges to the appropriate outside agencies in accordance with applicable law and accreditation standards.

### **CONFIDENTIALITY POLICY FOR THE MEDICAL STAFF SERVICES DEPARTMENT**

#### **1. CONTENT OF FILES**

The entire contents of the appointment and reappointment files will be maintained as noted below under Archives.

All current licensures, DEA registration and verifications, and malpractice insurance will be kept in the file.

#### **2. ACCESS TO FILES**

The Director of Medical Staff Services Department will determine who has access to credential files. Personal ID and passwords allow entry by designated staff to the computer databases within the Department. If an employee leaves, their password is deleted. Personnel are told during their orientation and HIPAA training about the importance of file confidentiality.

The Medical Staff office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except for major holidays. The office, if unattended, is securely locked.

The following individuals may have general access to individual credential files when a request is made of Medical Staff Services: President of the Hospital; General Counsel; Medical Director; Director of Quality Improvement; Director of Compliance and Risk

Management. Department Chairs will have access to the files of members of their department.

A practitioner has the right to review his/her credentialing file. (See page 2 "Conflicting Information/Information Review By Practitioner") with the exception of protected material. Health information is kept in Employee Health Services.

Requests for review by a practitioner of his/her own file will be considered on a case by case basis, with the approval from one of the following: President of the Hospital, General Counsel Chief Medical Officer; Department Chair, Director of Quality Improvement and Risk Management.

### **3. ARCHIVES**

When practitioners leave The Mount Sinai Hospital, their files are removed and sent to the Hospital's storage facility. The Hospital keeps all files (including House Staff) from the time they are stored plus 20 years.

#### **DATA VERIFICATION**

All licensure information will be primary source verified either through the respective medical board or AMA data via the Medical Staff Service's database.

The Office Of Professional Medical Conduct will be primary source verified for license sanctions at appointment, reappointment and licensure expiration and whenever received via email notifications.

Office of Inspector General (OIG) exclusions will be reviewed via the OIG database at the time of appointment and reappointment.

#### **ACTION ON ADVERSE INFORMATION**

Any adverse information obtained from the above mentioned sources (license revocation, suspension, revocation, restriction, probation, loss of Medicare/Medicaid provider status, failure to comply with DOH mandated requirements, loss of malpractice insurance) is **immediately** referred to the Departmental Chair, the Medical Director, the Credentials Committee, the Medical Board, and the Board of Trustees. The procedure for review and action on adverse information received from these sources adheres to the procedures set forth in The Mount Sinai Hospital Medical Staff Bylaws.

#### **ONGOING MONITORING**

Patient/visitor complaints within the hospital, adverse events and/or quality issues regarding a practitioner, will be reviewed in accordance with the Medical Staff Bylaws, Rules and Regulations and Performance Improvement Plan.

