HOSPITAL

BOARD OF TRUSTEES -- OPEN SESSION AGENDA
January 29, 2021 @ 9:00 AM
https://hsc-unm.zoom.us/j/91097014217 / Passcode: 219330
Meeting ID: 910 9701 4217 / Passcode: 219330
1-346-248-7799 / 910 970 142 17#,,,,*219330# US (Houston)
1-669-900-6833 / 910 970 142 17#,,,,*219330# US (San Jose)

I. CALL TO ORDER – Mr. Terry Horn, Chair, UNM Hospital Board of Trustees

II. ANNOUNCEMENTS (Informational – 5 Minutes)
- Welcome – Dr. Nathan Boyd, Chief of Staff – Mrs. Kate Becker, UNM Hospital CEO

III. ADOPTION OF AGENDA (Approval/Action - 5 Minutes)

IV. CONSENT ITEMS – Mrs. Bonnie White, UNM Hospital CFO (Approval/Action - 10 Minutes)
- Disposition of Assets
- Medical Equipment Consultant ($2,347,325)
- 1209 University Clinic – DOH Licensing ($1,265,000)
- 2400 Tucker Clinic – DOH Licensing ($2,500,000)
- Phase III New UNM Hospital Tower ($365,000,000)
- Crisis Triage ($1,300,000)
- Uptown Clinic Lease ($193,600)

V. PUBLIC INPUT (Informational)

VI. APPROVAL OF THE MINUTES
- November 20, 2020 UNMH Board of Trustees Meeting Minutes – Mr. Terry Horn, Chair **(Approval/Action – 5 Minutes)**

VII. MISSION MOMENT – Employee Well-Being / Peer Support Program (Kate Becker to Introduce Steve Nuanez**) (Informational – 10 Minutes)**

VIII. CLOSED SESSION: Vote to close the meeting and to proceed in Closed Session (Approval/Action – Roll Call Vote)

a. Discussion of limited personnel matters pursuant to Section 10-15-1.H (2), NMSA pertaining to the appointment and reappointment of medical providers to the medical staff of UNM Hospital and expansion of medical staff privileges for certain UNM Hospital medical staff providers, including the discussion of matters deemed confidential under the New Mexico Review Organization Immunity Act, Sections 41-9-1E(7) and 41-9-5, NMSA.

b. After discussion and determination where appropriate, of limited personnel matters per Section 10-15-1.H (2); and discussion and determination, where appropriate of matters subject to the attorney-client privilege regarding pending or threatened litigation in which UNMH is or may become a participant, pursuant to Section 10-15-1.H (7); and discussion of matters involving strategic and long-range business plans or trade secrets of UNMH pursuant to Section 10-15-1.H (9), NMSA, the Board certified that no other items were discussed, nor were actions taken.

RECONVENE OPEN SESSION

IX. BOARD INITIATIVES
- Carrie Tingley Hospital (CTH) – Mrs. Doris Tinagero, Executive Director CTH & Peds Ambulatory **(Approval/Action – 5 Minutes)**
  - Approval of Mary Cotruzzola as CTH Foundation Advisory Board Community Member
- Redesigned UNM Hospital Medical Staff Bylaws – Dr. Nathan Boyd **(Approval/Action – 5 Minutes)**
- A Resolution Ratifying and Approving the Execution and Delivery of the HUD Documents Relating to the Regents of the University of New Mexico's HUD-Insured Loan; and Authorizing Any Other Necessary Action to Effect the Delivery of the HUD-Insured Loan – Mrs. Bonnie White, UNM Hospital CFO **(Approval/Action – 10 Minutes)**

X. ADMINISTRATIVE REPORTS (Informational – 15 Minutes)
- Executive Vice President Update – Dr. Douglas Ziedonis
- HSC Committee Update – Dr. Michael Richards
- UNMH CEO Report – Mrs. Kate Becker
- UNMH CMO Report – Dr. Irene Agostini
- Chief of Staff Update – Dr. Nathan Boyd

XI. UNMH BOT COMMITTEE REPORTS (Informational – 10 Minutes)
- Finance Committee – Mr. Terry Horn
- Audit & Compliance Committee – Mr. Terry Horn
- Quality and Safety Committee – Mr. Erik Lujan
- Native American Services Committee – Mr. Erik Lujan
- Community Engagement Committee – Mr. Joe Alarid

XII. OTHER BUSINESS
- Financials – Mrs. Bonnie White, UNMH CFO **(Informational – 10 Minutes)**

XIII. Certification that only those matters described in Agenda Item IX were discussed in Closed Session; consideration of, and final action on the specific limited personnel matters discussed in Closed Session. (Approval/Action – Roll Call Vote)

XIV. Adjourn Meeting (Approval/Action)

Disposition of Assets

Date: January 27, 2021

To: Bruce Cherrin
Chief Procurement Officer, UNM Purchasing Department

From: Bonnie White
Chief Financial Officer, UNM Hospitals

Subject: Property Disposition – January 2021

Attached for your review and submission to the Board of Regents is the Property Disposition Detail list for the month of January 2021.

Consistent with UNM Board of Regents Policy 7.9 Property Management and the Disposition of Surplus Property Act, 13-6-1, NMSA 1978, and based upon documentation submitted by the UNM Hospitals' departments responsible for the equipment, I certify that the equipment identified on the list is worn-out, unusable/unlocated or beyond useful life to the extent that the items are no longer economical or safe for continued use by UNM Hospitals. I recommend that the items be deleted from UNM Hospitals inventory and disposed of in accordance with the above noted Regents Policy and Surplus Property Act.

Property Disposition Request
January 2021

Description Summary				
Description	Count of Items	Sum of Acquisiton Cost	Sum of Book Value	Average of Age In Years
Building	3	$ 53,016.94	$ -	19
Electronics	4	$ 81,135.70	$ -	14
Furniture	1	$ 12,094.36	$ -	18
Medical Equipment	25	$ 358,396.40	$ 12,588.03	10
Monitor	5	$ 40,603.56	$ -	13
Vehicle	2	$ 176,050.00	$ -	10
Food & Nutrition	1	$ 14,676.13	$ -	13
Grand Total	**41**	**$ 735,973.09**	**$ 12,588.03**	**14**

Disposal Summary				
Description	Count of Items	Sum of Acquisiton Cost	Sum of Book Value	Average of Age In Years
Auction	27	$ 356,360.60	$ 11,906.04	11
Electronics Recycling	4	$ 81,135.70	$ -	14
UNM Surplus	2	$ 176,050.00	$ -	10
Unable to Inventory	8	$ 122,426.79	$ 681.99	13
Grand Total	**41**	**$ 735,973.09**	**$ 12,588.03**	**12**

Company	Lawson Number	Asset Control Number	Description	Accounting Unit	Division Description	Model	Serial Number	Acquisition Date	Acquisiton Cost	Book Value	Proposed Method of Disposal	Reason for Disposal	Generalized Description	Comments
10	31761	10003	Digital Processing Unit	32047	Women's Care - Eubank	DPU-7000A	7A10-1171101	06/01/2017	$ 16,148.00	$ 4,575.28	Auction	Obsolete	Medical Equipment	
10	21238	80902	Goby System	34250	Urology	GOBY SYSTEM	GHUB-1-11041225	10/01/2011	$ 27,505.00	$ 2,062.86	Auction	Obsolete	Medical Equipment	
10	32163	105481	Venacure 1470 Laser	15000	Operating Room	1470	14705705	08/01/2017	$ 5,124.00	$ 1,622.60	Auction	Obsolete	Medical Equipment	
10	30689	SCOPE	Flexible Video Cystoscope	34250	Urology	CYSTOSCOPE	36163	06/01/2016	$ 16,079.87	$ 1,339.98	Auction	Replaced	Medical Equipment	
10	30690	SCOPE	Flexible Video Cystoscope	34250	Urology	CYSTOSCOPE	35808	06/01/2016	$ 16,079.87	$ 1,339.98	Auction	Replaced	Medical Equipment	
10	31018	95097	Bravo pH Recorder	30030	CTH Outpatient Clinic	FGS-0450	BR2-0202123	07/01/2016	$ 6,820.00	$ 681.99	Unable to Inventory	Unable to Inventory	Medical Equipment	
10	9849	70595	Audx Pro Plus & Notebook PC	76025	Audiology	AUDX PRO	11C16505E	06/01/2011	$ 11,584.48	$ 482.67	Auction	Obsolete	Medical Equipment	
10	9850	70596	Audx Pro Plus & Notebook PC	76025	Audiology	AUDX PRO	11C16510E	06/01/2011	$ 11,584.48	$ 482.67	Auction	Obsolete	Medical Equipment	
10	24507	VEH #1469	2013 Internat'l Shuttle Bus	80030	Parking and Transport	CE300	4DRBUAN1DB283270	07/01/2012	$ 99,500.00	$ -	UNM Surplus	Not Repairable	Vehicle	Parts for this vehicle are no longer available
10	7578	VEH #1366	2008 GMC Glaval Transport Bus	80030	Parking and Transport	TITAN GMC 5500	1GDE5V1978F404208	06/01/2008	$ 76,550.00	$ -	UNM Surplus	Not Repairable	Vehicle	
10	3442	IT EQUIP	MGE Comet 150kVA 120kw UPS Uni	96000	Information Technology	B04-12044	B04-12044	06/01/2004	$ 65,137.00	$ -	Electronics Recycling	Replaced	Electronics	
10	6346	62737	Airborne 750i Infant Transport	12455	Newborn ICU	NONE	A309	12/01/2007	$ 34,717.84	$ -	Auction	Not Repairable	Medical Equipment	
10	21226	80618	Life Tech Urolab	34250	Urology	JANUS IV	OL1160003	07/01/2011	$ 27,161.00	$ -	Auction	Replaced	Medical Equipment	
10	8934	70453	RF Generator 2	30110	Vein Center	RFG2	20101415BP	06/01/2010	$ 25,012.75	$ -	Unable to Inventory	Unable to Inventory	Medical Equipment	
10	10254	None	Pinon Mechanical - Chiller ***	81050	CTH Facilities Maint	UNKNOWN	UNKNOWN	10/01/2001	$ 23,000.00	$ -	Unable to Inventory	Obsolete	Building	Capitalized as MME in 2001, BSE equipment has been replaced multiple times over the years.
10	10251	None	Pinion Mechanical - Chiller **	81050	CTH Facilities Maint	UNKNOWN	UNKNOWN	08/01/2001	$ 22,645.50	$ -	Unable to Inventory	Obsolete	Building	Capitalized as MME in 2001, BSE equipment has been replaced multiple times over the years.
10	9366	NR	Assets 28264-28267 Balance Due	12415	Intermediate Care Nursery	IWS 4400	IWS 4400	07/01/2010	$ 17,035.86	$ -	Unable to Inventory	Unable to Inventory	Medical Equipment	
10	7577	67336	BVI 9400 Bladderscan	95700	Clinical Engineering	BVI 9400	00001900	06/01/2008	$ 16,002.95	$ -	Auction	Not Repairable	Medical Equipment	
10	17084	32630	Maternal/Fetal Monitor System	12000	Labor and Delivery	129	13002217	10/01/1999	$ 15,524.45	$ -	Auction	Not Repairable	Medical Equipment	
10	27021	SCOPE	Flexible Video Cytoscope	34250	Urology	11272VNU	24176	08/01/2013	$ 15,413.52	$ -	Auction	Replaced	Medical Equipment	
10	27022	SCOPE	Flexible Video Cytoscope	34250	Urology	11272VNU	24177	08/01/2013	$ 15,413.52	$ -	Auction	Replaced	Medical Equipment	
10	6906	54933	Ice Machine/Bin w/ Carts- F&N	84010	Food and Nutrition - BBRP	LITS1350SL	B96292-116-06	07/01/2007	$ 14,676.13	$ -	Auction	Not Repairable	Food & Nutrition	
20	20027	70218	Infant Warmer System & Scale	12415	Intermediate Care Nursery	4400	HCCP00100	03/01/2010	$ 14,534.84	$ -	Auction	Not Repairable	Medical Equipment	
10	3206	None	Versa Conference Tandum Seatin	77015	Pharmacy - Outpatient	NONE	NONE	01/01/2003	$ 12,094.36	$ -	Auction	Replaced	Furniture	
10	9367	NR	Assets 28264-28267 Balance Due	12415	Intermediate Care Nursery	IWS 4400	IWS 4400	07/01/2010	$ 11,357.24	$ -	Unable to Inventory	Unable to Inventory	Medical Equipment	
10	8390	73033	BIPAP Vision Ventilatory Suppo	71510	Pulmonary Services	BIPAP	137738	05/01/2009	$ 9,742.61	$ -	Auction	Not Repairable	Medical Equipment	
10	8392	73032	BIPAP Vision Ventilatory Suppo	71510	Pulmonary Services	BIPAP	137741	05/01/2009	$ 9,742.60	$ -	Auction	Not Repairable	Medical Equipment	
10	3546	50002	Cap Rotation Module - Eng	81040	Satellite Fac-Plant Op & Maint	P1938B100	P1938B00104	06/01/2004	$ 9,184.00	$ -	Unable to Inventory	Unable to Inventory	Medical Equipment	
20	19504	58673	Tram 451N Capitalize CIP 1630	95700	Clinical Engineering	TRAM 451N	SBB06442706GA	07/01/2007	$ 8,335.14	$ -	Auction	Monitor Project	Monitor	
10	7376	58429	Tram 451N Capitalize CIP 1630	95700	Clinical Engineering	451N	SBB06442716GA	07/01/2007	$ 8,335.14	$ -	Auction	Monitor Project	Monitor	
10	7377	58430	Tram 451N Capitalize CIP 1630	95700	Clinical Engineering	451N	SBB06432566GA	07/01/2007	$ 8,335.14	$ -	Auction	Monitor Project	Monitor	
10	7325	58965	Tram 451N Capitalize CIP 1630	95700	Clinical Engineering	451N	SBB06442689GA	07/01/2007	$ 8,236.14	$ -	Auction	Monitor Project	Monitor	
10	3957	45033	Jewett PRF Refrigerator/Freeze	77035	Pharmacy - OSIS	PRF17BSI-1B	N24N-617766-NN	05/01/2003	$ 7,699.00	$ -	Auction	Replaced	Medical Equipment	
10	10252	None	Pinion Mechanical - Chiller **	81050	CTH Facilities Maint	UNKNOWN	UNKNOWN	09/01/2001	$ 7,371.44	$ -	Unable to Inventory	Obsolete	Building	Capitalized as MME in 2001, BSE equipment has been replaced multiple times over the years.
10	7881	62373	Tram 451N	95700	Clinical Engineering	TRAM 451N	SBB07154517GA	09/01/2007	$ 7,362.00	$ -	Auction	Monitor Project	Monitor	
10	7228	60900	Vigilance Cardiac Monitor/Cath	12110	Neuroscience ICU	692515	VG003167	07/01/2007	$ 7,000.00	$ -	Auction	Not Repairable	Medical Equipment	
20	19847	68867	Jaundice Meter	32005	YCHC General	JM-103	B2003481	08/01/2008	$ 6,350.00	$ -	Auction	Not Repairable	Medical Equipment	
10	9310	75601	PowerEdge R410 Plateau4 Server	96140	IT - Customer Service	PE R410	6RBDSL1	07/01/2010	$ 5,627.20	$ -	Electronics Recycling	Replaced	Electronics	
10	6604	None	Refrigerator 23.3 Cu Ft Capita	77010	Pharmacy - Inpatient	0	0	07/01/2007	$ 5,578.52	$ -	Auction	Replaced	Medical Equipment	
10	6318	IT EQUIP	Quad Core Xeon Processor E5345	96000	Information Technology	E5345	D6BCRD1	11/01/2007	$ 5,346.50	$ -	Electronics Recycling	Obsolete	Electronics	
10	4638	IT EQUIP	3.0GHz/1MB Cache, Xeon 800MHz	96000	Information Technology	JS3FK71	JS3FK71	06/01/2005	$ 5,025.00	$ -	Electronics Recycling	Obsolete	Electronics	

Medical Equipment Consultant ($2,347,325

UNM Hospital Board of Trustees
Recommendation to Regents HSC Committee and Board of Regents
February 2021

Approval

Ownership:
Vizient, Inc.
290 East John Carpenter Freeway
Irving, Texas 75062-2710

Officers Information:
Mark Webb- Principal
Michael Merriman- Account Executive

Source of Funds: UNM Hospital FY21 Capital Initiatives Budget

Description: Vendor will provide services including: 1) Medical Equipment Consultation to assist with the final planning, procurement and installation of New Hospital Tower medical equipment, and 2) Move Management Consultation group to assist with the building activation (preparation of the new space for occupancy), move-in planning, relocation planning, Lean Design, and implementation of the move-in process including coordination and moving of equipment, furniture, etc. into the new building. $15,000 scope of work will be put in place for immediate needs and the primary scope of work will begin in early 2021.

Process: RFP P434-20

Contract Term: The initial term of Agreement shall be for four (4) years with an option to renew up to ten (10) years as provided for in NMSA 13-1-150 (Multi-Term Contract).

Contract Amount: Projected amount of $583,081 annually for a total amount of $2,332,325 (includes potential warehousing cost) for four (4) years. Additionally an interim SOW for $15, 000 for work prior to primary phases.

Termination Provision: Either party may terminate the Agreement or any individual SOW for convenience by either party upon ninety (90) days prior written notice to the other party. Either party may terminate the Agreement or any individual SOW for cause if the other party fails to cure a breach within thirty (30) days after receipt of written notice specifying the breach.

Previous Contract: NA

Previous Term: NA

Previous Contract Amount: **$**NA

1209 University Clinic – DOH Licensing ($1,265,000

CAPITAL PROJECT APPROVAL
1209 University Clinic – DOH Licensing Improvements
January 2021

RECOMMENDED ACTION:
As required by Section 7.12 of Board of Regents Policy Manual, the New Mexico Higher Education Department and the New Mexico State Board of Finance, capital project approval is requested for The DOH Licensing Improvements for 1209 University Clinic. For the project described below, UNM Hospitals requests the following actions, with action requested only upon requisite sequential approval and recommendation by any and all committees and bodies:

- Board of Trustee Finance Committee approval of and recommendation of approval to the UNMH Board of Trustees.
- UNMH Board of Trustees approval of and recommendation of approval to the UNM Board of Regents HSC Committee.
- UNM Board of Regents HSC Committee approval and recommendation of approval to the UNM Board of Regents.
- UNM Board of Regents approval

PROJECT DESCRIPTION:
Construction services to correct code deficiencies at the 1209 University Clinic necessitated by the Facility Guidelines Institute (FGI) recommendations and the Americans with Disabilities Act (ADA) regulations. The work will correct Health Insurance Portability and Accountability Act (HIPAA) violations by providing compliant spatial configuration for a combined patient check-in/reception area and open lobby to allow for visual control for added security. The project will create consultation spaces, expand an existing medication room and provide additional staff restrooms. The project will update light fixtures to incorporate dimmers and occupancy sensors, modify the HVAC system to allow for return air and fresh air exchanges throughout the building to increase efficiency and finishes will be updated in remodeled areas as needed.

RATIONALE:
This clinic is located in an older building that does not meet current code in a number of areas. These deficiencies are required to be corrected in order for the clinic to continue to operate for Department of Health (DOH) licensing and to provide improved conditions for patients and staff.

PURCHASING PROCESS:
The construction project will utilize UNM's Job Order Contract (JOC). Professional design services were purchased through UNMH PO #1347404.

FUNDING: Total project budget not to exceed at $1,265,000 from the UNMH Hospital Capital Improvement Funds.

2400 Tucker Clinic – DOH Licensing ($2,500,000

CAPITAL PROJECT APPROVAL
2400 Tucker Clinic – DOH Licensing Improvements
January 2021

RECOMMENDED ACTION:
As required by Section 7.12 of Board of Regents Policy Manual, the New Mexico Higher Education Department and the New Mexico State Board of Finance, capital project approval is requested for The DOH Licensing Improvements for 2400 Tucker Clinic. For the project described below, UNM Hospitals requests the following actions, with action requested only upon requisite sequential approval and recommendation by any and all committees and bodies:

- Board of Trustee Finance Committee approval of and recommendation of approval to the UNMH Board of Trustees.
- UNMH Board of Trustees approval of and recommendation of approval to the UNM Board of Regents HSC Committee.
- UNM Board of Regents HSC Committee approval and recommendation of approval to the UNM Board of Regents.
- UNM Board of Regents approval

PROJECT DESCRIPTION:
Construction services to correct code deficiencies at the 2400 Tucker Clinic necessitated by the Facility Guidelines Institute (FGI) recommendations and the Americans with Disabilities Act (ADA) regulations. The work will correct Health Insurance Portability and Accountability Act (HIPAA) violations by providing compliant spatial configuration for patient check-in and reception areas. The project will include relocation of the existing TriCore lab to increase usability, create enclosed triage rooms and consultation spaces, and reconfigures restrooms to be more secure to comply ADA. Additionally, the project will install code conforming doors that have proper clearance as required to provide appropriate separation between the Tucker Clinic and another UNMH clinic that are co-located on the same floor. Lastly, finishes will be updated in remodeled areas as needed.

RATIONALE:
This clinic is located on the second floor of an older building that does not meet current code in a number of areas. These deficiencies are required to be corrected in order for the clinic to continue to operate for Department of Health (DOH) licensing and to provide improved conditions for patients and staff.

PURCHASING PROCESS:
The construction project will utilize UNM's Job Order Contract (JOC). Professional design services were purchased through UNMH PO #1351760.

FUNDING:
Total project budget not to exceed at $2,500,000 from the UNMH Hospital Capital Improvement Funds.

Phase III New UNM Hospital Tower ($365,000,000

CAPITAL PROJECT APPROVAL
CIP 3126 UNM HOSPITALS – NEW HOSPITAL TOWER PROJECT - NEW HOSPITAL TOWER

JANUARY 27, 2021

RECOMMENDED ACTION:
As required by Section 7.12 of Board of Regents Policy Manual, the New Mexico Higher Education Department and the New Mexico State Board of Finance, capital project approval is requested for the UNM Hospitals – New Hospital Tower Project - New Hospital Tower. For the project described below, UNM Hospitals requests the following actions, with action requested only upon requisite sequential approval and recommendation by any and all committees and bodies:

- Board of Trustee Finance Committee approval of and recommendation of approval to the UNMH Board of Trustees.
- UNMH Board of Trustees approval of and recommendation of approval to the UNM Board of Regents HSC Committee.
- UNM Board of Regents HSC Committee approval and recommendation of approval to the UNM Board of Regents.
- UNM Board of Regents approval.

PROJECT DESCRIPTION:
The UNMH New Hospital Tower (NHT) Project includes development of a new 7 level hospital tower comprising approximately 570,000 GSF. The hospital structure includes 5 podium levels with 2 ICU bed floors on top of the podium. The scope includes installation of low voltage communication systems.

RATIONALE:
The New Hospital Tower project will be constructed in multiple phases in order to reduce the disruption of services and provide access to the North Campus. The New Hospital Tower is the third and final phase of the construction.

PURCHASING PROCESS:
Three (3)-stage Construction Manager at Risk selection process was used for Bradbury Stamm Hunt:

- Request for Qualifications from all interested firms
- Request for Proposals from qualified firms
- Interviews with selected firms

FUNDING:
Total project construction budget not to exceed $365,000,000. Funding at $320,000,000 from HUD-Insured Mortgage; $30,000,000 from NM State Appropriation; and $15,000,000 from FY21 Capital Initiatives.

Crisis Triage ($1,300,000

CAPITAL PROJECT APPROVAL
PROJECT NAME: Crisis Triage Center
DATE: January 2021

RECOMMENDED ACTION:
As required by Section 7.12 of Board of Regents Policy Manual, the New Mexico Higher Education Department and the New Mexico State Board of Finance, capital project approval is requested for The Crisis Triage Center. For the project described below, UNM Hospitals requests the following actions, with action requested only upon requisite sequential approval and recommendation by any and all committees and bodies:

- Board of Trustee Finance Committee approval of and recommendation of approval to the UNMH Board of Trustees.
- UNMH Board of Trustees approval of and recommendation of approval to the UNM Board of Regents HSC Committee.
- UNM Board of Regents HSC Committee approval and recommendation of approval to the UNM Board of Regents.
- UNM Board of Regents approval

PROJECT DESCRIPTION:
In collaboration with Bernalillo County, UNM Hospitals plan to design and renovate existing space on the University Psychiatric Center campus for use as a Crisis Triage Center. This facility is intended to provide development of crisis triage services in our community with a physical connection to existing services co-located on the University Psychiatric Center campus. The project program includes but not limited to: Two patient wings with ten patient beds each, support services areas, offices, law enforcement entrances, and modifications required to meet the most current code requirements.

RATIONALE:
Significant gaps exist in the crisis continuum of care in Bernalillo County. Although crisis services exist, clients are often contemplating next steps once they have been evaluated in the emergency room or inpatient facility. Due to medical necessity criteria, many patients in need of continued stabilization are deferred care until they are able to connect with outpatient services and continue to rotate through the emergency services creating a cyclical pattern. In addition to the need for continued stabilization, centralized triage and observation and triage services are in high demand in order to facilitate a full continuum of crisis services

PURCHASING PROCESS:
Procurement of the design professional shall be done utilizing a Request for Proposals (RFP) procurement method for professional design services.

FUNDING:
Total design budget for this project shall not to exceed $1,300,000 from the Capital Renovation Fund.

Uptown Clinic Lease ($193,600

LEASE of REAL PROPERTY APPROVAL
Uptown Clinic
January 2021

RECOMMENDED ACTION:
As required by Section 7.12 of Board of Regents Policy Manual, the New Mexico Higher Education Department and the New Mexico State Board of Finance, capital project approval is requested for The **LEASE OF REAL PROPERTY at 1901 Pennsylvania Street Northeast**. For the project described below, UNM Hospitals requests the following actions, with action requested only upon requisite sequential approval and recommendation by any and all committees and bodies:

- Board of Trustee Finance Committee approval of and recommendation of approval to the UNMH Board of Trustees.
- UNMH Board of Trustees approval of and recommendation of approval to the UNM Board of Regents HSC Committee.
- UNM Board of Regents HSC Committee approval and recommendation of approval to the UNM Board of Regents.
- UNM Board of Regents approval

PROJECT DESCRIPTION and RATIONALE:
UNM Hospital, through our 2020 Community Health Needs Assessment and neighborhood listening sessions, has worked with members of our community and the county to identify and resolve a need for primary care and increased access to behavioral health services. The Uptown clinic, to be located at Pennsylvania and Indian School, will serve adults, seniors, and families of the mid-town and uptown zip codes with an estimated growth of 2% over the next 10 years. Additionally, it is UNM Hospitals' intent to provide primary care and behavioral health and selected specialties through telehealth modalities. UNM Hospitals currently carries a wait list for patients waiting to establish in primary care, and has increased demand for behavioral health from the surrounding community. We have just one clinic in the NE Heights with the exception of the central University location, and there is increasing need to serve this population. The Uptown clinic will reduce the distance between UNMH primary care clinics serving the NE locations of Albuquerque to approximately 4 miles.

2,200 square feet
Initial term 9 years, option to renew for three consecutive terms of 36 months each
Initial term $193,600 total, additional terms CPI-U adjusted

FUNDING:
Operating Lease to be funded from UNMH Operations budget.

November 20, 2020 UNMH Board of Trustees Meeting Minutes

HOSPITAL

UNM Hospitals Board of Trustees
November 20, 2020
Via Zoom Conference Call

Agenda Item	Subject/Discussion	Action/Responsible Person
Voting Members Present	Terry Horn, Jennifer Phillips, Joseph Alarid, Erik Lujan, Del Archuleta, Tamra Mason, Kurt Riley, and Michael Brasher (Trey Hammond – Not Present)	
Ex-Officio Members Present	Kate Becker, Doug Ziedonis, Michael Richards, Garnett Stokes, and Irene Agostini	
Staff Members Present	Mike Chicarelli, Sara Frasch, Bonnie White, Dawn Harrington, Doris Tinagero, David Pitcher, Alex Sanchez, Jennifer James, Jessica Kelly, John Brandt, Kim Wagner, Kori Beech, Kris Sanchez, Patti Kelley, Rodney McNease, Rohini McKee, Ryan Randall, Sireesha Koppula, Chamiza Pacheco de Alas, Arthur Culpepper, and Fontaine Whitney. KOAT was also present – No Comment's for Public Input	
County Officials Present	Julie Morgas-Baca and Clay Campbell	
I. Call to Order	A quorum being established, Mr. Terry Horn, Chair, called the meeting to order at 9:00 AM	
II. Announcements	Mrs. Kate Becker, UNM Hospital CEO welcomed Dr. Doug Ziedonis, new Executive Vice President for Health Sciences and CEO of the UNM Health System. Dr. Ziedonis currently (until November 30th) holds the Associate Vice Chancellor for Health Sciences position at the University of California San Diego. His official start date is December 1, 2020. Dr. Ziedonis will join the health system in leading UNM's commitment to all aspects of education, research and clinical care and the mission to improve health outcomes for all New Mexicans. He has extensive experience at varied academic institutions such as UCSD, UCLA, UMass, Yale and Rutgers and has worked with Indigenous communities. Everyone welcomed Dr. Ziedonis. Dr. Ziedonis thanked everyone for the nice welcome and stated that he was looking forward to working with the leadership, staff, and the community. He said he is dedicated to the growth for UNM Health Sciences and the University of New Mexico along with student success and diversity.	
III. Adoption of Agenda	Mr. Terry Horn, Chair, requested a motion to adopt the Agenda.	Mr. Del Archuleta made a motion to adopt the agenda. Dr. Tamra Mason seconded the motion. Motion passed with no objections.
IV. Consent Items	Mrs. Bonnie White, UNM Hospital Chief Financial Officer, presented the below identified Consent Items (documents in BoardBook) for review and approval. Mr. Terry Horn, Chair, indicated the UNMH BOT Finance Committee discussed/reviewed the Consent Items in detail and recommend approval by the full UNMH Board of Trustees. After discussion, Chair Horn requested a motion to approve the Consent Item listed below. • Consent Item – Colburn Hill - $14,25,000 Consent Item – Telehealth Platform and Platform Software Support - $2,250,000	Mr. Michael Brasher made a motion to approve the Consent Item – Colburn Hill as presented and discussed by Mrs. Bonnie White. Dr. Tamra Mason seconded the motion. Motion passed with no objections. Mr. Del Archuleta made a motion to approve the Consent Item – Telehealth Platform and Platform Software Support as presented and discussed by Mrs. Bonnie White. Mr. Michael Brasher seconded the motion. Motion passed with no objections.

V. Public Input	N/A	
VI. Approval of Minutes	Mr. Terry Horn, Chair, requested a motion to approve the September 25, 2020 UNM Hospital Board of Trustees Meeting Minutes.	Mr. Del Archuleta made a motion to approve the September 25, 2020 UNM Hospital Board of Trustees Meeting Minutes. Mr. Michael Brasher seconded the motion. Motion passed unanimously.
VII. Mission Moment	Mrs. Kate Becker presented the Mission Moment, which was an appreciation to the COVID Team (report in BoardBook). Several members of the Board of Trustees and staff members expressed their gratitude for Mrs. Becker in her leadership and to the COVID Team. **Non-Clinical Support:** • Sara Frasch – Overseeing human resources, implementing salary structure and retirement plan improvements, and serving as the EOC Planning Section Chief for more than 200 days • Bonnie White – Overseeing financial operations, including preparing our feasibility study for HUD financing of the new hospital tower, managing the complexities of COVID accounting, and serving as the EOC Finance Section Chief • Kris Sanchez – Overseeing business development, our community health needs assessment, and Native American Health Services, and serving as the EOC Business Continuity lead **Clinical Support:** • Patti Kelley and Dr. Irene Agostini – Overseeing nursing and medical operations, serving as EOC Operations Section Chief and Medical Branch Director • Kori Beech and Dr. Sireesha Koppula – Overseeing ambulatory operations, implementing Huron outpatient access improvements and a conversion to virtual visits, serving on EOC Operations and Medical Branch • Mike Chicarelli and Dr. Rohini McKee – Overseeing quality and safety efforts, serving on EOC Operations and Medical Branch • Dawn Harrington and Dr. Dusadee Sarangarm – Overseeing IT, responding to cyberattacks, serving on EOC Logistics and Medical Branch • Mike Chicarelli – Overseeing hospital operations, including logistics and supply chain, overseeing the construction of the new hospital tower, serving daily on the State Medical Advisory Team since March, supporting the opening of the Gibson facility Mrs. Becker and her COVID Team were shown appreciation and gratefulness for all of their efforts during the COVID-19 pandemic.	

VIII. Board Initiatives	Mrs. Doris Tinagero, Executive Director Carrie Tingley Hospital (CTH) & Peds Ambulatory, reviewed the CTH Second Term Assignments, which were reviewed/discussed and approved at the CTH Board Meeting on September 28, 2020. After discussion, Mr. Terry Horn, Chair, requested a motion to approve the CTH Second Term Assignments. • Margaret Armstrong (Healthcare Member) • Sandra Whisler (Healthcare Member) • Mary Blessing (Parent Member)	Mr. Michael Brasher made a motion to approve the CTH Second Term Assignments of Armstrong, Whisler, and Blessing. Dr. Jennifer Phillips seconded the motion. Motion passed unanimously.
	Mrs. Tinagero reviewed the nomination of Mr. Thomas Todd Trautwein as a Member of the CTH Foundation Board to serve as the Foundation Representative, which was reviewed/discussed and approved at the CTH Board Meeting on September 28, 2020. After discussion, Mr. Horn requested a motion to approve Mr. Trautwein as a CTH Foundation Representative.	Mr. Michael Brasher made a motion to approve the Mr. Trautwein as a CTH Foundation Representative. Mr. Erik Lujan seconded the motion. Motion passed unanimously.
	Mrs. Doris Tinagero reviewed the Carrie Tingley Hospital (CTH) Advisory Board Bylaws, which were reviewed/discussed and approved at the CTH Board Meeting on September 28, 2020. After discussion, Chair Horn requested a motion to approve the CTH Advisory Board Bylaws. (CTH documents in BoardBook)	Dr. Tamra Mason made a motion to approve the CTH Advisory Board Bylaws. Mr. Michael Brasher seconded the motion. Motion passed unanimously.
	Executive Committee Recommendations for Chair, Co-Chair, and Secretary: Mr. Terry Horn, Chair, reported that the Board of Regents has reappointed him as a Member on the UNM Hospital Board of Trustees (UNMH BOT). Chair Horn stated that the UNM BOT Bylaws state that the election of officers should occur at the first meeting of the UNMH BOT, which is September. However, since his approval for reappointment from the Board of Regents was in October, the approval of Chair, Co-Chair, and Secretary was tabled until today's meeting. Therefore, Mr. Horn stated that the Executive Committee met and recommends a motion for approval of the following: • Mr. Terry Horn to remain Chair for one more year • Mr. Del Archuleta to become Vice Chair for one year • Mr. Kurt Riley to become Secretary for one year • After one year (September 2021) Mr. Archuleta to become Chair • After one year (September 2021) Mr. Kurt Riley to become Secretary	Mr. Michael Brasher made a motion to approval of Officers per the Executive Committee's recommendation. Mr. Joseph Alarid seconded the motion. Motion passed unanimously.
IX. Administrative Reports	Interim Executive Vice President for Health Sciences: Dr. Michael Richards' report is included in the BoardBook. Dr. Richards indicated that now that Dr. Ziedonis has joined the team, he would be presenting. Mr. Terry Horn, Chair, thanked Dr. Richards for his leadership, stepping into the Interim role and his guidance. Dr. Richards thanked Mr. Horn and expressed appreciation to Kate Becker for her leadership, her team and the providers. HSC Committee Update: Dr. Michael Richards' report is included in the BoardBook.	

	UNM Hospital CEO Update: Mrs. Kate Becker's report is included in the BoardBook. UNM Hospital CMO Update: Dr. Agostini (report in BoardBook) Chief of Staff Update: Dr. Davin Quinn reported that the Medical Executive Committee is currently in the process of the 2nd round of discussions for the revisions of their Bylaws. Dr. Quinn stated that Dr. Nathan Boyd has been named the new Chief of Staff as of January 2nd and will be attending meetings as an Ex-Officio Member. Dr. Quinn will join him at the January meetings for introductions.	
X. UNMH BOT Committee Reports	Mr. Terry Horn, Chair, reporting the UNMH BOT Finance Committee received a status report on the new hospital tower project, which continues to be on schedule and budget. Chair Horn stated that Dr. Sara Frasch updated the committee on retirement plans. Mr. Terry Horn stated the UNMH BOT Audit and Compliance Committee received an update on the HIPAA Privacy, Internal Audit(s) status and an update on the 2021 Compliance Audit Work Plan and 340B Audit. Mr. Erik Lujan stated the UNMH BOT Quality and Safety Committee reviewed and approved credentialing and Dr. Rohini McKee gave a Quality and Safety update. Mr. Erik Lujan stated the UNMH BOT Native American Services Committee discussed the upcoming November APCG meeting where Mrs. Kate Becker will present the new Hospital Tower Update and the December APCG Legislative Advisory Committee Meeting where information about White Coats for Black and Indigenous Lives (WC4BIL) will be presented. Mr. Terry Horn suggested the Native American Services Committee present to the full UNM Hospital Board of Trustees to educate them on the special responsibilities the full Board has to the committee. Mr. Lujan agreed. Mr. Joseph Alarid stated the UNMH BOT Community Engagement Committee met on November 11th and continues to discuss the Charter revisions which will be brought to the full Board for review and approval when the committee finalizes.	
XI. Other Business	Mrs. Bonnie White presented the Financial Update through October 2020 (report in BoardBook).	
XII. Closed Session	At 10:37 AM Mr. Terry Horn, Chair, requested a motion to close the Open Session of the meeting and move into Closed Session.	Mr. Del Archuleta made a motion to close the Open Session and move to the Closed Session. Mr. Kurt Riley seconded the motion. Per Roll Call, the motion passed. Roll Call: Mr. Terry Horn – Yes Dr. Jennifer Phillips – Yes Mr. Joseph Alarid -- Yes Mr. Erik Lujan - Yes Mr. Del Archuleta – Yes Mr. Kurt Riley – Yes Dr. Tamra Mason – Yes Mr. Michael Brasher – Yes Mr. Trey Hammond – Not Present

Vote to Re-Open Meeting	Mrs. Kate Becker, UNM Hospital CEO, provided a COVID-19 Update. Dr. Kori Beech, Chief Ambulatory Officer, and Dr. Sireesha Koppula, Chief Medical Officer – Ambulatory, presented the Huron Phase II Update. Dr. Davin Quinn, Chief of Staff, presented the Clinical Privileges and Credentialing as reviewed, discussed and approved at the October 2020 and November 2020 UNMH BOT Quality and Safety Committee Meetings. Mr. Terry Horn, Chair, requested a motion to acknowledge for the record the approval by the UNMH BOT Quality and Safety Committee of the Clinical Privileges and Credentialing as presented in the Closed Session. Mr. Terry Horn, Chair, requested the Board accept receipt of the following as presented in the Closed Session to acknowledge, for the record, that those minutes were, in fact, presented to, reviewed, and accepted by the Board. In addition, for the Board to accept the recommendations of those Committees as set forth in the minutes of those Committee's meetings and to ratify the actions taken in Closed Session. ❖ Medical Executive Committee September 16th and October 21, 2020 Meeting Minutes ❖ UNMH BOT Quality and Safety Committee September 18th and October 23, 2020 Meeting Minutes At 11:47 AM Mr. Terry Horn, Chair, requested a roll call motion be made to close the Closed Session and return the meeting to the Open Session.	Mr. Del Archuleta made a motion to acknowledge the UNMH BOT Quality and Safety Committee's October and November 2020 approval of the Clinical Privileges and Credentialing. Mr. Erik Lujan seconded the acknowledgement. Motion passed with no objections. Mr. Michael Brasher made a motion to close the Closed Session and return to the Open Session. Mr. Kurt Riley seconded the motion. Per Roll Call, the motion passed. Roll Call: Mr. Terry Horn – Yes Dr. Jennifer Phillips – Yes Mr. Joseph Alarid -- Yes Mr. Erik Lujan - Yes Mr. Del Archuleta – Yes Mr. Kurt Riley – Yes Dr. Tamra Mason – Yes Mr. Michael Brasher -- Yes Mr. Trey Hammond – Not Present
XIII. Certification	**After discussion and determination where appropriate, of limited personnel matters per Section 10-15-1.H (2); and discussion and determination, where appropriate of matters subject to the attorney-client privilege regarding pending or threatened litigation in which UNMH is or may become a participant, pursuant to Section 10-15-1.H (7); and discussion of matters involving strategic and long-range business plans or trade secrets of UNMH pursuant to Section 10-15-1.H (9), NMSA, the Board certified that no other items were discussed, nor were actions taken.**	

XIV. Adjournment	The next scheduled Board of Trustees Meeting will take place Friday, January 29, 2021 at 9:00 AM via Zoom Conference Call. There being no further business, Mr. Terry Horn, Chair, requested a motion to adjourn the meeting.	Mr. Joseph Alarid made a motion to adjourn the meeting. Mr. Michael Brasher seconded the motion. The motion passed unanimously. The meeting was adjourned at 12:05 PM.

Mr. Joseph Alarid, Secretary
UNM Hospitals Board of Trustees

MISSION MOMENT

Mission Moment(s): Employee Well-Being

Presented by Steve Nuanez, LCSW

Manager, Employee Well-Being Program

Nov 2014:

From triple to *quadruple* aim: Care of the patient requires care of the provider

Thomas Bodenheimer et al., Annals of Family Medicine

Improve patient experience

Focus on better outcomes

Lower costs

Take care of the healthcare workers

- Improved clinical experience
- Address widespread burnout
- Improved worklife

The Employee Well-Being Program at UNM Hospital

Initiated June 2017

Program Mission:

To create and support a thriving culture of well-being at UNMH by providing support services, resources, activities, and training.

Preparing for Wellness Rounds, November 2020

Melissa McConnell-Hand, LMHC
Steve Nuanez, LCSW
Liz Lawrence, MD (School of Medicine)

Shame and Blame Culture	→	Well-Being Culture
Personal invulnerability	→	Human factors
Expectation of emotional denial	→	Normalizes reactions
Isolation	→	Community/solidarity
Self-care is selfish	→	Gets you back to what you do well

EWB Mission Moments: Collaborating in culture change

- The momentary confusion for staff – followed by smiles (under the masks) and thanks – when we hand out snacks during wellness rounds on COVID care units.
- Debriefing with Lifeguard staff following a difficult and emotional patient transport and watching as various team members shared their different perspectives and ended with a better understanding of how they work together.
- Helping to create a Well-Being Champions team at Eubank Women's Clinic, which went on to provide some "glue" to the staff as they went through reorganization.
- Conducting a resilience and support session with Urgent Care when a staff member revealed the death of a close relative due to COVID.
- The nurse who reached out to talk about her mental health struggles, especially over the past several months.

Peer Support Program

Promoting a culture of wellbeing through listening, support and encouragement.

Peer support is about being here for one another.

It takes all of us.

Thank You…

…and welcome to the team!

Approval of Mary Cotruzzola as CTH Foundation Advisory Board Community Membe

CARRIE TINGLEY HOSPITAL

Memorandum

To: UNM Hospitals Board of Trustees

From: Carrie Tingley Hospital Advisory Board

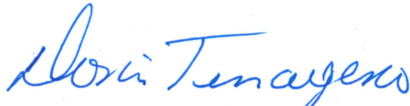
Date: Tuesday, December 29, 2020

Re: Nomination for Community Member Vacancy

The Carrie Tingley Hospital Advisory Board has approved the nomination of Mary Cotruzzola to join the Advisory Board as a community member.

We respectfully request the approval of this nomination by the UNM Hospital Board of Trustees.

Sincerely,



Doris Tinagero, DNP, RN, NEA-BC
Executive Director, CTH & Pediatric Ambulatory
CTH Advisory Board Ex-Officio

Attachment: Mary Cotruzzola Resume

Mary Cotruzzola
7508 Northridge Ave NE
Albuquerque, NM 87109
881-4848. (C) 715-1971

Carlow University Graduate BA English Literature
Pittsburgh PA. Secondary Education

University of New Mexico. MA Educational Administration
Albuquerque, NM

1981-1990
Teacher of English New Futures School
Assistant Principal New Futures School
Acting Principal New Futures School

1990-2003
Principal Freedom High School

NM Mediation Center
Served as a facilitator for Parent - Child mediation

Albuquerque Public Library member of the Albuquerque Library Board

Children's Grief Center
Served as a facilitator for various age groups
Served on Grief Center Board

Assistance League of Albuquerque
Served on Board for 6 years in different capacities

Golden Apple served as an observer

Presently Chair of Committee working with HealthCare for the Homeless and Silver Horizons

Mother of three and grand mother of three
Married to Joseph Cotruzzola

Redesigned UNM Hospital Medical Staff Bylaws

University of New Mexico Hospital

MEDICAL STAFF BYLAWS

Part I: Governance

January 2021

Table of Contents

Section 1.	Medical Staff Purpose and Authority	1
Section 2.	Medical Staff Membership	5
Section 3.	Categories of the Medical Staff	9
Section 4.	Officers of the Medical Staff [and MEC At-Large Members]	11
Section 5.	Medical Staff Organization	14
Section 6.	Committees	16
Section 7.	Medical Staff Meetings	18
Section 8.	Conflict Resolution	21
Section 9.	Review, Revision, Adoption, and Amendment	22

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at the University of New Mexico Hospitals in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the University of New Mexico Hospital Board of Trustees.

1.2 Authority

Subject to the authority and approval of the University of New Mexico Hospitals Board of Trustees the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies and under the corporate bylaws of the University of New Mexico Hospital. Henceforth, whenever the term "the hospital" is used, it shall mean the University of New Mexico Hospital; and whenever the term "the Board" is used, it shall mean the University of New Mexico Hospital Board of Trustees. Whenever the term "Chief Executive Officer" is used, it shall mean the Chief Executive Officer appointed by the Board to act on its behalf in the overall management of the University of New Mexico Hospital. The term Chief Executive Officer includes a duly appointed acting administrator serving when the Chief Executive Officer is away from the hospital.

1.3 Definitions

"Advanced Practice Professional" or "APP" means those individuals who are optometrists (ODs), pharmacist clinicians (PhCs), Physician Assistants (PAs), certified Anesthesiologist Assistants (CAAs), and Advanced Practice Registered Nurses: certified nurse midwives (CNMs), certified nurse practitioners (CNPs), certified registered nurse anesthetists (CRNAs) and clinical nurse specialists (CNS).

"Allied Health Professional" or "AHP" means those individuals eligible for privileges who are not staff Members who are qualified by academic education and clinical experience or other training to provide patient care services in a clinical or supportive role. Some AHPs provide services independently, although with Member authorization, such as chiropractors and doctors of oriental medicine. Some AHPs provide services only under supervision of a Member of the Medical Staff; these AHPs are privileged registered nurse first assistants (RNFAs) and scrub technicians.

"Application" means an application for appointment and/or privileges to the Medical Staff as described in Part III, Section 3 of the *Medical Staff Bylaws.*

"Appointee" means any medical or osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, clinical or counselling pscyhologists, or APP holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

"Associate Dean for Clinical Affairs" or "ADCA" is appointed by, and serves at the pleasure of the Dean of the School of Medicine. The ADCA is responsible for the functions of the Office of Clinical Affairs and Medical Staff Affairs not otherwise delegated to the CMO or COS. The ADCA will enforce these Bylaws, the Medical Staff Rules and Regulations, Medical Staff Policies and Procedures, and any applicable UNMH policies affecting Members of the Medical Staff. The ADCA is an ex officio Member with a vote on all committees of the

Medical Staff. The ADCA will prepare the agenda for all meetings thereof in consultation with the Chief of Staff and Chief Medical Officer and may serve as Vice Chair of the MEC.

"Board Certification" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

“Board of Trustees” or “Board” means the Board of Trustees of the University of New Mexico Hospitals.

“Chief Executive Officer” or “CEO” is the individual appointed by the Board of Trustees to serve as the Board’s representative in the overall administration of the University of New Mexico Hospital. The CEO may, consistent with his or her authority granted by the University of New Mexico Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

“Chief of Staff” or “COS” means the Chief of Staff of the Medical Staff as noted in Part I, Section 4 of these *Medical Staff Bylaws.*

“Clinical or Counseling Psychologists” means those individuals who are doctoral-level and meet qualifications for medical staff membership.

“Clinical Privileges” or “Privileges” mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services with the Hospital.

“Clinical Service” means a grouping of like practitioners as note in Part I, Section 5 of the *Medical Staff Bylaws* and further defined in the Rules and Regulations.

“Clinical Service Chief” means a Voting Medical Staff Member who has been appointed in accordance with and has the qualifications and responsibilities for Clinical Service Chief as outlined in Part I, Section 5.2 and Section 5.3 of these Bylaws.

“Days” shall mean calendar days unless otherwise stipulated in the *Medical Staff Bylaws.*

“Denial” means an adverse action or recommendation regarding privileges made by the Medical Executive Committee (MEC) or Board which is based on the competence or professional conduct of an individual practitioner.

“Dentist” means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in New Mexico.

“Good Standing” means having no adverse actions, limitations, or restriction on privileges or Medical Staff membership at the time of inquiry based on a reason of competence or conduct.

“Hearing Panel” means the committee appointed to conduct an evidentiary hearing pursuant to a request properly filed and pursued by a Practitioner in accordance with Part II, Section 5 of these *Medical Staff Bylaws.*

"Hospital" means the University of New Mexico Hospitals.

"Hospital Bylaws" mean those Bylaws established by the Board of Trustees.

"Licensed Independent Practitioner" or "LIP" means an individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision.

"Limitation" or "limited" means a restriction such that not the full extent of licensure/privileges are granted.

"Medical Executive Committee" or "MEC" shall mean the Executive Committee of the Medical Staff of the University of New Mexico Hospitals as provided for in Part I, Section 6 of the *Medical Staff Bylaws.*

"Medical Staff or "Staff" means the organization of those individuals who are either medical physicians, osteopathic physicians, dentists, oral and maxillofacial surgeons, podiatrists, clinical psychologists, pharmacist clinicians, optometrists, physician assistants, certified anesthesiologist assistants, or Advanced Practice Registered Nurses who have obtained membership status.

"Medical Staff Bylaws" means the Bylaws covering the operations of the Medical Staff of the University of New Mexico Hospitals.

"Medical Staff Rules and Regulations" means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

"Medical Staff Year" is defined as the 12-month time period beginning on January 1 of each year and ending December 31.

"Member" is a physician, dentist, oral and maxillofacial surgeon, podiatrist, clinical psychologist, pharmacist clinician, optometrist, physician assistant, certified anesthesiologist assistant, or Advanced Practice Registered Nurse who has been granted this status by the Board of Trustees of the University of New Mexico Hospital.

"Nominating Committee" means the committee that nominates candidates for available Medical Staff Officer positions. The composition of this committee is noted in the Rules and Regulations.

"Notice" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

"Oral and Maxillofacial Surgeon" means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery. The term "dentist" as used in these Bylaws includes oral surgeons.

"Physician" means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of New Mexico.

"Podiatrist" means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in New Mexico.

“Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, clinical or counseling psychologist, Advanced Practice Professional, or Allied Health Professional who has been granted clinical privileges.

“Prerogative” means the right to participate, by virtue of Staff category or otherwise, granted to a practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

“Reduction” means a limitation of previously granted prerogatives.

“Relinquished” means a surrender of previously granted prerogatives

“Representative” or “Hospital Representative” means the Board of Trustees and any Director or committee thereof; the CEO or his or her designee; other employees of the Hospital; a Medical Staff organization or any Member, Officer, Clinical Service or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use of dissemination of information.

“Restricted” or “restriction” means a limitation such as to not grant the full extent of licensure/privileges.

“Revocation” means a nullification, or withdrawal, of previously granted prerogatives.

“Special Notice” means written notice sent via certified mail, return receipt requested or by hand delivery evidenced by a receipt signed by the Practitioner to whom it is directed.

“Summary suspension” means a suspension imposed immediately, by the individuals identified in these Bylaws based on a good faith belief, in order to protect patients or staff from imminent danger.

“Suspension” or “suspended” means a temporary limitation on the prerogatives of membership and/or privileges.

“Termination” means a permanent limitation on the prerogatives of membership and/or privileges.

“UNMH” means the UNM Hospitals, including all its hospitals, clinics, inpatient and outpatient programs, including but not limited to the UNM Hospital, the UNM Children’s Hospital, the UNM Comprehensive Cancer Center, the UNM Psychiatric Center, the UNM Children’s Psychiatric Center and the UNM Carrie Tingley Hospital Outpatient Services.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (MD or DO), dentists, oral and maxillofacial surgeons, podiatrists, clinical or counseling psychologists, optometrists (OD), pharmacist clinicians (PhC), physician assistants (PA), advanced practice registered nurses (certified nurse midwives (CNM), certified nurse practitioners (CNP), certified registered nurse anesthetists (CRNA) and clinical nurse specialists (CNS) providing direct patient care), and certified anesthesiologist assistants (CAA) who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Part III of these Bylaws (Credentials Procedures Manual).

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, gender identification, sexual orientation, religion, cultural identification, military status, political affiliation, marital/relationship status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the MEC except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these Bylaws.

2.6 Responsibilities

2.6.1 Each Practitioner must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.6.2 Each Practitioner must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

2.6.3 Each Practitioner, consistent with their granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the Clinical Service Chief, to assist in meeting the patient care needs of the community.

2.6.4 Each Practitioner must submit to any pertinent type of health evaluation, which may include blood, urine, or other testing as requested by the Officers of the Medical Staff, CEO, and/or Clinical Service Chief when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the Member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment.

2.6.5 Each Practitioner must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and hospital.

2.6.6 Each Practitioner must abide by the relevant Code of Conduct policy.

2.6.7 Each Practitioner must provide evidence of adequate professional liability coverage, if during the applicant's membership on the Medical Staff, the applicant will not be covered by the Public Liability Fund administered by the New Mexico State Risk Management Division pursuant to the New Mexico Tort Claims Act. In addition, Practitioners shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff Member and practitioner with privileges shall notify Medical Staff Affairs immediately of any and all malpractice claims filed in any court of law against the Practitioner.

2.6.8 Each Practitioner must comply with Medical Staff approved clinical protocols and guidelines.

2.6.9 Each Practitioner agrees to notify Medical Staff Affairs of any changes on information in the application in the following manner:

a. Immediate notification for changes related to professional liability insurance, licensure, DEA, ability to participate in federally funded programs, a felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder), or termination/suspension at a hospital affiliated with the University of New Mexico Health System.

b. Prompt notification, within one (1) month, for changes related to felony conviction other than noted above, conviction of any alcohol or drug offenses, suspension or termination of Medical Staff membership and/or privileges at any hospital unaffiliated with the University of New Mexico Health System, and any final judgments in professional liability suits.

2.6.10 Each Practitioner agrees to fulfill the continuing education requirements as defined by the appropriate New Mexico licensing board.

2.6.11 Each Practitioner agrees to release from any liability performed or made in good faith and without malice, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Staff Member or Practitioner and their credentials.

2.6.12 Each Practitioner shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the Practitioner provides care in the hospital, or within its facilities and Clinical Services.

a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

c. The content of complete and focused history and physical examinations is delineated in the rules and regulations.

2.6.13 Each Practitioner will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.6.14 Each Practitioner must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate the Member's clinical privileges.

2.6.15 Each Voting Member of the MEC shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or hospital. Medical Staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.6.16 Each Practitioner must report any arrest, indictment or conviction of any alleged criminal act to Medical Staff Affairs within 24 hours of an arrest, notification of indictment or conviction, or before engaging in patient care, whichever comes first. An investigation into the circumstances of the arrest, indictment or conviction shall be made by Medical Staff Affairs. Medical Staff Affairs shall report the results of any such investigation to the MEC who shall review the circumstances leading to the arrest, indictment or conviction and will determine if further action is warranted prior to the outcome of the legal action (if applicable) or if further action is warranted subsequent to conviction. If the MEC recommends an action that adversely affects the Practitioner, this shall entitle the Practitioner to the right to a hearing and appeal to the extent provided in these bylaws. Nothing in this section shall be construed so as to prohibit summary suspension of the Member in accordance with these Bylaws.

2.7 Medical Staff Member Rights

2.7.1 Each staff Member in the Voting category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with their Clinical Service Chief or other appropriate Medical Staff leader(s), the practitioner may, upon written notice to the Chief of Staff of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.7.2 Each staff Member in the Voting category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Section 4.7 of these Bylaws regarding removal and resignation from office.

2.7.3 Each staff Member in the Voting category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twelve and a half percent (12.5%), but not less than two (2) Members, of the Voting category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than detailed in the petition may be transacted.

2.7.4 Each staff Member in the Voting category may challenge any rule, regulation, or policy established by the MEC. In the event a rule, regulation, or policy is thought to be inappropriate, any Medical Staff Member may submit a petition signed by twelve and a half percent (12.5%), but not less than two (2) Members, of the Voting category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each staff Member in the Voting category may call for a Clinical Service meeting by presenting a petition signed by twelve and a half percent (12.5%), but not less than two (2), of the Members of the Clinical Service. Upon presentation of such a petition the Clinical Service Chief will schedule a Clinical Service meeting.

2.7.6 The above Sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7.7 Any practitioner eligible for Medical Staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

2.8 Indemnification

2.8.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and Medical Staff.

2.8.2 Subject to applicable law, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff Member in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or Medical Staff. However, no Member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Voting Category

3.1.1 Qualifications

Members of this category must have a full-time or part-time faculty appointment in the School of Medicine, excluding clinical or counseling psychologists and APPs, and either be in their first year on Staff or have served on the Medical Staff for at least one (1) year and be involved in either:

At least twenty-four (24) patient contacts per year (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic), **OR**

Have attended at least eight (8) Medical Staff (Medical Staff, Clinical Service, or committee) or hospital/UNM health System committee meetings.

In the event a Member of the Voting category does not meet the qualifications for reappointment to the Voting category, and if the Member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and hospital, the Member may be appointed to another Medical Staff category if they meet the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

a. Attend Medical Staff or Clinical Service meetings of which they are a Member and any Medical Staff or hospital education programs;

b. Vote on all matters presented by the Medical Staff or Clinical Service and committee(s) to which the Member is assigned; and

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;

b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

3.2 The Nonvoting Category

3.2.1 Qualifications

The Nonvoting category is reserved for Medical Staff Members who do not meet the eligibility requirements for the Voting category. These individuals, excluding clinical or counseling psychologists and APPs, shall be Volunteer Faculty or shall possess a Letter of Academic Title.

3.2.2 Prerogatives

Members of this category:

a. May attend Medical Staff or Clinical Service meetings of which they are a Member and any Medical Staff or hospital education programs;

b. May not vote on matters presented by the entire Medical Staff or Clinical Service, or be an Officer of the Medical Staff; and

c. May serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities

Members of this category shall:

a. Have the same responsibilities as Voting category Members.

3.3 UNM Children's Hospital

For those community providers invited by a Clinical Service Chief to seek credentialing and privileging solely through the clinical services of the UNM Children's Hospital and who seek Medical Staff membership under sections 3.3.1 or 3.3.2 of these bylaws, there is no requirement for a UNM faculty appointment or letter of academic title.

3.4 Non Medical Staff

3.4.1 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those practitioners who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff or Clinical Service meetings, continuing medical education activities, and may be appointed to committees. They are not Members and shall not hold clinical privileges, hold office or be eligible to vote.

3.4.2 Privileged Only Practitioners

Privileged Only Practitioners are those individuals holding clinical privileges who are not Members of the medical staff and do not qualify for voting or non-voting membership. They must be invited and recommended by the clinical service, the MEC and approved by the Board and will be bound by the Medical Staff Bylaws and Rules and Regulations.

Section 4. Officers of the Medical Staff and MEC At-Large Members

4.1 Officers of the Medical Staff and MEC At-Large Members

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.1.3 Immediate Past Chief of Staff

4.2 Qualifications of Officers and MEC At-Large Members

4.2.1 Officers must be Members in good standing of the Voting category holding MD, DO or DDS/DMD licenses and be actively involved in patient care in the hospital or in hospital-licensed clinics, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have demonstrated an ability to work well with others, and be in compliance with the professional conduct policies of the hospital. The Medical Staff Nominating committee will have discretion to determine if a staff Member wishing to run for office meets the qualifying criteria.

4.2.2 MEC At-Large Members must be Members in good standing of the Voting category and be actively involved in patient care in the hospital or in hospital-licensed clinics, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have demonstrated an ability to work well with others, and be in compliance with the professional conduct policies of the hospital. The Medical Staff Nominating committee will have discretion to determine if a staff Member wishing to run for office meets the qualifying criteria.

4.2.3 Officers and MEC At-Large Members may not simultaneously hold a leadership position (MEC or Board) on another hospital's or Health System's medical staff directly competing with the hospital. Noncompliance with this requirement will result in the Officer being automatically removed from office.

4.3 Election of Officers and MEC At-Large Members

4.3.1 The Nominating committee shall solicit nominations from the Medical Staff for the available leadership positions. This committee will vet these nominations against the qualifications and shall offer from one (1) to four (4) nominees for each available position. The slate of nominees will be presented to the Medical Executive Committee prior to conducting the elections electronically.

4.3.2 Officers and MEC At-Large Members shall be elected prior to the expiration of the term of the current Officers. Only Members of the Active category shall be eligible to vote. All voting will occur through electronic balloting, with ballots submitted prior to the date noted on the ballot. The nominee(s) who receives the most votes cast (plurality vote) will be elected, when at least twelve and a half percent (12.5%) of the eligible votes have been cast.

4.4 Term of Office

All Officers serve a term of two (2) years. They shall take office in the month of January of odd years. An individual may not be elected to consecutive terms. Each Officer shall serve in office until the end of their term of office or until a successor is appointed/elected, unless they resign sooner or are removed from office. The Vice Chief of Staff shall take office as Chief of Staff when the term of the prior Chief of Staff ends, and upon affirmation by the Medical Executive Committee.

All MEC At-Large Members serve a single term of two (2) years.

4.5 Removal and Resignation from Office or MEC At-Large Member Position

4.5.1 **Automatic removal:** Automatic removal shall be for failure to meet the qualifying criteria for being an Officer.

4.5.2 **Removal by vote:**

a. **Criteria**. Criteria for removal are failure to meet the responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs.

b. **Initiation**. The Medical Staff may initiate the removal of any Officer or MEC At-Large Member if at least twelve and a half percent (12.5%) of the Voting Members sign a petition advocating for such action. The MEC may initiation the removal of any Officer or MEC At-Large Member by a majority vote of the MEC.

c. **Removal**. Written notice of the reasons for the proposed removal shall be distributed to the individuals voting for removal. Removal shall become effective upon an affirmative vote by two-thirds (2/3) of those Voting staff Members casting ballot votes when there is a quorum.

4.5.3 **Resignation:** Any elected Officer or MEC At-Large Member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

4.6 Vacancies of Office

If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term. If there is a vacancy in the office of Immediate Past Chief of Staff, this position will go unfilled. If there is a vacancy in the office of Vice Chief of Staff or MEC At-Large Member, the Chief of Staff, with MEC approval, will appoint a Member to fill the vacancy.

4.7 Duties of Officers and MEC At-Large Members

4.7.1 **Chief of Staff:** The Chief of Staff shall represent the interests of the Medical Staff to the MEC and the Board. The Chief of Staff is the primary elected Officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff Bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;

b. Serve as chair of the MEC with vote and as ex-officio member of all other Medical Staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

c. Enforce Medical Staff Bylaws, rules, regulations, and Medical Staff/hospital policies;

d. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with hospital administration, appoint Medical Staff Members to appropriate hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the Medical Staff Members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

e. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;

f. Report to the Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

i. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

j. Attend Board meetings, without a vote, and Board committee meetings as invited by the Board;

k. Ensure the decisions of the Board are communicated and carried out within the Medical Staff; and

l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

4.7.2 **Vice Chief of Staff:** In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The Vice Chief of Staff shall also serve on the Credentials Committee and perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.7.3 **Immediate Past Chief of Staff:** The Immediate Past Chief of Staff shall serve as an advisor to the Chief of Staff and shall serve as a voting member of the Medical Executive Committee.

4.7.4 **MEC At-Large Members:** These members will advise and support the Medical Staff Officers and are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be departmentalized and is organized into Clinical Services. The organization of the Medical Staff (as pertains to Departments/Clinical Services) will correspond to the departmental organization of the UNM School of Medicine. Designation and dissolution of Departments/Clinical Services shall be at the discretion of the Dean of the School of Medicine.

5.2 Qualifications, Selection, Term, and Removal of Clinical Service Chief

5.2.1 **Qualifications:** All Chiefs must be Members in good standing of the Voting category for and be actively involved in patient care in the hospital or in hospital-licensed clinics, be board certified or have comparable competence, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, be interested in furthering quality of care, be interested in faithfully discharging the duties of the position, and be in compliance with the professional conduct policies of the hospital. Clinical Service Chiefs may not simultaneously hold a leadership position (MEC or Board) on another hospital's or Health System's medical staff that is directly competing with the hospital. Noncompliance with this requirement will result in the Clinical Service Chief being automatically removed from office.

5.2.2 **Selection**: The School of Medicine Department Chair shall serve as the Clinical Service Chief of the corresponding hospital service.

5.2.3 **Removal and Resignation of the Clinical Service Chief**

a. **Automatic removal:** Automatic removal shall be for failure to meet the qualifying criteria for being a Clinical Service Chief.

5.3 Responsibilities of Clinical Service Chief

a. To oversee all clinically-related activities of the Clinical Service;

b. To oversee all administratively-related activities of the Clinical Service, unless otherwise provided by the hospital;

c. To provide ongoing surveillance of the performance of all individuals in the Medical Staff Clinical Service who have been granted clinical privileges;

d. To recommend to the credentials committee the criteria for requesting clinical privileges relevant to the care provided in the Medical Staff Clinical Service;

e. To recommend clinical privileges for each Member of the Clinical Service and other licensed independent practitioners practicing with privileges within the scope of the Clinical Service;

f. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the Medical Staff Clinical Service or the hospital;

g. To integrate the Clinical Service into the primary functions of the hospital;

h. To coordinate and integrate functions and communication between and within Services;

i. To develop and implement Medical Staff and hospital policies and procedures to guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

j. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service;

k. To provide input to the CEO regarding the qualifications and competence of Clinical Service personnel who are not LIPs but provide patient care, treatment, and services;

l. To continually assess and improve of the quality of care, treatment, and services;

m. To maintain quality control programs as appropriate;

n. To orient and continuously educate all persons in the Clinical Service; and

o. To make recommendations to the MEC and the hospital administration for space and other resources needed by the Medical Staff Clinical Service to provide patient care services.

5.5 Assignment to Clinical Service

The MEC will, after consideration of the recommendations of the Chief of the appropriate Clinical Service, recommend Clinical Service assignments for all Members in accordance with their qualifications. Each Member will be assigned to one primary Clinical Service. Clinical privileges are independent of Clinical Service assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual which is part of the Rules and Regulations. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such hospital committees as are established to perform such functions. The Chief of Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition of Voting Members. The Medical Executive Committee will be comprised of the following voting Members: Chief of Staff (as Chair), the Vice Chief of Staff, the Immediate Past Chief of Staff, the Dean of the School of Medicine, the Vice Chancellor of Clinical Affairs, the UNMH Chief Medical Officer, the Senior Associate Dean for Clinical Affairs, the Chiefs of all Clinical Departments, the Senior Associate Dean for Graduate Medical Education, the CMO of the Cancer Center, five (5) at-large members from the Voting Medical Staff in good standing, at least one of which shall be a APP, and the chair of the Credentials Committee. If any of the foregoing voting members designate another member of the voting Medical Staff to serve in his or her stead, such a designate member of the Medical Executive Committee shall not have voting rights.

b. Composition of Ex Officio Non-Voting Members. The Medical Executive Committee will also have the following non-voting Members:, the UNMH Chief Executive Officer, the Chief Operations Officer, the Chief Nursing Officer, the Chief Ambulatory Officer, the Chief Medical Quality Officer, the Associate CMO Children's Hospital, the Associate CMOs of Inpatient and Outpatient, the Chief Medical Information Officer, and a resident physician representative appointed by the Chief of Staff.

c. Other Deans of the School of Medicine, members of the medical staff and hospital or health system leadership may also participate in a non-voting capacity at the invitation of the Chief of Staff.

6.2.2 Duties: The duties of the MEC, as delegated by the Medical Staff, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Clinical Service assignments, clinical privileges, and corrective action;

d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from Medical Staff committees, Clinical Services, and other assigned activity groups;

j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures;

k. Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner's ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee the portion of the corporate compliance plan pertaining to the Medical Staff;

o. Hold Medical Staff leaders, committees, and Clinical Services accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws; and

q. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.

6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting of the Medical Staff shall be held at a time determined by the MEC. Other meetings may be called as noted below in Part I, Section 7.1.3. Notice of the meeting shall be given to all Medical Staff Members via appropriate media and posted conspicuously.

7.1.2 Except for Bylaws amendments or as otherwise specified in these Bylaws, all other items to be voted on will be done solely by paper or electronic voting.

7.1.3 Special Meetings of the Medical Staff

a. Special meetings may be called by the Chief of Staff or by the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff at least three (3) business days before the date of such meeting. No business shall be transacted at any special meeting, except stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Clinical Services

Clinical Services shall meet on as needed basis by call of the Clinical Service Chief. Committees and Clinical Services may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Clinical Services

A special meeting of any committee or Clinical Service may be called by the committee chair or Chief of the Clinical Service thereof or by the Chief of Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: A quorum will exist when twelve and one-half percent (12.5%) of the Members are present.

7.4.2 MEC, Credentials Committee, and Peer Review Committee(s): A quorum will exist when fifty percent (50%) of the members are present. When dealing with Category 1 requests for expedited credentialing the MEC quorum will consist of at least two (2) members.

7.4.3 Clinical Service meetings or Medical Staff committees other than those listed in 7.4.2 above: Those present and eligible Medical Staff Members voting on an issue.

7.5 Attendance Requirements

7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

c. MEC, Credentials Committee, and Peer Review Committee(s) meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held.

d. Clinical Services and committees other than those noted in Section 7.5.1.a above: Members of these Clinical Services and committees are encouraged to attend.

e. Special meeting attendance requirements: Whenever there is a reason to believe a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Clinical Service Chief or Medical Staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) business days prior to the meeting. This notice shall include the date, time, place, issue involved and the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic suspension of the practitioner's membership and privileges. Such suspension would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

f. Telephonic/virtual meetings may occur.

g. Nothing in the foregoing paragraphs shall preclude the initiation of a summary suspension of clinical privileges as outlined in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the Chief Executive Officer

The CEO or their designee may attend any general, committee, or Clinical Service meetings of the Medical Staff as an ex-officio member without vote.

7.7 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each Member of the Clinical Service or committee not less than three (3) business days before the time of such meeting by the person or persons calling the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Clinical Service

Action may be taken either through electronic voting, or voting at a meeting. The recommendation of a majority of its members present at a meeting at which a quorum is present, at any point in time, shall be the action of a committee or Clinical Service. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.10 Rights of Ex officio Members

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee or Clinical Service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Clinical Service Chief shall authenticate the minutes and copies thereof shall be submitted to the MEC or another designated committee. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, CEO, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.5 of Part I of these Bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff Bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws and rules & regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Proposed amendments to these Bylaws may be originated by the MEC or by a petition signed by twelve and a half percent (12.5%), but not less than two (2) Members, of the Voting category. When an amendment is proposed by the Medical Staff, the amendment will be reviewed by the MEC and will be forwarded to the Medical Staff with either a positive or negative recommendation.

Each Voting Member of the Medical Staff will be eligible to vote on the proposed amendment via secure electronic ballot in a manner determined by the MEC. All Voting Members of the Medical Staff shall receive at least fourteen (14) calendar days advance notice of the proposed changes. The amendment shall be considered approved by the Medical Staff when 12.5% of the Voting category members participate in the vote and the amendment is approved by a simple majority vote of members voting.

Amendments so adopted shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, and Policies

9.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.

9.3.2 If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff at least fourteen (14) days prior to the vote.

9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by a simple majority of the MEC, rules and regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.4 In addition to the process described in 9.3.3 above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twelve and a half percent (12.5%), but not less than two (2), of the Members of the Voting category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action.

9.3.6 The MEC may adopt such amendments to these Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations. Organizational changes that affect membership on the Medical Executive Committee (other than those affecting inclusion or exclusion of Chiefs of the Clinical Services) shall be considered non-substantive and shall not require a vote of the medical staff.

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

December 2020

Table of Contents

Section 1.	Collegial, Educational, and/or Informal Proceedings	1
Section 2.	Investigations	2
Section 3.	Corrective Action	5
Section 4.	Initiation and Notice of Hearing	10
Section 5.	Hearing Panel and Presiding Officer or Hearing Officer	13
Section 6.	Pre-Hearing and Hearing Procedure	15
Section 7.	Appeal to the Hospital Board	19

Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions raised. All collegial intervention efforts by Medical Staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve their clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and hospital. Collegial intervention efforts may include but are not limited to the following:

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and

c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following collegial intervention efforts, if it appears the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing by a Medical Staff Officer, committee chair, CEO, CMO, hospital Board chair, or Clinical Service Chief for a member of that Clinical Service, to the MEC. The Chief of Staff shall notify the ADCA, the Dean, the CMO and Chief of Staff, the member and their Chair/Chief of a request for investigation. The request must be supported by references to the specific activities or conduct of concern. The MEC itself may initiate an investigation, and shall appropriately document its reasons and notify the practitioner and the Clinical Service Chief and Department Chair, if applicable.

2.2 Investigation

If the MEC decides an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. In the event the Board believes the MEC has incorrectly determined an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or assign the investigation to an ad hoc committee of the Medical Staff.

2.2.1 **Deferral to ADCA and/or CMO.**

2.2.1.1. When, in the opinion of the Medical Executive Committee, allegations in a written request for professional review of a Member do not rise to a level ordinarily requiring invocation of professional review and/or corrective action, the MEC may refer the matter to the ADCA or the CMO or their designee(s) for further evaluation, with an opportunity for the affected Member to be heard in a manner to be decided by the ADCA or their designee.

2.2.1.2. Action by the ADCA, CMO, or their designee resulting from such inquiries may not adversely affect the Member, his or her membership on the Medical Staff, or the exercise of his or her privileges beyond thirteen (13) days without further investigation and action of the MEC as set forth more fully in these Bylaws.

2.2.1.3. Documentation regarding the act or omission leading to any such evaluation under this sub-section will be maintained in the affected Member's credentialing file and may be considered in any subsequent credentialing review or professional review of the Member, along with the practitioner's compliance or failure to comply with the corrective action. The affected Member will not be entitled to hearing or appeal procedures as set forth in these Bylaws. The ADCA, CMO, or their designee will report on such evaluation and actions at the next regularly scheduled MEC meeting.

2.2.2 Assignment to the Ad Hoc Committee If the investigation is delegated to a committee other than the MEC, the MEC shall appoint three members to such committee, and such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible but no longer than 30 days. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.2.1 An external peer review consultant should be considered when:

a. Litigation seems likely;

b. The hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;

c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

b. Deferring action for a reasonable time when circumstances warrant;

c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Clinical Service Chiefs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's quality file;

d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;

e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

g. Recommending suspension, revocation, or probation of Medical Staff membership; or

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges, the practitioner shall be entitled to the procedural rights afforded in this hearing and appeal plan. The Board shall act on the MEC's recommendation unless the Member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. The timeframe for reporting these events is noted in Part I, Section 2.6.9 of these Bylaws. Where a bona fide dispute exists as to whether the circumstances have occurred, or extenuating circumstances exist, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The Chief of Staff, with the approval of the CMO or CEO, may reinstate the practitioner's privileges or membership after determining the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty days, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

3.1.1 Licensure

a. **Revocation, suspension, expiration, or voluntary relinquishment:** Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. **Restriction:** Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

3.1.2 Medicare, Medicaid, Tricare (a managed-care program replacing the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is excluded or precluded from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3.1.3 Controlled substances

a. **DEA certificate:** Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or New Mexico Controlled Substance Registration (NM CSR) is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

b. **Probation:** Whenever a practitioner's DEA certificate or New Mexico Controlled Substance Registration (NM CSR) is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Professional liability insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic suspension of a practitioner's clinical privileges. If within 60 calendar days of the suspension the practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must notify Medical Staff Affairs immediately of any change in professional liability insurance carrier or coverage.

3.1.5 **Felony conviction:** A practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder) in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

3.1.6 **Failure to satisfy the special appearance requirement:** A practitioner who fails without good cause to appear at a meeting where their special appearance is required in accordance with these Bylaws shall be considered to have all clinical privileges automatically suspended. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.7 **Failure to participate in an evaluation:** A practitioner who fails to participate in an evaluation of their qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills) and authorizes release of this information to the MEC, shall be considered to have all privileges automatically suspended. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.8 **Failure to become board certified or failure to maintain board recertification:**

Revocation of board certification for cause by a certifying board of the American Board of Medical Specialties or American Osteopathic Association, for reasons other than failure to

meet requirements for Maintenance of Certification or failure to pay dues, shall constitute a voluntary resignation of Medical Staff membership and clinical privileges at such time as an order of revocation shall be final.

A practitioner who fails to become board certified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have voluntarily relinquished his or her Medical Staff appointment and clinical privileges, becoming effective at the next reappointment date. If a practitioner fails to become recertified, they shall have a grace period of three (3) years in which to become recertified. A practitioner who fails to be recertified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges. The board certification requirements are noted in Part III, Section 2.2 of these Bylaws; any board certification exceptions are noted in Part III, Section 2.4 of these Bylaws.

3.1.9 **Loss of Privileges at Other Health Care Organization:** A Medical Staff Member who has clinical privileges at another health care organization or other UNM Health System entity, and whose clinical privileges are involuntarily reduced, suspended, or revoked by that other health care organization or entity, must immediately report such action to the UNM Associate Dean for Clinical Affairs, CMO and the Chief of Staff.

3.1.10 **Loss of Faculty Appointment or UNM Health System Employment Status:** A practitioner who is not credentialed subject to provision 3.3 of the Governance section of these bylaws, nor for whom Faculty or Staff appointment is not required, who loses their faculty appointment or employment status with a UNM Health System entity will automatically lose their Medical Staff membership without further action required of the Medical Executive Committee or Governing Body without right to a hearing or appeal procedures provided by these Bylaws.

3.1.11 **Loss of Clinical Affiliation Agreement:** A practitioner whose Clinical Affiliation Agreement to provide services for the benefit of UNMH has terminated, or whose employment or contractual relationship with an entity with a Clinical Affiliation Agreement to provide services for the benefit of UNMH has terminated, will automatically lose their Medical Staff membership without further action required of the Medical Executive Committee or Governing Body without the right to a hearing or appeal procedures provided by these Bylaws.

3.1.12 **Involuntary Change in Employment Status:** For providers employed outside of the UNM Health System, any involuntary change in employment status must immediately be reported to the UNM Associate Dean for Clinical Affairs, CMO and the Chief of Staff.

3.1.13 **Failure of an APP or AHP to Maintain a Collaborating or Supervisory Agreement, if required:** The privileges of these APPs and AHPs who require either a collaborating or supervisory agreement shall terminate immediately, without right to due process, in the event the employment or contractual relationship of the APP or AHP is terminated for any reason or if the employment contract or contractual relationship of the APP or AHP with a physician Member of the Medical Staff organization is terminated for any reason.

3.1.14 **Failure to Complete Medical Records:** Should a provider exhibit frequent or high volume medical record delinquencies in spite of maximal utilization of Clinical Service administrative means to encourage completion, the Clinical Service Chief may refer the matter to the Medical Staff through the ADCA, the CMO, or the COS for consideration of further Medical Staff professional review and corrective action, which may include a recommended focused professional practice review for timely completion of medical documentation, or up to referral for consideration of automatic suspension. Failure to comply with UNM Hospitals clinical documentation policies and requirements may result in the automatic suspension of a Medical Staff Member, provided that the suspension must be preceded by a written warning to the Member from the ADCA, the CMO, the COS, or their designate that the Member has fourteen (14) calendar days to comply with UNM Hospitals clinical documentation policies and requirements or automatic suspension may be imposed. The ADCA, the CMO, the COS, or their designate will provide the Medical Staff Member and the Medical Staff Member's Clinical Service Chief with a copy of the written warning. If the ADCA, the CMO, the COS, or their designate subsequently initiates an automatic suspension, he/she will provide the Medical Staff Member and the Medical Staff Member's Clinical Service Chief with immediate written notification of the automatic suspension. The suspension will be in effect for the time specified in the notice of suspension, but may not exceed ten (10) consecutive calendar days.

3.1.15 **Failure to Execute Release and/or Provide Documents:** A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the Chief of Staff or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. After thirty (30) calendar days, the Member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.16 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC may convene to review and consider the facts, and may subsequently recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

3.2 Summary Suspension

3.2.1 **Criteria for Initiation:** A summary suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CEO determines that there is a need to carefully consider any event, concern, or issue, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances one (1) Medical Staff Leader (Chief of Staff, Vice Chief of Staff, Dean, or ADCA **AND** one (1) administrator (CEO, CMO, or Senior Administrator-on-call) may restrict or suspend the Medical Staff membership or clinical privileges of such practitioner. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such summary suspension shall become effective immediately upon imposition and the persons responsible shall promptly give written notice to the practitioner, the Clinical Service Chief, the MEC through the Chief of Staff, the ADCA, the CEO, and the Board through the CEO. If the affected Member has a faculty relationship with UNM, written notice shall also be given to the Dean of the School of Medicine. The summary suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances causing the suspension.

Unless otherwise indicated by the terms of the summary suspension, the practitioner'spatients shall be promptly assigned to another Medical Staff Member by the Chief of Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.1.1 **Right to Rescind Summary Suspension or Restriction**. The Medical Staff leader and hospital administrator who initially imposed a summary suspension may rescind that summary suspension or restriction with notice to the practitioner, the Clinical Service Chief, the MEC through the Chief of Staff, the Dean, the Associate Dean for Clinical Affairs, the CEO, and the Board through the CEO.

3.2.2 **MEC action:** In the event that the summary suspension has not been automatically lifted, as soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary suspension, but in any event, it shall furnish the practitioner with notice of its decision.

3.2.3 **Procedural rights:** Unless the MEC promptly terminates the summary suspension prior to or immediately after reviewing the results of any investigation described above, the Member or other physician or dentist with privileges without membership shall be entitled to the procedural rights afforded by this hearing and appeal plan once the summary suspension lasts more than fourteen (14) calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an adverse recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

a. Denial of Medical Staff appointment or reappointment;

b. Revocation of Medical Staff appointment;

c. Denial or restriction of requested clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the Member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;

d. Involuntary reduction or revocation of clinical privileges;

e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff Member and is imposed for more than fourteen (14) calendar days; or

f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the Member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

a. Issuance of a letter of guidance, warning, or reprimand;

b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;

c. Failure to process a request for a privilege when the applicant/Member does not meet the eligibility criteria to hold that privilege;

d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;

e. Requirement to appear for a special meeting under the provisions of these Bylaws;

f. Automatic relinquishment or voluntary resignation of appointment or privileges;

g. Imposition of a summary suspension that does not exceed fourteen (14) calendar days;

h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination an application is incomplete or untimely;

j. Determination an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination an applicant for membership does not meet the requisite qualifications/criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by hospital;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned staff category;

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges after a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;

z. Grant of conditional appointment or appointment for a limited duration; or

aa. Appointment or reappointment for duration of less than 24 months.

4.3 Notice of Recommendation of Adverse Action

When a summary suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no later than five (5) calendar days) be given written notice by the Chief of Staff delivered either in person or by email, or via certified mail, return receipt requested, if unable to confirm receipt by in-person or email delivery. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);

b. Notice the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to request a hearing on the recommendation;

c. Notice the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and

d. The individual shall receive a copy of Part II of these Bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the Chief of Staff or designee. In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the Chief of Staff or designee shall schedule the hearing and shall give written notice to the person who requested the hearing and to the applicable Clinical Service Chief. The notice shall include:

a. The time, place, and date of the hearing;

b. A proposed list of witnesses (as known at the time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;

c. The names of the hearing panel members and presiding officer or hearing officer, if known; and

d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request the other party provide either a list of, or copies of, all documents offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. The CMO and Chief of Staff shall jointly present a slate of candidates to the MEC. The MEC will appoint the panel from the slate or from nominations accepted from the floor. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level and shall have no obvious personal or professional conflict with the member. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the Member requesting the hearing.

b. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in private professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

c. The Chief of Staff, or designee, shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the Chief of Staff, who, in conjunction with the CMO, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, they are not entitled to veto the member’s participation. Final authority to appoint panel members will rest with the MEC.

5.2 Hearing Panel Chairperson

5.2.1 The Hearing Panel shall select one of its own to serve as chair.

5.2.2 The hearing panel chair shall do the following:

a. Act to ensure all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or causes undue delay. In general, it is expected a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions pertaining to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

h. Seek legal counsel when they feel it is appropriate. The Office of University Counsel may advise the panel.

5.3 Hearing Officer

5.3.1 As an alternative to the hearing panel described above, the CMO in conjunction with the Chief of Staff (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

5.3.2 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

6.1.1 There is no right to formal "discovery" in connection with the hearing. The hearing panel chair or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee minutes;

d. Copies of any other documents relied upon by the MEC or the Board;

e. No information regarding other practitioners shall be requested, provided, or considered; and

f. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

6.1.2 Prior to the hearing, on dates set by the hearing panel chair or hearing officer, or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The hearing panel chair or hearing officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

6.1.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that individual or their counsel.

6.2 Pre-Hearing Conference

The hearing panel chair or hearing officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the hearing panel chair or hearing officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the, chair of the hearing panel, or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at the individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of New Mexico.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To introduce exhibits;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by legal counsel, or the Member may select a Medical Staff Member in good standing or a Member of the affected Member's local professional society, who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for their client. Both sides shall notify the other of the name of their counsel or advisor at least ten (10) calendar days prior to the date of the hearing;

e. In lieu of or in conjunction with legal counsel, the MEC may appoint a voting member of the Medical Executive Committee to represent the Medical Executive Committee at the hearing, to present facts in support of the Medical Executive Committee's adverse recommended action, and to call, examine, and cross-examine witnesses;

f. To submit a written statement at the close of the hearing.

6.5.2 Any individuals requesting a hearing who do not testify on their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed within ten (10) business days, following the close of the hearing.

6.8 Official Notice

The hearing panel chair or hearing officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.9 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the hearing panel chair or hearing officer on a showing of good cause.

6.10 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief of Staff or CMO. All members of the hearing panel shall be present, absent good cause, for all stages of the hearing and deliberations.

6.11 Order of Presentation

The Board or the MEC's designee, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

6.12 Adjournment and Conclusion

The hearing panel chair or hearing officer may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.13 Basis of Recommendation

The Hearing Panel shall recommend in favor of the MEC (or the Board) unless it finds the individual who requested the hearing has proved, by a preponderance of the evidence, the recommendation prompting the hearing was arbitrary, capricious, or not supported by credible evidence.

6.14 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except counsel if so desired) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation. A hearing panel member absent from any part of the hearing may not vote unless he/she reads the transcript for the portion of the hearing which he/she was absent.

6.15 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the MEC through the Chief of Staff with copy to the member, the ADCA, the CMO, and the Clinical Service Chief. At its next regular meeting, at a special meeting called for that purpose, or as soon thereafter as practicable, the Medical Executive Committee will consider and act upon the report and recommendations submitted to Medical Executive Committee. The Chief of Staff, or designee, will inform the affected Member of the Medical Executive Committee's decision, in writing, delivered by certified or registered U.S. mail, return receipt requested, to the last address provided by the affected Member, by verified hand-delivery to the Member, or by other reasonable means expected to provide actual notice to the affected Member, at the earliest practicable date after the Medical Executive Committee renders its decision.

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

a. If the Medical Executive Committee's recommended action adversely affects an applicant for membership on the Medical staff or an affected Member's membership on the Medical Staff or the exercise of his or her privileges, the Member may appeal that recommended action to the Governing Body, through the Associate Dean for Clinical Affairs, as provided in Section 13.009 of these Bylaws.

b. The affected Member shall request such an appellate review by delivering, by first class U.S. Mail or hand-delivery, a written request which shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review to the Governing Body, through the Chief of Staff, within fifteen (15) calendar days after the affected Member receives notice of an adverse Medical Executive Committee recommended action.

c. If the affected Member does not submit a written request for appellate review within fifteen (15) calendar days after the Member receives the Medical Executive Committee's adverse recommended action, the Member will be deemed to have waived the Member's right to an appellate review and to have accepted the adverse recommended action.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

a. The chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate it is new, relevant evidence and any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at the individual's expense. The review panel may, but shall not be required to, order oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of New Mexico.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty (30) minute oral argument. The review panel shall recommend final action to the Board.

d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the Medical Executive Committee and the affected Member through the Associate Dean for Clinical Affairs. In turn, the Associate Dean for Clinical Affairs will provide notice of the Governing Body's final decision to the affected Member by certified or registered U.S. mail, return receipt requested, to the last address provided by the Member, by verified hand-delivery, or by other means reasonably expected to provide actual notice to the Member, with copy to CMO, Chief of Staff, Clinical Service Chief, and Credentials Committee Chair.

7.6 Right to One Appeal Only

No applicant or Medical Staff Member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current Member or a physician or dentist with privileges without membership, that individual may not apply for Medical Staff appointment or for those clinical privileges at this hospital.

7.7 Fair hearing and appeal for those with privileges without Medical Staff membership and who are not physicians or dentists

It is noted, if the practitioner is to be voluntarily reported to the NPDB, the practitioner must have the full fair hearing and appeal process as noted above, instead of the simplified version below.

Doctors of oriental medicine and chiropractors, or other practitioners not providing a medical level of care, are not entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect their exercise of clinical privileges, the practitioner and their supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The practitioner and the supervising physician, if applicable, must request such a meeting in writing to the CEO within ten (10) business days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician, if applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board.

The practitioner and the supervising physician, if applicable, may request an appeal in writing to the CEO within ten (10) days of receipt of the findings of the review body. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the practitioner, they will not be allowed to reapply for privileges.

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

December, 2020

Table of Contents

Section 1.	Medical Staff Credentials Committee	1
Section 2.	Qualifications for Membership and/or Privileges	3
Section 3.	Initial Appointment Procedure	7
Section 4.	Reappointment	15
Section 5.	Clinical Privileges	17
Section 6.	Clinical Competency Evaluation	21
Section 7.	Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies	22
Section 8.	Practitioners Providing Contracted Services	23
Section 9.	Medical Administrative Officers	24

Section 1. Medical Staff Credentials Committee

1.1 Composition

Voting membership of the Credentials Committee shall consist of: at least ten (10) Voting Members of the Medical Staff including at least one APP representative appointed as voting members by the Chief of Staff. Additional voting membership of the Credentials Committee shall consist of the Chief of Staff, ADCA, CMO or designee, CNO or designee.

The appointed Members shall be appointed for staggered 3-year terms, with no term limits. The chair shall be an experienced Credentials Committee member appointed by the Chief of Staff in consultation with the ADCA and CMO for a 3-year term, with no term limits.

1.2 Meetings

The Medical Staff credentials committee shall meet at least ten (10) times per year and on call of the chair or Chief of Staff.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;

1.3.3 To recommend eligibility criteria for the granting of Medical Staff membership and privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports referred to it from other Medical Staff committees, Medical Staff or hospital leaders;

1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical Staff, administrative leaders, and payor auditors may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Chief of Staff, CMO Credentials Committee Chair, who shall consult with the ADCA and the Office of University Counsel. Review of such files will be conducted in the presence of the Medical Staff Service Professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

2.1 No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate their background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.2.2 Demonstrate they have successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.3 Have a current state license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of New Mexico. The license must be unrestricted for initial application;

2.2.4 Possess a current, valid, drug enforcement administration (DEA) number and New Mexico Controlled Substance Registration (NM CSR), if applicable. The DEA and NM CSR must be unrestricted for initial application;

2.2.5 Possess a valid NPI number;

2.2.6 Be a US citizen or have work permit or Visa if not a US citizen;

2.2.7 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC if during the applicant's membership on the Medical Staff, the applicant will not be covered by the Public Liability Fund administered by the New Mexico State Risk Management Division pursuant to the New Mexico Tort Claims Act;

2.2.8 Have a record free from past or current Medicare/Medicaid exclusions and not be on the OIG List of Excluded Individuals/Entities;

2.2.9 Have a record showing the applicant has not been convicted of, or entered a plea of guilty or no contest to, any felony, relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder) in the past ten (10) years;

2.2.10 Have a record showing the applicant has never had appointment or privileges denied, limited, or terminated for a reason related to competence or conduct (or resigned while under investigation);

2.2.11 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within six (6) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association;

2.2.12 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.13 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved residency program accredited by the Commission of Dental Accreditation and be board certified or become board certified within six (6) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

2.2.14 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within six (6) years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

2.2.15 A psychologist must have an earned a doctorate degree, (PhD, Psy.D, or EdD) in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA);.

2.2.16 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either;

2.2.17 A certified anesthesiologist assistant (CAA) must have successfully completed a graduate level degree program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or any of the commission's successor organizations, which qualifies the candidate to sit for the National Commission for Certification of Anesthesiologist Assistants (NCCAA) examination. Current certification by the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) as a Certified Anesthesiologist Assistant (CAA);

2.2.18 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB);

2.2.19 A certified nurse practitioner (CNP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program [within the Nurse Practitioner's specialty area] accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC), the American Association of Critical Care Nurses (AACN), the American Academy of Nurse Practitioners Certification Board (AANPCB), the Pediatric Nursing Certificaton board (PNCB), the National Certificaiton Corporation (NCC), or an equivalent body.;

2.2.20 A clinical nurse specialist (CNS) must have a masters, or post-masters degree or certification in an accredited nursing program within the CNS's specialty area. Current certification by the American Nurses Credentialing Center (ANCC), or by the American Association of Critical Care Nurses (AACN);

2.2.21 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C;

2.2.22 A Pharmacist Clinician (PhC) must have completed a Pharm D degree from an Accreditation Council for Pharmacy Education (ACPE) accredited school or College of Pharmacy and one year professional pharmaceutical (clinical residency or fellowship) training in clinical pharmacotherapy within a clinical setting, or one year of commensurate clinical work experience and New Mexico board of Pharmacy Pharmacist Clinical Approved Protocol with UNMH credentialed supervisor;

2.2.23 A Doctor of Optometry (OD) must have completed a Doctor of Optometry (OD) degreed program at a college of optometry approved by the American Optometric Association's Council of Optometric Education (AOACOE).

2.3 In addition to privilege-specific criteria, the following qualifications must also be met and maintained by all applicants requesting clinical privileges:

2.3.1 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of their responsibilities of Medical Staff membership and/or the specific privileges requested by and granted to the applicant;

2.3.2 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.3 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.4 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan;

2.3.5 Have appropriate written and verbal communication skills; and

2.3.6 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum:

a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and

b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

2.4 Exceptions

2.4.1 All practitioners who are current Medical Staff Members and/or hold privileges as of the date listed below and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements. Specific dates are: University of New Mexico Hospital: July 1, 1999.

2.4.2 Only the Board may create additional exceptions but only after consultation with the MEC and if there is documented evidence a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

2.4.3 For any applicant seeking an exception to any requirements in 2.2.1, 2.2.2, 2.2.11 thorough 2.2.23, and/or 2.3, and who seeks exception through documentation of similar training and certification, the Clinical Service Chief must submit a recommendation for said exception.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 Applications will be sent only upon request of the Clinical Service Chief. Completed applications are to be returned to Medical Staff Affairs. Upon receipt of the request, Medical Staff Affairs will provide the applicant an application package, which will include a complete set or overview of the Medical Staff Bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

d. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card;

e. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested. At least one (1) reference should be from someone of the same professional discipline as the applicant;

f. Relevant practitioner-specific data as compared to aggregate data, when available;

g. ECFMG for foreign graduates only;

h. Visa, or work permit, for non-US citizens only;

i. DD-214 to document military service, if applicable; and

j. Clinical activity, and when available, morbidity and mortality data.

k. Applicants seeking credentials based upon foreign education and/or training, may be required to register for an ECFMG EPIC account and authorize release of information to Medical Staff Affairs.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application, except for those with pending state licensure only, will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure Medical Staff Affairs receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to Medical Staff Affairs within thirty (30) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the credentials chair, or designee, in collaboration with Medical Staff Affairs, will determine if the requirements of Sections 2.2 and 2.3 are met. In the event the requirements of Sections 2.2 and 2.3 are not met, the potential applicant will be notified they are ineligible to apply for membership or privileges on the Medical Staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Sections 2.2 and 2.3 are met, the application will be accepted for further processing.

3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.1.5 Upon receipt of a completed electronic application, Medical Staff Affairs will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, Medical Staff Affairs will collect relevant additional information which may include:

a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past five (5) years;

b. Verification of the applicant's past clinical work experience for at least the past five (5) years;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, Medical Staff Affairs will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

d. Verification of DEA and NPI status;

e. Information from the AMA or AOA Physician Profile, OIG list of Excluded Individuals/Entities or SAM (System for Award Management);

f. Information from professional training programs including residency and fellowship programs;

g. Information regarding board certification status;

h. Information from the National Practitioner Data Bank (NPDB); In addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;

i. Other information about adverse credentialing and privileging decisions;

j. At least three (3) peer recommendations, as selected by the credentials committee, and at least one (1) peer recommendation, as selected by the applicant, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

k. Information from a lifetime criminal background check consistent with the medical staff policy on Criminal Background Checks;

l. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges; and

m. Clinical activity, and when available, morbidity and mortality data.

Note: In the event there is undue delay in obtaining required information, Medical Staff Affairs will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after thirty (30) calendar days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Acknowledgement

The applicant must complete and sign the application form. By signing this application, the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to their application.

3.2.3 Authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on their professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to hospital and Medical Staff representatives' inspection of all records and documents material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the Medical Staff, including otherwise privileged or confidential information to the hospital representatives concerning their background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.6 Authorizes the hospital Medical Staff and administrative representatives to release any and all credentialing information to other hospitals, licensing boards, delegated payors, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any Medical Staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges the applicant has had access to the Medical Staff Bylaws, including all rules, regulations, policies and procedures of the Medical Staff, and agrees to abide by their provisions.

Notwithstanding Sections 3.2.5 through 3.2.6, if an individual institutes legal action and does not prevail, they shall reimburse the Hospital and any Member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.2.8 Agrees to provide accurate answers to the questions on the application, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

3.3.1 **Credentialing Process:** An expedited review and approval process may be used for initial appointment or for reappointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Clinical Service Chief, credentials chair acting on behalf of the credentials committee, a quorum of the MEC pursuant to Section 7.4.2 of Part I of these Bylaws, and a Board committee consisting of at least two individuals.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Clinical Service Chief, credentials committee, MEC, and the Board. The credentials committee may request an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence they meet the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC, upon review of a Category I file, is adverse or with limitation;

c. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

e. Applicant has had either an unusual pattern of, or an excessive number of, professional liability actions against the applicant.

f. Applicant changed medical schools or residency programs or has unexplained gaps in training or practice, excluding maternity, paternity, or military leave;

g. Applicant has changed practice affiliations more than three times in the past ten (10) years, excluding telemedicine and locum tenens practitioners;

h. Applicant has one or more reference responses that raise concerns or questions;

i. Discrepancy is found between information received from the applicant and references or verified information;

j. Applicant has an adverse National Practitioner Data Bank report unrelated to professional liability actions;

k. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

l. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

m. Applicant has potentially relevant physical, mental, and/or emotional impairments;

n. Other reasons as determined by a Medical Staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.3.2 Applicant Interview

a. All applicants for appointment to the Medical Staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Clinical Service Chief, credentials committee, MEC, or Board. The interview may take place in person or by telephone or teleconference, at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate Medical Staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.3.3 Clinical Service Chief Action

a. All completed applications are presented to the Clinical Service Chief for review, and recommendation. The Clinical Service Chief reviews the application to ensure it fulfills the established standards for membership and/or clinical privileges. The Clinical Service Chief, in consultation with the Medical Staff Professional, determines whether the application is forwarded as a Category 1 or Category 2. The Clinical Service Chief may obtain input if necessary from an appropriate subject matter expert. If a Clinical Service Chief believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation they will notify the credentials chair and forward the application without comment.

b. The Clinical Service Chief forwards to the Medical Staff credentials committee the following:

i. A recommendation as to whether the application should be acted on as Category 1 or Category 2;

ii. A recommendation as to whether to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

iii. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

iv. Comments to support these recommendations.

3.3.4 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the credentials chair, or designee, for review and recommendation. The Credentials Chair reviews the application to ensure it fulfills the established standards for membership and/or clinical privileges. The Credentials Chair has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the Medical Staff credentials committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the Medical Staff credentials committee reviews the application and forwards the following to the MEC:

a. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

c. Comments to support these recommendations.

3.3.5 MEC Action

If the application is designated Category 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. The Chief of Staff has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. The application is reviewed to ensure it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;

b. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and

c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.

d. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.6 Board Action:

The Board, or committee of the Board by designation, reviews the application and votes for one of the following actions:

a. If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

b. If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:

   i. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;

   ii. If the Board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or

   iii. The Board shall take final action in the matter as provided in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.3.7 **Notice of final decision:** Notice of the Board's final decision shall be given, through the CEO to the Medical Staff Affairs office. The Medical Staff Affairs office will notify the Chief of Staff who will, through the appropriate credentialing/enrollment Liaison, provide notice to the applicant and the Chief of each Clinical Service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Clinical Service to which they are assigned, the clinical privileges he/she may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.3.8 **Time periods for processing:** All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment

4.1 Criteria for Reappointment

4.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine the practitioner provides effective care consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff Members or other practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 6.1 below concerning focused professional practice evaluation. A suitable peer shall substitute for the Clinical Service Chief in the evaluation of current competency of the Clinical Service Chief, and recommend appropriate action to the credentials committee.

4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before four (4) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from Medical Staff Affairs notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least ninety (90) calendar days prior to this date the practitioner must return the following to Medical Staff Affairs:

a. A completed reapplication form, which includes complete information to update their file on items listed in their original application, any required new, additional, or clarifying information.

b. Information concerning continuing training and education internal and external to the hospital during the preceding period; and

c. By signing the reapplication form the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 From internal and/or external sources: Medical Staff Affairs collects and verifies information regarding each practitioner's professional and collegial activities to include responses on the professional practice questions as delineated on the credentialing application and primary source verification as listed in 3.1.5..

4.2.3 The following information is also collected:

a. A summary of clinical activity at this hospital for each practitioner due for reappointment;

b. Performance and conduct in this hospital and other healthcare organizations in which the practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. Attestation of any required hours of continuing medical education activity;

d. Service on Medical Staff, Clinical Service, and hospital committees;

e. Timely and accurate completion of medical records;

f. Compliance with all applicable Bylaws, policies, rules, regulations, and procedures of the hospital and Medical Staff;

g. Any significant gaps in employment or practice since the previous appointment or reappointment;

h. Verification of current licensure;

i. National Practitioner Data Bank query and information from the OIG List of Excluded Individuals/Entities or SAM (System for Award Management);

j. Two peer evaluations, one or both of which may be directed by the credentials committee.

k. When peer review data is either not available or insufficient to evaluate competency, or in the discretion of credentials committee, one or more additional peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges; and

l. Malpractice history for the past two (2) years, which is primary source verified by Medical Staff Affairs with the practitioner's malpractice carrier(s).

4.2.4 Failure, without good cause, to provide any requested information, at least sixty (60) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, Medical Staff Affairs verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1 above.

4.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of the Medical Staff Bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

Section 5. Clinical Privileges

5.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not Members of the Medical Staff. Such individuals may be chiropractors, doctors of oriental medicine, physicians serving as telemedicine physicians, or others deemed appropriate by the MEC and Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the Medical Staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

5.3.2 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

5.3.3 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

5.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require all dental patients receive a basic medical evaluation (history and physical) by a physician Member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

5.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician Member of the Medical Staff will be recorded in the medical record. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence.

5.6 Special conditions for practitioners eligible for privileges without membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges.

5.7 Special Conditions for Fellows in Training

5.7.1 Fellows in training in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges unless they are functioning in an unaccredited program. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Graduate Medical Education Committee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

5.7.2 The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.8 Telemedicine Privileges

5.8.1 Requests for telemedicine privileges at the hospital including patient care, treatment, and services will be processed through one of the following mechanisms:

a. The hospital fully privileges and credentials the practitioner if the telemedicine hospital/entity is not Joint Commission accredited; or

b. The hospital privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission accredited hospital or telemedicine entity and the information is then processed through the routine Medical Staff credentialing and privileging process. The distant-site practitioner must have a license issued or recognized by the State of New Mexico.

5.9 Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in one (1) circumstances: 1) to fulfill an important patient care, treatment, or service need. Any applicant desiring temporary privileges when they are an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board will be processed using the expedited credentialing process.

5.9.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.

5.9.2 Clean Application Awaiting Approval: These applications will be processed using the expedited credentialing process.

5.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

5.9.4 Termination of temporary privileges: The CEO, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose a summary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief of Staff or their designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

5.9.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because their request for temporary privileges is refused or because all or any part of their temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.9.6 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Clinical Service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.9.7 Disaster Privileges:

a. If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected licensed independent practitioners (LIPs). These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

   i. A current picture hospital ID card clearly identifies professional designation;

   ii. A current license to practice;

   iii. Primary source verification of the license;

   iv. Identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

   v. Identification indicating the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

   vi. Identification by a current hospital or Medical Staff Member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The Medical Staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

c. The Medical Staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

d. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in seventy-two (72) hours, there is documentation of the following: 1) why primary source verification could not be performed in seventy-two (72) hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

e. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

f. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The credentials committee, after receiving a recommendation from the Clinical Service Chief, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration for such FPPE and triggers indicating the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The Medical Staff will also engage in OPPE to identify professional practice trends affecting quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

6.3 Practitioner Re-Entry

A practitioner who has not provided care within an area of practice within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, acceptable to the credentials committee and MEC, either with a current Member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent practitioner practicing outside of the hospital. If a practitioner has not provided any clinical care within the past five (5) years as determined by their New Mexico licensing board or the MEC, they may be required to go through a formal re-entry process through an ACGME or AOA accredited residency program or other formal process to assess and confirm clinical competence. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. A description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Clinical Service Chief and/or credentials committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a. The scope and intensity of the required activities;

b. The requirement for submission of a written report from the preceptor or training program prior to termination of the preceptorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges.

7.2 Request for modification of appointment status or privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Clinical Service assignment, or clinical privileges by submitting a written request to Medical Staff Affairs. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines they no longer exercise, or wish to restrict or limit the exercise of, particular privileges they have been granted shall send written notice, through Medical Staff Affairs, to the credentials committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign their staff appointment and/or clinical privileges must provide written notice to the appropriate Clinical Service Chief or Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns their staff appointment and/or clinical privileges is obligated to fully and accurately complete all residual medical staff obligations, including available portions of all medical records for which they are responsible prior to the effective date of resignation. Failure to do so may result in an entry in the practitioner's credentials file acknowledging the resignation and indicating it became effective under unfavorable circumstances.

7.4 Exhaustion of administrative remedies

Every practitioner agrees they will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting requirements

The CEO through their designee, the Associate Dean for Clinical Affairs shall be responsible for assuring the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Reportable actions include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Practitioners Providing Contracted Services

8.1 When the hospital contracts for care services with licensed independent practitioners who provide readings of images, tracings, or specimens through a telemedicine mechanism, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the hospital through the mechanisms established in this manual.

8.2 Exclusivity policy

Whenever hospital policy specifies certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other practitioners must, except in an emergency or life-threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to the hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital. Practitioners who have previously been granted privileges, which then become covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

8.3 Qualifications

A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of their appointment category as any other applicant or staff appointee.

8.4 Disciplinary Action

The terms of the Medical Staff Bylaws will govern disciplinary action taken by or recommended by the MEC.

8.5 Effect of contract or employment expiration or termination

The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

Section 9. Medical Administrative Officers

9.1 A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

9.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge staff obligations appropriate to their staff category in the same manner applicable to all other staff Members.

9.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

9.3.1 Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect an adverse change in the officer's staff appointment or clinical privileges has on their remaining in office.

9.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Board.

9.3.3 A medical administrative officer has the same procedural rights as all other staff Members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

A Resolution

THE REGENTS OF THE UNIVERSITY OF NEW MEXICO
RESOLUTION

RATIFYING AND APPROVING THE EXECUTION AND DELIVERY OF THE HUD DOCUMENTS RELATING TO THE REGENTS OF THE UNIVERSITY OF NEW MEXICO'S HUD-INSURED LOAN; AND AUTHORIZING ANY OTHER NECESSARY ACTION TO EFFECT THE DELIVERY OF THE HUD-INSURED LOAN.

WHEREAS, the Regents of the University of New Mexico (the "**University**") is a state educational institution and body corporate under the Constitution and laws of the State of New Mexico with requisite corporate power and authority to operate hospital facilities and to carry on its business as presently being conducted; and

WHEREAS, the Board of Regents (the "**Board**") is constituted and empowered under the Constitution and laws of the State of New Mexico to control and manage the affairs of the University, including the care and preservation of all its property, the erection and construction of all buildings necessary for its use, with the authority to contract and be contracted with; and

WHEREAS, the Board previously approved the development of a project to construct a new hospital tower as a part of the UNM Hospitals (the "**Hospital**") as described more fully in Attachment A to these Resolutions and incorporated herein by reference (collectively, the "**Project**"); and

WHEREAS, the Board has determined it is appropriate for the University and the Hospital to seek a Commitment for Mortgage Insurance (the "**HUD Commitment**") in an amount not to exceed $320,000,000 (the "**HUD Commitment Amount**"), to finance the Project pursuant to a mortgage loan insurance program administered by the U.S. Department of Housing and Urban Development ("**HUD**") under Section 241, pursuant to Section 242, of Title II of the National Housing Act; and

WHEREAS, in order to obtain this HUD Commitment, the University, by and through the Hospital, must prepare and submit to HUD an application for mortgage insurance, which include previous participation clearance forms, the results of its financial audit for fiscal year ended June 30, 2020, and a financial feasibility study with respect to the Project; and

WHEREAS, the Board of Trustees of the Hospitals has considered the Project and the Hospital's desire seek the HUD Commitment at the HUD Commitment Amount and has voted to recommend the same to the Board; and

WHEREAS, the Board deems it to be in the best interests of the University and the Hospital to (1) have the Chief Executive Officer ("**Hospital CEO**") of the Hospital and/or the Chief Financial Officer ("**Hospital CFO**"), as authorized by Exhibit B-2 to University Administrative Policies and Procedures Manual Policy 2010, execute one or more Previous Participation Certifications ("**HUD Form 2530**") on behalf of the Hospital and all of the principals of the Hospital; and (2) certify that the Hospital CEO's or Hospital CFO's signature on such HUD Form 2530 attests to the University and the Hospital and all principals of the University and the

Hospital having the same previous participation experience, except as may be otherwise indicated by the Hospital CEO or Hospital CFO on the HUD Form 2530;

NOW, THEREFORE, BE IT RESOLVED THAT, the University and the Hospital through the Authorized Officers (as defined below), is authorized to prepare, execute and file with HUD the Section 242/241 HUD Application, all relevant attachments, instruments, certificates, and other documents thereto necessary to secure the HUD Commitment for HUD Commitment Amount for the Project (each, an "**Application Document**" and, collectively, the "**Application Documents**"); and be it

FURTHER RESOLVED, that the Financial Feasibility Study prepared in connection with the Project by M Rosadini Consultants LLC, dated January 26, 2021, as presented, is accepted and approved; and be it

FURTHER, RESOLVED, that HUD's form of Hospital Regulatory Agreement (HUD-92466-OHF) is accepted and approved and that the Authorized Officers be, and they each hereby are, authorized to execute and deliver said instrument on behalf of the University and the Hospital in connection with the closing of the loan related to the Application Documents; and be it

FURTHER RESOLVED, that the University and the Hospital shall have an Authorized Officer, execute one or more HUD Form 2530s on behalf of all of the principals of the University and the Hospital and that the Board hereby certifies that the Hospital CEO or Hospital CFO's signature on such HUD Form 2530 attests to all principals of the University and the Hospital having the same previous participation experience, except as may be otherwise indicated by the Hospital CEO or of Hospital CFO on the HUD Form 2530; and be it

FURTHER RESOLVED, that the Board designates and authorizes the following: the President, Vice-President and Secretary of the Board of Regents, and the President, Senior Vice President for Finance & Administration, the Executive Vice President for Health Sciences and Chief Executive Officer of the UNM Health System, the HSC Senior Executive Officer for Finance and Administration, the Hospital CEO, and the Hospital CFO (each, an "**Authorized Officer**," and, collectively, the "**Authorized Officers**") to do or cause to be done all such acts or things, and to sign and deliver, or cause to be signed and delivered, all documents, instruments, and certificates, in the name and on behalf of the University and the Hospital or otherwise, including the Application Documents, as they deem necessary, advisable or appropriate to effectuate or to carry out the purposes and intent of the foregoing resolutions.

ADOPTED AND APPROVED this ___ day of ___________, 2021.

THE REGENTS OF THE UNIVERSITY OF NEW MEXICO

[SEAL]

By: ____

Douglas M. Brown, Regent President

ATTEST:

By: ________________________________

Sandra K. Begay,
Regent Secretary and Treasurer

Exhibit A

Description of the Project

The Project consists of the construction of a seven story, approximately 570,000 s.f. new hospital tower structure that will house:

- 96 new inpatient beds, in four 24-bed intensive care units;
- An interventional platform that includes 18 operating rooms, 4 catheterization labs, 6 interventional radiology suites, and a perioperative area with 73 PACU/preop/recovery beds;
- A diagnostic imaging platform that includes 2 MRIs, 3 CT Scanners, 1 Radiology – Fluoroscopy, 2 General Radiation and 2 Ultrasound Rooms; and,
- An adult emergency department that includes 2 trauma, 8 resuscitation, 40 exam, 2 triage, 8 fast track rooms, 10 behavioral exam (2 rooms for persons under the custody of law enforcement).

Executive Vice President Update

EVP Health Sciences & CEO UNM Health System Report to BOT

Good Morning Chairperson Horn, Board of Trustees members, and CEO Becker.

Thank you for this opportunity to share some reflections with you from my first 60 days, to learn from you, and to serve the people of New Mexico. Let me say up front that I have come to understand how deeply important UNMH is to our local community, Bernalillo County and indeed to our state. Our hospital and clinics care for everyone, and the people who work in the hospital are united by one of the most powerful commitments to mission that I have experienced over my career. I am extremely impressed and proud of how we are addressing the COVID crisis: caring for patients with COVID; vaccinating our fellow community-members at the PIT; and all the while keeping our staff safe. The COVID response has required unbelieveable work and commitment from the entire UNMH team, frontline workers and caregivers to leadership, and they are still doing that work on top of everything else. I want to thank them and you for your continued leadership during this time.

I look forward to learning from all of you on the BOT, and already appreciate so deeply your commitments of time and talent to the UNMH Board. Your support of the hospital and work with hospital leadership truly makes a difference.

Reflection of my first 60 days – Over the past 60 days I have had the opportunity to meet, listen and learn from many administrative leaders, faculty, students, and staff in our health system and health sciences campus. I have had the opportunity to tour UNMH, some of the clinics and the mental health center (along with SRMC and the VA). There are so many points of pride at UNM, in the Health Science Center, and our UNM health system. Some key themes are arising on issues and opportunities which I look forward to sharing in the future as I dive more deeply into each. Clearly COVID care, vaccinations, public health, and equity lessons learned are at our forefront; but critically important too are the ongoing efforts to enhance quality and safety; improve patient access to primary through tertiary and quarternary care, advocacy and engagement, continue progress on the new Tower, continue successful School of Medicine residency reaccreditation, educate future healthcare workers, and prepare for the upcoming Cancer Center site visit on February 10th. Addressing legislative matters at the same time has been invigorating and humbling. Our UNM hospitals and clinics provide so many services and so much expertise only available here - our Level I trauma center, our NCI Comprehensive Cancer Center, hopefully our Comprehensive Stroke Center designation on which we are awaiting a decision. We also provide excellent primary care that is the foundation of any health system and subspecialty care that is outstanding. There are many pearls – for example, did you know that our medical school is a national leader in students choosing Family Medicine, our nursing school is a national leader in midwifery, our pharmacy school is a research leader, and our College of Population Health has taken state leadership roles in addressing the public health challenges surrounding COVID-19?

Through many leadership meetings of the UNM Hospital and UNM Health System, I am immersing myself in our clinical operations, care, finances, community outreach, and strategic

thinking. I want to thank CEO Kate Becker and Senior Vice Chancellor Mike Richards, in particular, for their fantastic job of welcoming me and helping to bring me up to speed. I know I have a lot to learn but really feel like I am getting my footing. They have given me great insights and perspectives as I engage with regents, state leaders (the Governor, legislators, etc.), donors, community leaders, Patient and Family Advisory Councils, city and county leaders, Diversity Equity and Inclusion leaders, Wellness initiative leaders, leaders, deans, and department chairs who serve as clinical service chiefs. I am impressed and grateful for how UNMH supports all of the HSC's mission areas – of clinical service, teaching, research and community engagement.

Vaccinations at The Pit – As many of you know, the UNM basketball arena has been turned into a mass vaccination site. I was able to visit the PIT for the first time on the day of the soft launch and have become a fan of all the incredible people who have made this happen. I want to thank Eddie Nuñez, Director of UNM Athletics, and his terrific team in the athletics department. Big thanks to our UNM leadership team at the PIT, including Mike Chicarelli, Carol Thornton, Rob Perry, and Christina O'Connell. These leaders have helped us all create, implement, and adapt our plans of getting to vaccinating more than 3,000 people a day at this site. As many of you know, New Mexico is a national leader in getting the vaccine out to our community and this challenge has more moving parts than we maybe could have ever imagined. The Pit site is working very well and helps us truly deliver more for New Mexicans.

Legislative Session – The 55th legislative session is underway. This 60-day session is unlike any other previously and while we are not allowed to physically be at the capitol we do have excellent representation by Chief Government Affairs Officer Dr. Barbara Damron and her team. There are many important issues, and we are grateful for the preparation and work of the legislative team and our state partners. Examples of our state partnership programs that could help our UNMH patients and families include the Poison and Drug Information Center; the Office of the Medical Investigator focused on learning how to improve health, safety and justice; and also the expansion of our Comprehensive Cancer Center facilities and programs. We hope to see State initiatives on health care work force development that we will be part of.

Chief of Staff Change - I wanted to thank and congratulate Chamiza Pacheco de Alas who has served as the EVP & CEO Chief of Staff for the past few years. Chamiza has an incredible opportunity with the W. K. Kellogg foundation to oversee their New Mexico programs that include improving health. I am sure we will continue to work together. During the transition, please contact Emily Morelli and Alex Sanchez for the support you might need.

Issues coming into focus for the coming year – Lastly, I just want to thank you again for your leadership, time, commitment, and the opportunity to start a dialogue with you. In the future I hope to be able to call on you to get your ideas on how to address the critical issues we all face. COVID challenges have also been new opportunities to provide clinical services, including expanded and enhanced telehealth, teach our learners, and challenge our researchers. COVID has brought focus to the great health inequities and the need to address social determinants of health better. How do we further enhance our patient and family advocacy, access, and

engagement? How will we better help our faculty, staff, and students transition back to the new normal and better enhance wellness, reduce burnout, and expand career development and leadership development opportunities? As an Academic Health Center, we are committed to our patients and families first as well as educating a workforce for the current and future health needs of New Mexicans and our communities in order to discover and apply new knowledge to address health challenges, and engage with our community toward better health. Our education and training programs will enhance our workforce development needs, and continue to improve with new innovations while always focusing on enhancing communication, compassion, dignity, and respect. At a future meeting I hope to be able to share more with you about the initiatives that are occurring in the SOM, COP, CON, and COPH because in an Academic health system we are interconnected to the academics.

In conclusion, together we are committed to our health care mission and the need to further the patient experience, listen to their lived experience and wisdom, and work to enhance quality in our quaternary and tertiary specialty care, as well as expand our primary care and population health to serve all New Mexicans. UNMH has a unique mission in our system, serving our Native American community on whose ancestral lands we sit, our County, and our state, and I look forward to partnering with you as we work to deliver more to New Mexico. I am happy to be here, am continuing to learn, and I am grateful for your support.

HSC Committee Update

MEMORANDUM

To: UNMH Board of Trustees

From: Mike Richards, MD
Vice Chancellor, UNM Health System

Date: January 29, 2021

Subject: Monthly Health System Activity Update

This report represents unaudited year to date December 2020 activity and is compared to audited year to date December 2019 activity.

Activity Levels: Health System total inpatient discharges and observation discharges are down 7% compared to prior year.

Health System total inpatient discharges are down 3% compared to prior year, with discharges down 4% at UNMH and up 5% at SRMC. Health System adult length of stay (without obstetrics) is up 11% compared to prior year, with length of stay up 10% at UNMH and up 21% at SRMC.

Health System observation discharges are down 15% compared to prior year, with observation discharges down 14% at UNMH and down 19% at SRMC.

Case Mix Index (CMI) is up 7% compared to prior year and up 4% compared to FY 21 budget.

Births are down 10% year over year and down 5% compared to budget.

Health System total outpatient activity is up 2% compared to prior year. Primary care clinic visits are up 4% compared to prior year. Specialty and Other clinic visits are down 5% compared to prior year. Emergency visits are up 55% over prior year.

Surgeries overall are down 7% year over year, but up 1% over budget. UNM surgical volume is down 7% and community physician surgical volume is down 23%.

Medical Group RVUs are down 8% over prior year and 6% under budget.

Finances: Health System had total year-to-date operating revenue of $810.4 million, representing a 9% increase over prior year. Total non-operating revenue was $106 million, representing a 6% increase over prior year primarily due to Non-recurring State Appropriations in FY20 and increase in CARES Act Funding not recognized during the same time period last year. Total operating expenses were $850.7 million, representing an 8% increase over prior year. Health System margin was $66.1 million as compared to $51.9 million prior year.

The balance sheet is stable with a current ratio of 1.75 as compared to 1.90 prior year. The cash and cash equivalents for UNM Health System is $553.4 million as compared to $422.8 million prior year. Net patient receivables are up 7% and total assets are up 16%. Total liabilities are up 21% over prior year. Total net position is up 11% over prior year.

UNM HS Total Operations - Stats Snapshot
YTD December 31, 2020

	FY 2021	FY 2020	Change		FY 2021	Variance	
	Actual	Actual	Units	%	Budget	Units	%
Patient Days							
HS	**110,192**	**107,317**	**2,875**	**3%**	**107,593**	**2,599**	**2%**
UNMH	**90,761**	**87,991**	**2,770**	**3%**	**87,443**	**3,319**	**4%**
Adult	58,349	51,675	6,674	13%	51,494	6,855	13%
Obstetrics	6,097	5,959	138	2%	5,990	107	2%
Pediatric	20,430	21,890	(1,460)	-7%	22,192	(1,762)	-8%
Observation	5,885	8,467	(2,582)	-30%	7,767	(1,881)	-24%
Psychiatric	**11,203**	**11,979**	**(776)**	**-6%**	**12,370**	**(1,167)**	**-9%**
Adult	6,817	7,152	(335)	-5%	7,282	(465)	-6%
Pediatric	4,386	4,827	(441)	-9%	5,088	(702)	-14%
SRMC	**8,228**	**7,347**	**881**	**12%**	**7,780**	**448**	**6%**
Adult	6,747	5,331	1,416	27%	5,734	1,013	18%
Observation	1,481	2,016	(535)	-27%	2,046	(565)	-28%
Discharges							
HS	**20,839**	**22,496**	**(1,657)**	**-7%**	**22,416**	**(1,577)**	**-7%**
UNMH	**17,328**	**18,598**	**(1,270)**	**-7%**	**18,463**	**(1,135)**	**-6%**
Adult	7,633	7,418	215	3%	7,315	318	4%
Obstetrics	1,687	1,733	(46)	-3%	1,838	(151)	-8%
Pediatric	2,905	3,532	(627)	-18%	3,656	(751)	-21%
Observation	5,103	5,915	(812)	-14%	5,654	(551)	-10%
Psychiatric	**1,028**	**1,241**	**(213)**	**-17%**	**1,239**	**(211)**	**-17%**
Adult	686	791	(105)	-13%	799	(113)	-14%
Pediatric	342	450	(108)	-24%	440	(98)	-22%
SRMC	**2,483**	**2,657**	**(174)**	**-7%**	**2,714**	**(231)**	**-9%**
Adult	1,441	1,373	68	5%	1,430	11	1%
Observation	1,042	1,284	(242)	-19%	1,284	(242)	-19%
LOS							
HS	**5.3**	**4.8**	**0.5**	**11%**	**4.8**	**0.5**	**10%**
UNMH	**5.2**	**4.7**	**0.5**	**11%**	**4.7**	**0.5**	**11%**
Adult	7.6	7.0	0.7	10%	7.0	0.6	9%
Obstetrics	3.6	3.4	0.2	5%	3.3	0.4	11%
Pediatric	7.0	6.2	0.8	13%	6.1	1.0	16%
Observation	1.2	1.4	(0.3)	-19%	1.4	(0.2)	-16%
Psychiatric	**10.9**	**9.7**	**1.2**	**13%**	**10.0**	**0.9**	**9%**
Adult	9.9	9.0	0.9	10%	9.1	0.8	9%
Pediatric	12.8	10.7	2.1	20%	11.6	1.3	11%
SRMC	**3.3**	**2.8**	**0.5**	**20%**	**2.9**	**0.4**	**16%**
Adult	4.7	3.9	0.8	21%	4.0	0.7	17%
Observation	1.4	1.6	(0.1)	-9%	1.6	(0.2)	-11%
CMI w/o Newborn							
HS (excluding Behavioral)	**2.175**	**2.021**	**0.154**	**8%**	**2.080**	**0.095**	**5%**
UNMH	2.233	2.069	0.164	8%	2.081	0.153	7%
Psychiatric-Adult	1.169	1.143	0.026	2%	1.140	0.029	3%
Psychiatric-Pediatric	1.129	1.086	0.043	4%	1.103	0.026	2%
SRMC	1.698	1.594	0.104	7%	1.622	0.076	5%
Primary Clinics							
HS	**97,837**	**94,292**	**3,545**	**4%**	**90,526**	**7,311**	**8%**
UNMH	90,243	86,902	3,341	4%	82,829	7,414	9%
SRMC	7,594	7,390	204	3%	7,697	(103)	-1%

UNM HS Total Operations - Stats Snapshot
YTD December 31, 2020

	FY 2021	FY 2020	Change		FY 2021	Variance	
	Actual	Actual	Units	%	Budget	Units	%
Specialty Clinics							
HS	**207,608**	**225,402**	**(17,794)**	**-8%**	**206,713**	**895**	**0%**
UNMH - Adult	135,760	147,306	(11,546)	-8%	131,570	4,190	3%
UNMH - Pediatric	38,155	43,291	(5,136)	-12%	38,102	53	0%
SRMC	14,083	15,508	(1,425)	-9%	14,677	(594)	-4%
UNMMG	19,610	19,297	313	2%	22,364	(2,754)	-12%
Other Clinics							
Rad/Onc	12,460	13,935	(1,475)	-11%	15,320	(2,860)	-19%
Med/Onc	19,237	22,572	(3,335)	-15%	23,036	(3,799)	-16%
CPC	22,676	17,094	5,582	33%	18,483	4,193	23%
UPC	74,778	70,907	3,871	5%	79,857	(5,080)	-6%
Urgent Care	4,864	10,808	(5,944)	-55%	10,380	(5,516)	-53%
Emergency Room							
HS	**73,950**	**47,573**	**26,377**	**55%**	**53,510**	**20,440**	**38%**
UNMH - Adult	56,984	26,974	30,010	111%	30,240	26,744	88%
UNMH - Pediatric	8,062	10,193	(2,131)	-21%	11,980	(3,918)	-33%
SRMC	8,904	10,406	(1,502)	-14%	11,290	(2,386)	-21%
Total Outpatient Visits							
HS	**513,409**	**502,583**	**10,827**	**2%**	**497,825**	**15,584**	**3%**
UNMH	463,218	449,982	13,237	3%	441,797	21,421	5%
SRMC	30,581	33,304	(2,723)	-8%	33,664	(3,083)	-9%
UNMMG	19,610	19,297	313	2%	22,364	(2,754)	-12%
Total Surgeries							
HS	**11,012**	**11,869**	**(857)**	**-7%**	**10,870**	**142**	**1%**
UNMH	9,650	10,184	(534)	-5%	9,136	514	6%
SRMC	1,362	1,685	(323)	-19%	1,734	(372)	-21%
Other							
Births	1,374	1,519	(145)	-10%	1,448	(74)	-5%
ECT	269	338	(69)	-20%	326	(57)	-17%
Derm MOHS	2,043	1,829	214	12%	1,892	151	8%
CC Procedures	871	845	26	3%	849	22	3%
Infusion Clinics	10,036	11,996	(1,960)	-16%	12,407	(2,371)	-19%
Work RVU's							
HS	**1,570,537**	**1,704,217**	**(133,680)**	**-8%**	**1,662,300**	**(91,763)**	**-6%**
SOM	1,328,217	1,417,602	(89,385)	-6%	1,358,250	(30,033)	-2%
SRMC	146,029	177,270	(31,241)	-18%	187,297	(41,268)	-22%
MG Clinic	27,176	32,651	(5,475)	-17%	38,814	(11,638)	-30%
Cancer Center	69,115	76,694	(7,579)	-10%	77,939	(8,824)	-11%
FTE's							
HS	**7,505**	**7,477**	**28**	**0%**	**7,815**	**(311)**	**-4%**
UNMH	6,368	6,402	(34)	-1%	6,632	(264)	-4%
SRMC	555	518	36	7%	555	0	0%
UNMMG	582	557	25	5%	628	(46)	-7%

UNM HS Total Operations Snapshot
YTD December 31, 2020
(in thousands)

	FY 2021	FY 2020	Change		FY 2021	Variance	
	Actual	Actual	$	%	Budget	$	%
Net Patient Revenue							
HS	**781,822**	**714,212**	**67,610**	**9%**	**713,315**	**68,507**	**10%**
UNMH	547,913	478,800	69,112	14%	470,215	77,698	17%
CANCER CENTER	53,056	48,405	4,650	10%	52,092	964	2%
PSYCHIATRIC-ADULT	12,319	12,933	(613)	-5%	14,603	(2,284)	-16%
PSYCHIATRIC-PEDIATRIC	5,451	5,539	(87)	-2%	6,047	(596)	-10%
SRMC	40,091	40,678	(587)	-1%	40,010	81	0%
UNMMG	122,992	127,856	(4,865)	-4%	130,348	(7,357)	-6%
Other Operating Revenue							
HS	**28,613**	**27,980**	**634**	**2%**	**30,989**	**(2,375)**	**-8%**
UNMH	24,910	25,330	(420)	-2%	27,793	(2,882)	-10%
CANCER CENTER	-	-	-		-	-	
PSYCHIATRIC-ADULT	1,369	956	413	43%	1,353	17	1%
PSYCHIATRIC-PEDIATRIC	230	163	66	41%	179	50	28%
SRMC	814	627	187	30%	823	(9)	-1%
UNMMG	1,290	903	386	43%	841	449	53%
Total Operating Revenue							
HS	**810,435**	**742,191**	**68,243**	**9%**	**744,303**	**66,132**	**9%**
UNMH	572,823	504,131	68,693	14%	498,007	74,816	15%
CANCER CENTER	53,056	48,405	4,650	10%	52,092	964	2%
PSYCHIATRIC-ADULT	13,688	13,889	(200)	-1%	15,955	(2,267)	-14%
PSYCHIATRIC-PEDIATRIC	5,681	5,702	(21)	0%	6,226	(545)	-9%
SRMC	40,905	41,305	(400)	-1%	40,833	72	0%
UNMMG	124,282	128,760	(4,478)	-3%	131,189	(6,908)	-5%
Total Operating Expense							
HS	**850,730**	**790,902**	**59,828**	**8%**	**807,531**	**43,200**	**5%**
UNMH	594,799	540,654	54,145	10%	545,467	49,332	9%
CANCER CENTER	53,056	48,405	4,650	10%	52,092	964	2%
PSYCHIATRIC-ADULT	21,588	21,301	288	1%	22,577	(989)	-4%
PSYCHIATRIC-PEDIATRIC	11,714	11,155	559	5%	11,441	272	2%
SRMC	45,366	42,275	3,090	7%	44,274	1,092	2%
UNMMG	124,208	127,112	(2,904)	-2%	131,679	(7,471)	-6%
Operating (Loss)/Gain							
HS	**(40,295)**	**(48,711)**	**8,415**	**-17%**	**(63,227)**	**22,932**	**-36%**
UNMH	(21,976)	(36,523)	14,547	-40%	(47,460)	25,484	-54%
CANCER CENTER	(0)	-	(0)		(0)	(0)	100%
PSYCHIATRIC-ADULT	(7,900)	(7,412)	(488)	7%	(6,622)	(1,278)	19%
PSYCHIATRIC-PEDIATRIC	(6,033)	(5,453)	(580)	11%	(5,215)	(818)	16%
SRMC	(4,460)	(970)	(3,490)	360%	(3,440)	(1,020)	30%
UNMMG	74	1,648	(1,574)	-96%	(490)	563	-115%
Non-Operating Revenue							
HS	**106,394**	**100,576**	**5,818**	**6%**	**69,597**	**36,797**	**53%**
UNMH	86,696	83,607	3,089	4%	52,410	34,286	65%
CANCER CENTER	-	-	-		-	-	
PSYCHIATRIC-ADULT	8,542	8,354	188	2%	8,130	413	5%
PSYCHIATRIC-PEDIATRIC	3,573	3,827	(254)	-7%	3,598	(25)	-1%
SRMC	4,460	998	3,463	347%	1,878	2,583	138%
UNMMG	3,123	3,790	(667)	-18%	3,582	(459)	-13%

UNM HS Total Operations Snapshot
YTD December 31, 2020

(in thousands)	FY 2021 Actual	FY 2020 Actual	Change $	Change %	FY 2021 Budget	Variance $	Variance %
Increase/(Decrease) in Net Position							
HS	**66,099**	**51,865**	**14,233**	**27%**	**6,370**	**59,729**	**938%**
UNMH	64,720	47,083	17,636	37%	4,950	59,770	1208%
CANCER CENTER	(0)	-	(0)		(0)	(0)	100%
PSYCHIATRIC-ADULT	642	942	(300)	-32%	1,507	(865)	-57%
PSYCHIATRIC-PEDIATRIC	(2,460)	(1,626)	(834)	51%	(1,617)	(843)	52%
SRMC	0	28	(28)	-100%	(1,563)	1,563	-100%
UNMMG	3,197	5,438	(2,241)	-41%	3,092	104	3%

UNM HS Total Operations - Balance Sheet Snapshot
YTD December 31, 2020

(in thousands)	FY 2021 Actual	FY 2020 Actual	Change $	Change %
Cash & Cash Equivalents				
HS	**553,423**	**422,779**	**130,644**	**31%**
UNMH	499,626	370,280	129,346	35%
SRMC	29,933	32,070	(2,136)	-7%
UNMMG	23,863	20,429	3,434	17%
Total Assets				
HS	**1,365,407**	**1,180,578**	**184,829**	**16%**
UNMH	1,067,719	902,348	165,371	18%
SRMC	152,444	161,211	(8,767)	-5%
UNMMG	151,328	121,830	29,499	24%
Elimination	(6,085)	(4,811)	(1,274)	26%
Total Liabilities				
HS	**697,183**	**578,453**	**118,730**	**21%**
UNMH	492,952	390,483	102,469	26%
SRMC	131,832	140,599	(8,767)	-6%
UNMMG	78,483	52,181	26,302	50%
Elimination	(6,085)	(4,811)	(1,274)	26%
Total Net Position				
HS	**668,224**	**602,125**	**66,099**	**11%**
UNMH	574,767	511,865	62,902	12%
SRMC	20,612	20,611	0	0%
UNMMG	72,845	69,649	3,197	5%

UNM HS Total Operations - Balance Sheet
YTD December 31, 2020
(In thousands)

	Total HS	Total HS FY 2020	FY 20 vs. FY 21 $ Change	FY 20 vs. FY 21 % Change
ASSETS				
Cash	516,427	385,799	130,628	34%
Marketable Securities	36,996	36,980	16	0%
Patient Receivable	460,871	439,859	21,012	5%
Total Allowance for Doubtful Accounts	(282,901)	(273,833)	(9,068)	3%
Total Net Patient Receivable	**177,970**	**166,026**	**11,944**	**7%**
IME, GME, DSH Receivable	58,167	71,210	(13,043)	-18%
Related Party A/R	9,102	7,829	1,274	16%
AR- County Mill Levy	30,681	1,936	28,744	1484%
Other Receivables	20,884	19,614	1,270	6%
3rd Party Settlements	11,009	11,287	(277)	-2%
Prepaid	7,054	7,453	(399)	-5%
Inventory	21,138	19,194	1,944	10%
Total Current Assets	**889,428**	**727,327**	**162,101**	**22%**
Assets Whose Use is Limited	140,561	112,821	27,741	25%
Rest Cash Equiv for Debt Service	-	6,313	(6,313)	-100%
Prepaid Expense & Deposits - Mgmt Co	1,496	2,053	(558)	-27%
PP&E	844,296	825,318	18,978	2%
Accumulated Depreciation	(511,305)	(494,186)	(17,120)	3%
Total Net PP&E	**332,991**	**331,132**	**1,858**	**1%**
Total Non-Current Assets	**475,047**	**452,319**	**22,728**	**5%**
Total Assets	**1,364,475**	**1,179,646**	**184,829**	**16%**
DEFERRED OUTFLOWS	**932**	**932**	**-**	**0%**
LIABILITIES				
Payable to UNM & UNM Affiliates	81,764	52,293	29,471	56%
Accounts Payable	127,484	77,013	50,471	66%
3rd Party Settlements	92,415	67,159	25,257	38%
Accrued Compensation	43,052	32,802	10,250	31%
Payroll Liabilities	27,866	43,655	(15,789)	-36%
Bonds Payable - Current	5,950	10,225	(4,275)	-42%
Interest Payable Bonds	78	2,651	(2,573)	-97%
Other Accrued Liabilities	128,602	97,224	31,378	32%
Total Current Liabilities	**507,211**	**383,021**	**124,189**	**32%**
Total Long-Term Liabilities	**188,913**	**194,372**	**(5,459)**	**-3%**
Total Liabilities	**696,124**	**577,394**	**118,730**	**21%**
DEFERRED INFLOWS	**1,059**	**1,059**	**-**	**0%**
NET POSITION				
Restricted Fund	33,585	37,442	(3,858)	-10%
Restrict Trst Ind & Debt Agree	36,315	39,565	(3,250)	-8%
PP&E Fund	137,494	131,560	5,934	5%
General Fund	460,831	393,559	67,272	17%
Total Net Position	**668,224**	**602,125**	**66,099**	**11%**
Current Ratio	*1.75*	*1.90*	*(0.15)*	*-8%*

UNMH CEO Report

HOSPITAL

MEMORANDUM

To: Board of Trustees

From: Kate Becker
Chief Executive Officer

Date: January 29, 2021

Subject: UNMH Monthly Activity Update

The Hospital has been involved in a variety of activities and this report will focus on operations through December 2020.

Finance: Inpatient adult volume is better than budget by 20% for the month of December and better than budget by 12% year to date. Inpatient pediatric volume is behind budget 6% for the month of December and behind budget by 7% year to date. Observation days are below budget by 24% year to date. Total inpatient discharges are 4% lower than budget year to date. Case mix index is higher than prior year by 7.7% at 2.23 year to date and average length of stay is up 11% compared to prior year. Outpatient clinic visits are 3% better than budget for the month of December and are 5% better than budget for the year. Emergency department arrivals are 27% under budget for the month of December and below year to date budget by 17%. Behavioral health patient days are under budget by 9.4% and behavioral health clinic visits are behind budget by 2% year to date. Net margin year to date is positive at $62.9 million with $40.4 million available for operations after setting aside $22.5 million for capital investment. Net patient revenues are positive compared to year to date budget and prior year. Operating expenses are over budget by $49.6 million, primarily in employee compensation and benefits, medical services and equipment. Non-operating revenues include $35 million recorded for CARES Act funding received from HHS.

Native American Liaison: UNMH provided its quarterly referrals report to Albuquerque Area I.H.S. in January; of note: Native American Health Services department facilitated 1,181 referred inpatients and 1,797 referred outpatients. The BOT Native American Services committee pre-viewed our January report to Albuquerque Area I.H.S. concerning selected specialty clinic wait times. The committee acknowledged the hospital's improvement of 6% overall, with 10 of the 14 tracked clinics reducing wait time during Q32020. We also provided data to the county through our monthly report; of note, the hospital maintained a Native American bed census above 100 beds for 8 of the 10 months beginning January 2020, with a high of 119 beds occupied, on average, each day in June 2020. UNMH met with APCG during its November session to share information on the New Hospital Tower and the status of our application with HUD, as well as the county approval and AAIHS consultation on the plan. We also provided a detailed update on planned spiritual/ceremonial healing space in the NHT, set aside for use of Native American patients and families. The council acknowledged this was an 'ask' from years ago and shared appreciation for the plan. UNMH facilitated an introduction of the WC4BIL representatives to the APCG Legislative Council for the purpose of consultation on student-led concerns. The council provided perspective, and some members of the council welcomed more effort around existing work to increase healthcare workforce diversity through pipeline programs.

Bernalillo County: UNMH and the County have developed an initial program plan and scope of work for the new Crisis Triage Center at UNMHSC. This is being used to finalize and RFP for architectural services for the new facility. UNMH is also working with the county on development of additional Behavioral Health programing to support the continuum of care. The County Commission has approved and executed the needed document related to proceed with the financing of the New Hospital Tower. The County along with the Indian Health Services and the APCG will continue to receive regular updates on the project.

If there are any questions on this or other matters, please feel free to contact me.

UNMH CMO Repor

NM HOSPITAL

Date: January 29, 2021
To: UNMH Board of Trustees
From: Irene Agostini, MD
UNMH Chief Medical Officer

The CMO Board report for January will highlight the COVID-19 Therapeutics Committee, the Vaccine Operations Committee along with the status of the COVID-19 Follow-up and Monoclonal Antibody Infusion Clinic.

COVID-19 Therapeutics Committee

The COVID-19 Therapeutics Committee was established by the EOC Operations Medical Branch. This committee is meeting the need for COVID-19 therapeutics, focusing on protocols like the bamlanivimab infusion, inpatient treatment options such as remdesivir and research therapeutic trials currently in process. This committee has representation from major stakeholders including individuals from the ICU, OB, Hospitalist Teams, ED, Nursing, Pharmacy, IT, Infection Control, SRMC and medicine and family medicine trainees. The committee chair also does frequent check-ins with the COVID-19 Follow-Up Clinic.

The committee scope includes:

- Review of potential new therapies for COVID-19.
- Operationalizing new therapies.
- Monitoring delivery of therapies.
- Stop therapies that are no longer viewed as standard of care.
- Reviewing for comment protocols for COVID-19 treatment from Pediatrics, OB, and Hospitalist Teams.

Chair: Mark Unruh, MD
Co-Chair: Lisa Anselmo
Attendees: Michelle Harkins, Mathew Wilks, Farinaz Khan, Grant Scott, Anthony Worsham, Meghan Brett, Diamone Gathers, Grant Scott, Taylor Patek, Taylor Goot, Vivek Katukuri. Matthew Ley, Nestor Sosa, Preeyaporn Sarangarm, Matthew Ley, Lou Branch, Martha Muller, Miriam Knof, Kenedi Hubbard, Cheryl Greif , Eileen Barret, Crystal Baca, Carla Walraven, Natasha Khan

Vaccine Operations Committee

As efforts began to focus around the COVID-19 vaccine and distribution, we formed the Vaccine Operations Committee (VOC) led by Dr. Gary Mlady, Mike Chicarelli, Kori Beech, Candra Phillips, Kathleen Cahill and Dr. Denece Kesler. The VOC goals include:

- Develop, document, and implement efficient and effective plans, processes, and systems to address all aspects of the COVID-19 vaccination initiative including communication and knowledge management.
- Successfully provide COVID-19 vaccinations to our various patient populations **(including the community)**.

Vaccine Progress:

- All Health System health care workers that wanted to receive the COVID-19 vaccine were able to do that in the 2ACC Learning Center.
- Worked closely with NM DOH to provide our availability for their scheduling system.
- Once the NM DOH had their vaccine registration site up and running, UNMH began vaccinations at the Pit on Jan. 19, including everyone in Phase 1a.
- **As of Jan. 26, UNMH has administered 28,001 vaccines!**

Attachments include the following:

- COVID-19 Vaccine Operations Committee Organizational Chart.
- NM DOH Toolkit with information to distribute to patients/community members/anyone receiving the vaccine (FAQs, How to Sign-up) in both Spanish and English.

COVID-19 Follow-up Clinic (CFC)

A special clinic was developed for those patients who have tested positive for COVID-19. The goal is to see these patients within 48-72 hours after they have been discharged from the hospital. These are examples of reasons why a patient would be referred to the CFC:

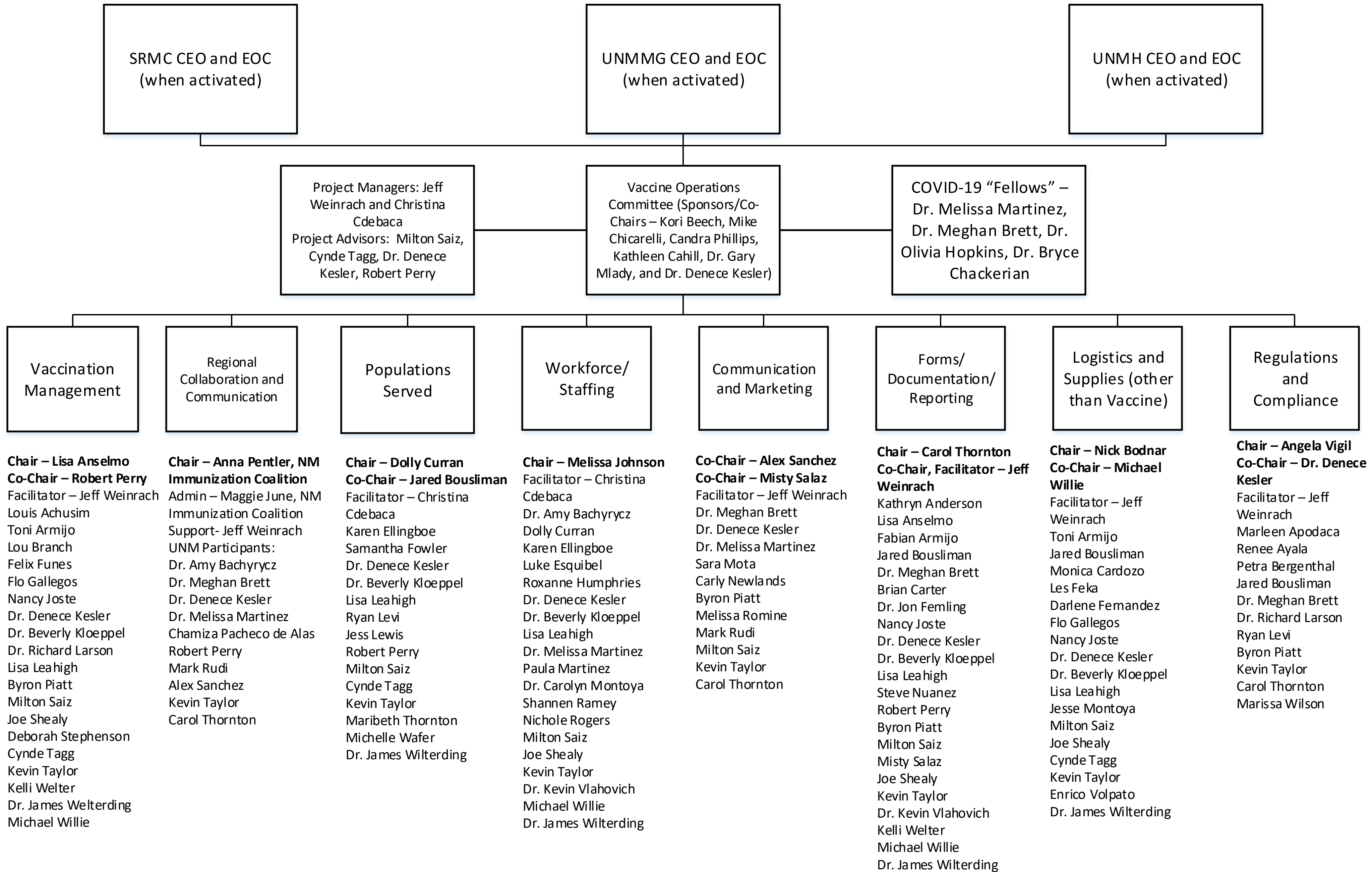
- Anyone who has tested positive for COVID-19 infection (all ages, OB) and is a paneled patient at UNMH.
- Anyone who has tested positive at any clinical site at UNMH and actively infectious or recovering (needs additional COVID-related care and questions related to long-term COVID-19 infection effects).
- Hospital discharges for close monitoring and determination of additional needs at home (DME, supplemental O2, home health).

We have seen more than 2,000 patients in the CFC since the pandemic began. We are able to keep the patients at home instead of in the hospital due to the special care this clinic provides. This has been extremely valuable to help with our high inpatient census.

COVID-19 Monoclonal Antibody Infusion Clinic

In addition to the CFC, the COVID-19 Monoclonal Antibody Infusion Clinic was developed for those patients infected with COVID-19 who are considered high-risk for adverse outcomes and are moderate to high risk for hospitalization. This would include patients with confirmed COVID-19 infection who meet certain criteria including but not limited to those with diabetes, chronic kidney disease, immunosuppressive disease, etc. Patients are referred as soon as possible after a positive COVID-19 test (ideally within 48 hours). There is some data that these patients have less risk for hospitalization after receiving Monoclonal Antibody infusion. We have completed 140 infusions of Bamlanivimab.

COVID Vaccination Org Chart 12/20/20



Vaccination Management

Chair – Lisa Anselmo
Co-Chair – Robert Perry
Facilitator – Jeff Weinrach
Louis Achusim
Toni Armijo
Lou Branch
Felix Funes
Flo Gallegos
Nancy Joste
Dr. Denece Kesler
Dr. Beverly Kloeppel
Dr. Richard Larson
Lisa Leahigh
Byron Piatt
Milton Saiz
Joe Shealy
Deborah Stephenson
Cynde Tagg
Kevin Taylor
Kelli Welter
Dr. James Welterding
Michael Willie

Regional Collaboration and Communication

Chair – Anna Pentler, NM Immunization Coalition
Admin – Maggie June, NM Immunization Coalition
Support- Jeff Weinrach
UNM Participants:
Dr. Amy Bachyrycz
Dr. Meghan Brett
Dr. Denece Kesler
Dr. Melissa Martinez
Chamiza Pacheco de Alas
Robert Perry
Mark Rudi
Alex Sanchez
Kevin Taylor
Carol Thornton

Populations Served

Chair – Dolly Curran
Co-Chair – Jared Bousliman
Facilitator – Christina Cdebaca
Karen Ellingboe
Samantha Fowler
Dr. Denece Kesler
Dr. Beverly Kloeppel
Lisa Leahigh
Ryan Levi
Jess Lewis
Robert Perry
Milton Saiz
Cynde Tagg
Kevin Taylor
Maribeth Thornton
Michelle Wafer
Dr. James Wilterding

Workforce/Staffing

Chair – Melissa Johnson
Facilitator – Christina Cdebaca
Dr. Amy Bachyrycz
Dolly Curran
Karen Ellingboe
Luke Esquibel
Roxanne Humphries
Dr. Denece Kesler
Dr. Beverly Kloeppel
Lisa Leahigh
Dr. Melissa Martinez
Paula Martinez
Dr. Carolyn Montoya
Shannen Ramey
Nichole Rogers
Milton Saiz
Joe Shealy
Kevin Taylor
Dr. Kevin Vlahovich
Michael Willie
Dr. James Wilterding

Communication and Marketing

Co-Chair – Alex Sanchez
Co-Chair – Misty Salaz
Facilitator – Jeff Weinrach
Dr. Meghan Brett
Dr. Denece Kesler
Dr. Melissa Martinez
Sara Mota
Carly Newlands
Byron Piatt
Melissa Romine
Mark Rudi
Milton Saiz
Kevin Taylor
Carol Thornton

Forms/Documentation/Reporting

Chair – Carol Thornton
Co-Chair, Facilitator – Jeff Weinrach
Kathryn Anderson
Lisa Anselmo
Fabian Armijo
Jared Bousliman
Dr. Meghan Brett
Brian Carter
Dr. Jon Femling
Nancy Joste
Dr. Denece Kesler
Dr. Beverly Kloeppel
Lisa Leahigh
Steve Nuanez
Robert Perry
Byron Piatt
Milton Saiz
Misty Salaz
Joe Shealy
Kevin Taylor
Dr. Kevin Vlahovich
Kelli Welter
Michael Willie
Dr. James Wilterding

Logistics and Supplies (other than Vaccine)

Chair – Nick Bodnar
Co-Chair – Michael Willie
Facilitator – Jeff Weinrach
Toni Armijo
Jared Bousliman
Monica Cardozo
Les Feka
Darlene Fernandez
Flo Gallegos
Nancy Joste
Dr. Denece Kesler
Dr. Beverly Kloeppel
Lisa Leahigh
Jesse Montoya
Milton Saiz
Joe Shealy
Cynde Tagg
Kevin Taylor
Enrico Volpato
Dr. James Wilterding

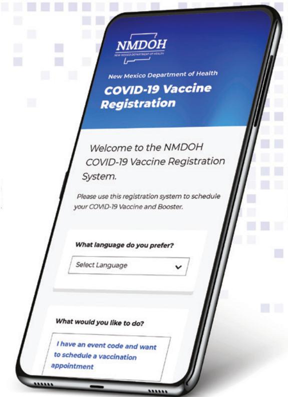
Regulations and Compliance

Chair – Angela Vigil
Co-Chair – Dr. Denece Kesler
Facilitator – Jeff Weinrach
Marleen Apodaca
Renee Ayala
Petra Bergenthal
Jared Bousliman
Dr. Meghan Brett
Dr. Richard Larson
Ryan Levi
Byron Piatt
Kevin Taylor
Carol Thornton
Marissa Wilson

COVID-19 VACCINE FAQ'S

HOW DO I REGISTER FOR THE COVID-19 VACCINE?

Please use the New Mexico Department of Health (NMDOH) registration tool available at VaccineNM.org. When a vaccine is available, NMDOH will send you a notification to schedule your appointment.



VACCINENM.ORG

For more FAQ's on the registration tool, visit: cvvaccine.nmhealth.org/faqs.html or call 1.855.600.3453

Will the vaccine be safe?

Clinical trials involving many thousands of participants are used to investigate possible COVID-19 vaccines. These studies generate scientific data and other information that the Food and Drug Administration (FDA) uses to determine vaccine safety and effectiveness.

After the FDA makes its determination, an independent group of scientific experts – the Advisory Committee on Immunization Practices (ACIP) – reviews available data before making vaccine recommendations to the CDC.

That means that the scientific data from the research on each of these vaccines has been reviewed by two independent teams of experts.

Should I get the vaccine?

Yes. While many people with COVID-19 have only a mild illness, others may get a severe case or they may even die. There is no way to know in advance how COVID-19 will affect you, even if you are not at increased risk of severe complications.

Also, if you get infected, you may spread the disease to friends, family and others around you. COVID-19 vaccination helps protect you by creating an antibody response without having to experience sickness. The sooner most people are vaccinated and protected against COVID-19 disease, the sooner New Mexicans and all Americans can get back to normal life.

Will there be enough vaccine for everyone?

Vaccines will be prioritized for frontline health care workers in hospital settings. The state will then provide vaccine to other frontline healthcare workers and first responders, as well as staff and residents of nursing homes and other long-term care facilities. This is in line with federal recommendations.

This means that not everyone will be able to be vaccinated right away, and vaccine may not be available to the general public until mid-2021.

The goal is for everyone to be able to easily get a COVID-19 vaccine when large quantities are available. We expect that several thousand vaccination providers and numerous locations throughout the state will eventually be available, including doctors' offices, retail pharmacies, hospitals, community locations, and federally qualified health centers.

What will it cost to get a COVID-19 vaccine? What if I don't have health insurance?

The vaccine is free to all people.

Vaccination providers will be able to charge an administration fee that is reimbursed by the patient's public or private insurance company or, for uninsured patients, by the federal Health Resources and Services Administration's (HRSA) Provider Relief Fund.

The federal government is requiring vaccine providers to administer vaccine to people regardless of their insurance status or immigration status. And they must administer without charging them for the vaccine.

Does the Governor or the Department of Health intend or have plans to make the COVID-19 vaccine mandatory?

No.

Can I stop wearing a mask after I have been vaccinated?

There is not enough information currently available to say that it's safe to stop wearing a mask after getting the vaccine. A mask protects you, and it also protects your family, friends and community. You should continue to wear a mask, practice social distancing, and wash your hands regularly when around people outside your household.

Will the COVID-19 vaccine make me test positive?

No. Vaccines currently in clinical trials in the United States won't cause you to test positive on viral tests, which are used to see if you have current infection.

If your body develops an immune response, which is the goal of vaccination, there is a possibility you may test positive on some antibody tests. These tests indicate you had a previous infection and that you may have some level of protection against the virus.

REGISTER TODAY

STEP UP
TO RECEIVE YOUR VACCINE.

REGISTER AT VACCINENM.ORG

1 2

REGISTER AT VACCINENM.ORG

Fill out the registration form at vaccinenm.org and receive a confirmation code.

COMPLETE YOUR PROFILE

Use your confirmation code to access your profile and enter your chronic medical conditions, employer, insurance, and demographic information.

WAIT FOR NMDOH TO NOTIFY YOU OF VACCINE AVAILABILITY

3 4

SCHEDULE YOUR APPOINTMENT

Once you receive an invitation from DOH, enter your event code and select a location, day, and schedule your COVID-19 vaccine appointment.

RECEIVE THE COVID-19 VACCINE

On the day of the appointment you will be able to complete the medical questionnaire. Attend the appointment at the location and receive your vaccine.

The New Mexico Department of Health (NMDOH) is leading the State of New Mexico's COVID-19 vaccination planning and implementation in close collaboration with other state agencies, as well as public, private and tribal partners throughout the state.

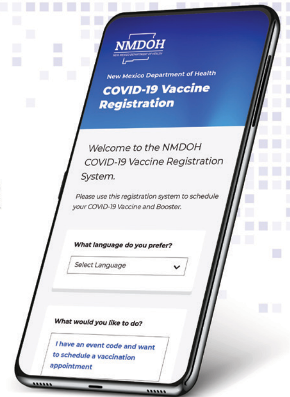
Continue to practice COVID-19 Safe Behavior and follow all the safety precautions to protect yourself, your family, your friends and your community. Cover your mouth and nose with a mask or face covering when around others. Avoid close contact with people who are sick. Stay 6 feet away from others and avoid crowds. Wash your hands often. Use hand sanitizer if soap and water are not available.

VACCINENM.ORG | 1.855.600.3453

PREGUNTAS HECHAS FRECUENTEMENTE SOBRE LA VACUNA COVID-19

¿CÓMO ME REGISTRO PARA LA VACUNA COVID-19?

Por favor use la herramienta de registro del Departamento de Salud de Nuevo México (NMDOH) disponible en VaccineNM.org. Cuando la vacuna esté disponible, NMDOH le enviará una notificación para que programe su cita.



VACCINENM.ORG

¿Será segura la vacuna?

Estudios clínicos que envuelven miles de participantes son usados para investigar las posibles vacunas COVID-19. Estos estudios generan información científica y otra información que la Administración de Drogas y Alimentos (FDA) usa para determinar la seguridad y efectividad de la vacuna.

Depués que FDA hace su determinación, un grupo independiente de expertos científicos - El Comité Asesor en Prácticas de Imnunización (ACIP) - revisa la información disponible antes de hacerle las recomendaciones de la vacuna a CDC.

Ello significa que la información científica de la investigación de cada una de estas vacunas ha sido revisada por dos equipos expertos independientes

¿Me debo vacunar?

Sí. Mientras que muchas personas con COVID-19 han tenido una enfermedad leve, otros pueden tener casos graves o hasta morir. No hay forma de saber con anticipación cómo COVID-19 le afectará, no importando si usted no está en alto riesgo de complicaciones graves.

También, si usted es infectado, usted podría propagar la enfermedad a sus amigos, familiares, y otros a su alrededor. La vacuna COVID-19 le ayuda a crear anticuerpos sin experimentar la enfermedad. Mientras más pronto las personas se vacunen y se protejan contra COVID-19, más pronto los nuevomexicanos y todos los americanos podrán volver a su vida normal.

¿Habrán sufientes vacunas para todos?

Las vacunas serán priorizadas para los trabajadores del cuidado de la salud de primera línea y hospitales. Entonces el estado le ofrecerá la vacuna a los otros trabajadores del cuidado de la salud y de primera línea, además de los empleados y residentes en los hogares para ancianos y otras facilidades de cuidado a largo plazo. Estas recomendaciones van a la par con las recomendaciones federales.

Esto significa que no todos podrán ser vacunados inmediatamente, y que puede que la vacuna no esté disponible para el público en general hasta mediados de 2021.

La meta es que cuando hayan suficientes suministos, que todos puedan obtener fácilmente la vacuna COVID-19. Esperamos tener disponibles miles de proveedores de vacunación en numerosas localidades por todo el estado, incluyendo oficinas médicas, farmacias, hospitales, localidades comunitarias, y centros de salud cualificados federalmente.

¿Cuánto costará la vacuna? ¿Qué pasa si no tengo seguro médico?

La vacuna es gratis para todas las personas.

Los proveedores de vacunación podrán factuar un cargo de administración, que es reembolsable por la compañía de seguros pública o privada, o para los pacientes sin seguro, por la Administración de Recursos y Servicios de Salud (HRSA).

El gobierno federal le requiere a los proveedores de vacunación que le administren la vacuna a las personas, sin importar su estatus de seguro médico o inmigración. Y ellos deben administrarlas sin facturarlos por dichas vacunas.

¿Tiene la Gobernadora o el Departamento de Salud planes para hacer obligatoria la vacuna COVID-19?

No.

¿Puedo dejar de usar una mascarilla después de haber sido vacunado?

Hasta el momento no hay suficiente información disponible para decidir si es seguro dejar de usar una mascarilla después de ser vacunado. Una mascarilla le protege, y también protege a su familia, amigos y comunidad. Usted debe continuar con el uso de mascarillas, distanciamiento social, y lavado de manos frecuentemente cuando esté con otras personas fuera de su hogar.

¿Me hará la vacuna positivo a COVID-19?

No. Las vacunas actuales en estudios clínicos en los Estados Unidos no causan que usted dé positivo en pruebas virales, que son las que ven si usted tiene una infección actual.

Si su cuerpo desarrolla una respuesta inmune, que es la meta de la vacunación, hay una posibilidad de que usted dé positivo en algunas pruebas de anticuerpos. Estas pruebas indican que usted tuvo una infección previa y que usted tiene un nivel de protección contra el virus.

Para otras preguntas hechas en la herramienta de registro, visite: cvvacine.nmhealth.org/faqs.html o llame al 1.855.600.3453

REGÍSTRESE HOY

PROGRAME RECIBIR SU VACUNA.

REGÍSTRESE EN VACCINENM.ORG

1

2

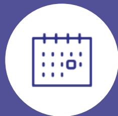
REGÍSTRESE EN VACCINENM.ORG

Llene la forma de registro en vaccinenm.org y reciba un código de confirmación.

COMPLETE SU PERFIL

Use su código de confirmación para ganar acceso a su perfil y entrar sus condiciones médicas crónicas, patrono, seguro médico e información demográfica.

ESPERE A QUE NMDOH LE NOTIFIQUE QUE SU VACUNA ESTÁ DISPONIBLE

3 

4

PROGRAME SU CITA

Una vez que reciba la invitación de NMDOH, entre su código de evento y seleccione una localidad, día, y programe su cita para la vacuna COVID-19.

RECIBA LA VACUNA COVID-19

El día de la cita, usted podrá completar el cuestionario médico. Vaya al lugar de la cita y reciba su vacuna.

El Departamento de Salud de Nuevo México (NMDOH) encabeza la planificación e implementación de la vacunación COVID-19 en Nuevo México, en estrecha colaboración con otras agencias estatales, además de socios públicos, privados y tribales a través del estado.

Continúe llevando las Prácticas Seguras COVID y siga todas las precauciones de seguridad para progeterse, proteger a su familia, amigos y comunidad. Cubra su boca y nariz con una mascarilla o cobertura facial cuando esté con otros. Evite el contacto cercano con personas enfermas. Manténgase a 6 pies de distancia de otras personas y evite muchedumbres. Lávese las manos a menudo. Use desinfectante para las manos si no hay agua y jabón disponibles.

VACCINENM.ORG | 1.855.600.3453

Finance Committee

UNM HOSPITALS

UNM HOSPITAL BOARD OF TRUSTEES
Finance Committee Meeting

Wednesday, January 27, 2021 10:00 AM via Zoom

Objectives

- Provide financial and human resources oversight of UNM Hospitals.

Finance Committee Meeting:

- Approval of November 18, 2020 meeting minutes
- Disposition of Assets, Consent Items, and Capital Project Items
  - Disposition of assets
  - Uptown Clinic Lease $193,600
  - Medical Equipment Consultant $2,347,325
  - 2400 Tucker Clinic – DOH Improvements $2,500,000
  - 1209 Clinic – DOH Improvements $1,265,000
  - Crisis Triage Center $1,300,000
  - Phase III New Hospital Tower $365,000,000
- Resolution – HUD Financing $320,000,000
- Financial Update for the six months ended December 31, 2020
- HR Updates
  - Managing multiple resources
  - Employees given extra time in minor sick leave bank

Next UNM Hospital Finance Committee meeting is scheduled to convene February 24, 2021.

Audit & Compliance Committee

HOSPITALS

UNM HOSPITAL BOARD OF TRUSTEES

Audit and Compliance Committee Meeting

Tuesday, January 26, 2021 1:30 pm
Zoom Video Conference

Objectives

- Provide audit and compliance oversight of UNM Hospitals.

Finance Committee Meeting:

- Approval of November 16, 2020 meeting minutes
- Review of annual Audit and Compliance calendar
- Internal Audits:
  - Internal Audit RFP Status
  - 2020 Audit Work Plan Status
  - Huron Audit Report
- Compliance:
  - 2021 Compliance Audit Work Plan Status
  - 2020 Year-End Metrics
  - Fraud, Waste and Abuse Training Module
  - Turnkey 340B Audit

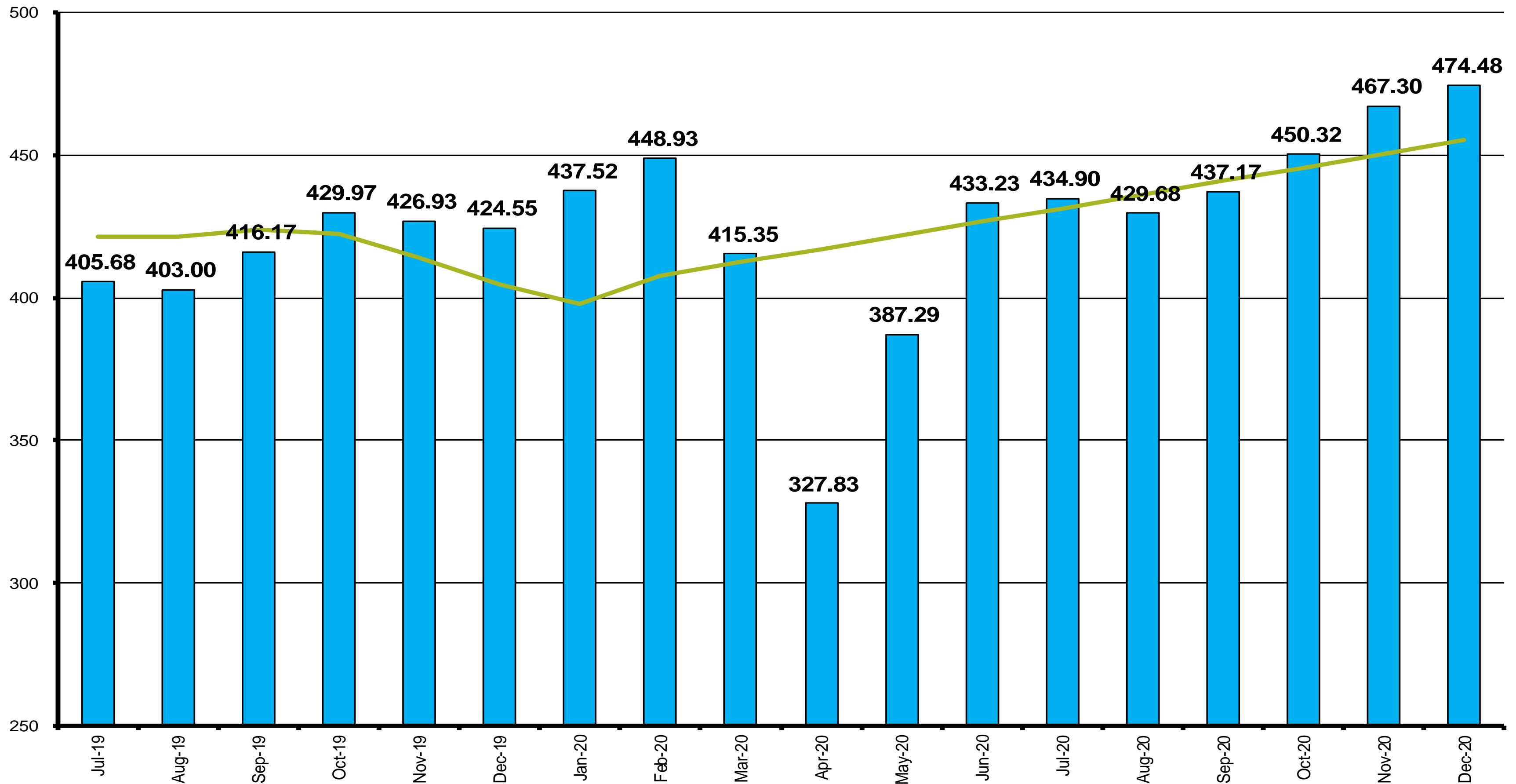
Next UNM Hospital Audit and Compliance Committee meeting is scheduled to convene April 27, 2021

Financials

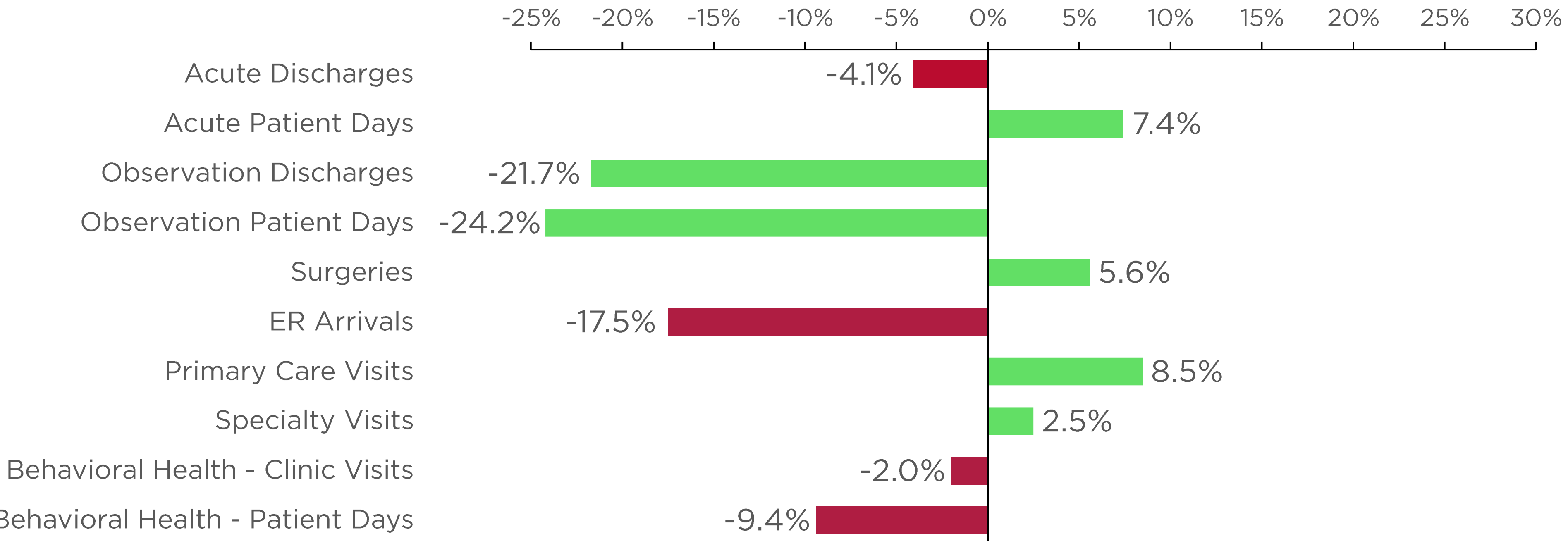
UNM Hospitals

Financial Update
Through December 2020

UNM Hospital
Average Daily Census
Through December 2020

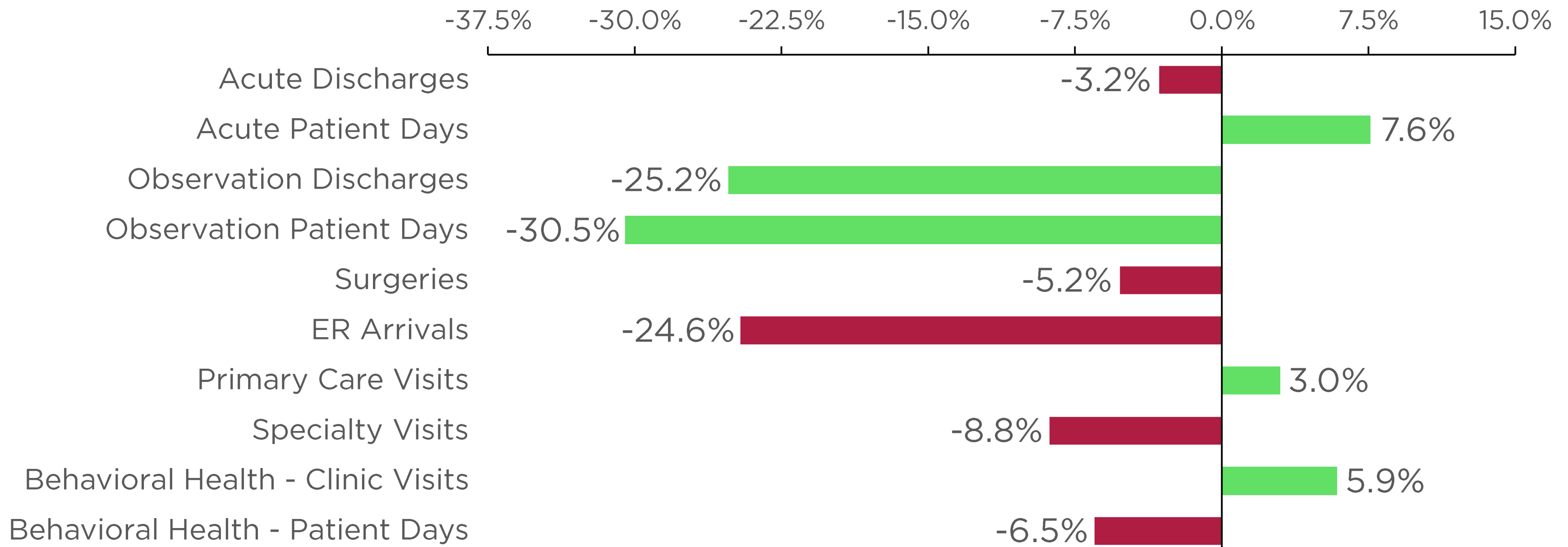


UNM Hospital
YTD Stats Variance to Budget
Through December 2020



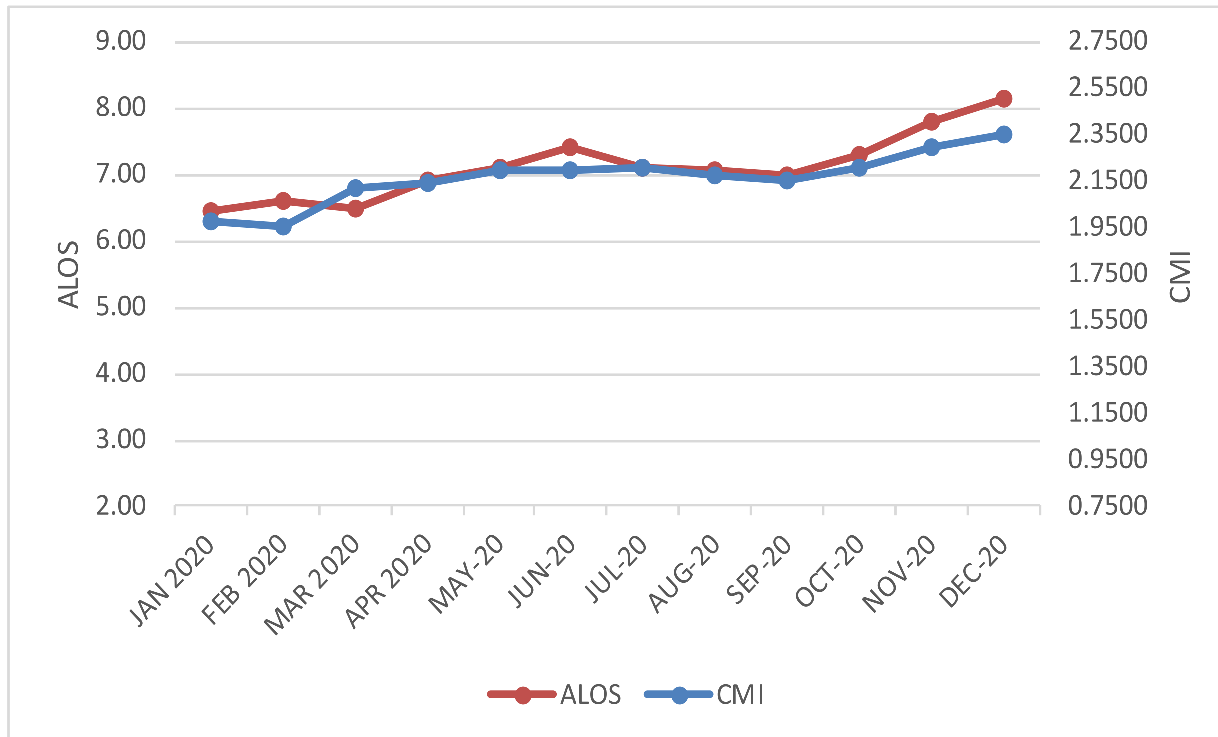
	MTD Actual	MTD Budget	MTD Variance	MTD % Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Acute Discharges	1,804	1,962	(158)	-8.1%	11,173	11,645	(472)	-4.1%
Acute Patient Days	14,709	12,973	1,736	13.4%	82,670	77,006	5,664	7.4%
Observation Discharges	648	942	(294)	-31.2%	4,425	5,654	(1,229)	-21.7%
Observation Patient Days	863	1,309	(445)	-34.0%	5,885	7,767	(1,881)	-24.2%
Surgeries	1,285	1,656	(371)	-22.4%	9,650	9,136	514	5.6%
ER Arrivals	4,862	6,663	(1,801)	-27.0%	32,643	39,548	(6,905)	-17.5%
Primary Care Visits	19,855	16,120	3,735	23.2%	96,503	88,932	7,571	8.5%
Specialty Visits	26,651	29,073	(2,422)	-8.3%	167,655	163,569	4,086	2.5%
Behavioral Health - Clinic Visits	15,760	7,284	8,476	116.4%	43,851	44,754	(903)	-2.0%
Behavioral Health - Patient Days	2,005	2,084	(79)	-3.8%	11,203	12,370	(1,167)	-9.4%

UNM Hospital
YTD Stats Variance to Prior YTD
Through December 2020



	MTD Actual	Prior MTD	MTD Variance	MTD % Variance	YTD Actual	Prior YTD	YTD Variance	YTD % Variance
Acute Discharges	1,804	1,960	(156)	-8.0%	11,173	11,539	(366)	-3.2%
Acute Patient Days	14,709	13,161	1,548	11.8%	82,670	76,852	5,818	7.6%
Observation Discharges	648	963	(315)	-32.7%	4,425	5,918	(1,493)	-25.2%
Observation Patient Days	863	1,267	(404)	-31.9%	5,885	8,467	(2,582)	-30.5%
Surgeries	1,285	1,551	(266)	-17.2%	9,650	10,184	(534)	-5.2%
ER Arrivals	4,862	7,817	(2,955)	-37.8%	32,643	43,318	(10,675)	-24.6%
Primary Care Visits	19,855	13,322	6,533	49.0%	96,503	93,733	2,770	3.0%
Specialty Visits	26,651	29,562	(2,911)	-9.8%	167,655	183,766	(16,111)	-8.8%
Behavioral Health - Clinic Visits	15,760	6,324	9,437	149.2%	43,851	41,406	2,445	5.9%
Behavioral Health - Patient Days	2,005	1,846	159	8.6%	11,203	11,979	(776)	-6.5%

UNM Hospital
CMI and ALOS
Monthly Trend through December 2020



UNM Hospitals
Executive Summary
Through December 2020

UNM Hospitals	Action OI Benchmark	Dec-20	YTD	YTD Budget	% Budget YTD	Prior YTD	% Growth
ALOS		8.15	7.40	6.61	-11.89%	6.66	-11.09%
Case Mix Index		2.35	2.23	2.08	7.34%	2.07	7.93%
CMI Adjusted Patient Days *	56,648	66,741	375,727	351,295	6.95%	348,486	7.82%
Net Core Patient Revenues ($ in thousands)		$ 95,837	$ 531,092	$ 472,231	12.46%	$ 498,871	6.46%
Total Operating Expenses** ($ in thousands)		$ 128,023	$ 671,251	$ 620,682	-8.15%	$ 611,811	-9.72%
Total Operating Expenses*** ($ in thousands)		$ 127,563	$ 668,446	$ 615,584	-8.59%	$ 582,747	-14.71%
Net Operating Income ($ in thousands)		$ (16,623)	$ (35,909)	$ (59,297)	39.44%	$ (49,388)	27.29%
Net Income ($ in thousands)		$ 10,565	$ 40,402	$ 4,840		$ 46,400	
Net Core Revenue/CMI Adj Patient Day		$ 1,436	$ 1,414	$ 1,344	5.15%	$ 1,432	-1.26%
Cost**/CMI Adj Patient Day	$ 1,888	$ 1,918	$ 1,787	$ 1,767	-1.12%	$ 1,756	-1.76%
Cost***/CMI Adj Patient Day	$ 1,888	$ 1,911	$ 1,779	$ 1,752	-1.53%	$ 1,672	-6.39%
FTEs		6,974	6,776	7,062	4.06%	6,402	-5.84%

* CMI Adjusted Patient Days (Adjusted Patient Days X CMI) is to account for the outpatient activities in the hospital and the relative acuity of the patients. CMI is a relative value assigned to a diagnosis-related group. Adjusted patient days (Patient Days X (Gross Patient Revenue/Gross Inpatient Revenue)) is to account for outpatient and other non-inpatient activities in the Hospital. Action OI benchmark is a quarterly report and for July - September 2020 the 50th percentile is 169,943. The metric above divided by three months for comparative purposes.

** Operating expenses exclude Contract Retail Pharmacy Expense

*** Operating expenses exclude Contract Retail Pharmacy & HS Exec Initiatives