Lake Health

MEDICAL STAFF BYLAWS

Part I: Governance

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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 Lake Health in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the hospital Board of Trustees.

1.2 Authority

Subject to the authority and approval of the 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 Lake Health. Henceforth, whenever the term "the hospital" is used, it shall mean Lake Health; and whenever the term "the Board" is used, it shall mean Board of Trustees. Whenever the term "President of the Hospital" is used, it shall mean the individual appointed by the Board to act on its behalf in the overall management of the hospital. The term President of the Hospital includes a duly appointed acting administrator serving when the President of the Hospital is away from the hospital.

1.3 Definitions

"Advanced Practice Professional or APP" means those individuals who are physician assistants (PAs), or advance practice registered nurses (APRNs) such as certified registered nurse anesthetists (CRNAs), certified nurse midwives, clinical nurse specialists or nurse practitioners.

"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 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, chiropractor, or clinical psychologist holding a current license to practice within the scope of his or her license who is a Member of the Medical Staff.

"Board of Trustees" or "Board" means the Board of Trustees of Lake Health.

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

"Chiropractor" means an individual who has received a Doctor of Chiropractic Medicine and is currently fully licensed to practice chiropractic medicine in the State of Ohio.

"Days" shall mean calendar days unless otherwise stipulated in the Medical Staff Bylaws.

"Denial" means – means an adverse action or recommendation regarding privileges made by the 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 Ohio.

"Department" means a grouping of like practitioners as noted in Part I, Section 5 of the Medical Staff Bylaws and further defined in the Organization and Functions Manual.

"Department Chair" means an Active Medical Staff Member who has been elected/appointed in accordance with and has the qualifications and responsibilities for Department Chair as outlined in Part I, Section 5.2 and Section 5.3 of these Bylaws.

"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 Lake Health.

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

"President of the Hospital" is the individual appointed by the Board of Trustees to serve as the Board's representative in the overall administration of the Hospital. The President of the Hospital may, consistent with his or her authority granted by the Hospital Bylaws, appoint a representative to perform certain administrative duties identified in these Bylaws.

"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" shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the Medical Staff Bylaws.

"Medical Staff or "Staff" means the organization of those individuals who are medical physicians, osteopathic physicians, dentists, oral and maxillofacial surgeons, podiatrists, chiropractors, and clinical psychologists who have obtained membership status.

"Medical Staff Bylaws" means these Bylaws covering the operations of the Medical Staff of Lake Health.

"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 30.

"Member" is a physician, dentist, oral and maxillofacial surgeon, podiatrist, chiropractor, or clinical psychologist who has been granted this status by the Board of Trustees of Lake Health.

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

"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 Ohio.

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

"Practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, chiropractor, clinical 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.

"President" means the President of the Medical Staff as noted in Part I, Section 4 of these Medical Staff Bylaws.

"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 Trustee or committee thereof; the President of the Hospital or his or her designee; other employees of the Hospital; a Medical Staff organization or any member, officer, Department 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 and dissemination of information.

"Restricted" or "restriction" means – a limitation such that not the full extent of licensure/privileges are granted.

"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.

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 (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, chiropractors, or clinical psychologists 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, 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 Medical Executive Committee (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 Medical Staff Practitioner Responsibilities

2.6.1 Each Practitioner must provide for appropriate, timely, and continuous care of his/her 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 staff member, excluding Advanced Practice Professionals and Allied Health Practitioners, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, 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 as requested by any of the Officers of the Medical Staff, President of the Hospital, and/or their Department Chair 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. This exam will be performed by a practitioner acceptable to both the staff member and the officer or other person who ordered the exam to be done.

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 provide evidence of professional liability coverage of a type and in an amount, sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members 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 the President of the Hospital or designee immediately of any and all malpractice claims filed in any court of law against the Medical Staff member.

2.6.7 Each applicant for privileges or Practitioner agrees to release from any liability, 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 Practitioner and his/ her credentials.

2.6.8 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 or departments.

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.

2.6.9 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.

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

2.6.11 Each Practitioner must give prompt notification of changes in information required at the time of appointment to the Medical Staff Office. There shall be immediate notification, within twenty-four (24) hours, of changes in licensure, DEA, participation status in Medicare / Medicaid, and limitation or loss of professional liability insurance. There shall be prompt notification, within five (5) business days, of loss of privileges at another facility, filing of charges by a law enforcement agency, and whether the practitioner is under investigation by a healthcare related entity. The notification for loss of privileges at another facility does not include any loss of privileges subject to a loss of an exclusive contract.

2.6.12 Each Medical Staff leader 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.

2.7 Medical Staff Member Rights

2.7.1 Each staff Member in the Active 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 his/her Department Chair or other appropriate Medical Staff leader(s), that Practitioner may, upon written notice to the President 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 Active 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 Active 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 twenty-five percent (25%) of the members of the Active 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 that detailed in the petition may be transacted.

2.7.4 Each staff Member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff Member may submit a petition signed by twenty-five percent (25%) of the Members of the Active 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 Active category may call for a Department meeting by presenting a petition signed by twenty-five percent (25%) of the Active Members of the Department, but in no case less than three (3). Upon presentation of such a petition the Department Chair will schedule a Department 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; this excludes action taken for reasons of professional medical negligence. 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 Active Category

3.1.1 Qualifications

Members of this category must have served on the Medical Staff for one (1) year, be in good standing, and be involved in either:

At least sixty (60) patient contacts per two (2) years (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 other form of patient contact deemed acceptable for the MEC), **AND**

Have at least fifty percent (50%) attendance at general medical staff and department meetings.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active 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 he/she meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

a. Attend Medical Staff and Department meetings of which he/she is a member and any Medical Staff or hospital education programs;

b. Vote on all matters presented by the Medical Staff, Department, 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:

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

e. 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

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

3.2 The Associate Category

3.2.1 Qualifications

The Associate category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives

Members of this category may:

a. Attend Medical Staff and Department meetings of which he/she is a member and any Medical Staff or hospital education programs;

b. Not vote on matters presented by the entire Medical Staff or Department or be an officer of the Medical Staff; and

c. 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 have the same responsibilities as Active Category Members.

3.3 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 members 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 and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned. Honorary recognition does not require recredentialing.

Section 4. Officers of the Medical Staff and Representative to the Organized Medical Staff Section of the AMA

4.1 Officers of the Medical Staff

4.1.1 President of the Medical Staff

4.1.2 Vice President of the Medical Staff

4.1.3 Secretary-Treasurer

4.2 Qualifications of Officers

Officers must be members of the Active category and be actively involved in patient care in the hospital, indicate a willingness and ability to serve, have previous leadership experience by having served on at least two (2) standing committees or as a Department Chair, and be in compliance with the professional conduct policies of the hospital. Qualifications for Officer positions also include the professional designation of physician, dentist, or podiatrist. The Medical Staff Nominating committee will have discretion to determine if a Staff Member wishing to run for office meets the qualifying criteria. The Officer may have no significant conflict of interest (for example, by serving on the MEC or Board of a hospital not affiliated with the Lake Health) as determined by the MEC. All Officers must disclose any other Conflict of Interest as noted in policy.

4.3 Election of Officers

4.3.1 The Nominating Committee shall consist of five (5) Members who are elected at the Interim Medical Staff meeting.

4.3.2 The Nominating Committee shall present a slate of candidates for the positions of President, Vice President, Secretary-Treasurer, and Representative, and alternate, to the Organized Medical Staff Section (OMSS) of the AMA for presentation to the Medical Staff at least two (2) weeks prior to the election.

4.3.3 Nominations may also be made by petition signed by at least twenty-five percent (25%) of the Members of the Active Staff and filed with the Secretary-Treasurer of the Medical Staff at least five (5) business days prior to the annual meeting. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.

If an Active Medical Staff member is contractually obligated to be in-hospital at the time of the General Staff meeting, he or she must submit in writing the name of the person who will cast their proxy vote to the Medical Staff Office by noon on the day of the meeting. The voting member present at the meeting may receive and cast only one written proxy.

4.3.4 The election will be held at the annual meeting. The nominee who receives a majority of the votes cast at the annual meeting, at which a quorum is present, shall be elected as a Medical Staff Officer or OMSS Representative and alternate and shall take office on the first day of the next Medical Staff Year.

4.4 Term of Office

All officers serve a term of two (2) years and may not serve more than two (2) consecutive terms. They shall take office on January 1st following their election. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless he/she resigns sooner or is removed from office. No Officer can hold another leadership position on the Medical Staff; the individual must resign his/her other leadership position upon being elected as an Officer.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the Medical Staff year, except the office of the President of the Medical Staff. If there is a vacancy in the office of the President of the Medical Staff, the Vice President of the Medical Staff shall serve the remainder of the term.

4.6 Duties of Officers

4.6.1 **President of the Medical Staff:** The President of the Medical Staff shall represent the interests of the Medical Staff to the MEC and the Board. The President of the Medical 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 President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of Departments 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, as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the President of the Hospital or the Board on hospital or Board committees;

c. Serve on the Joint Conference Committee, with vote;

d. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/hospital policies;

e. 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;

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

g. 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;

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

i. 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;

j. 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;

k. Attend Board meetings and Board committee meetings as invited by the Board;

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

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

4.6.2 **Vice President of the Medical Staff:** In the absence of the President of the Medical Staff, the Vice President of the Medical Staff shall assume all the duties and have the authority of the President of the Medical Staff. This officer shall be a voting member of the Joint Conference Committee and shall act as co-chair of the Quality Improvement Coordinating Committee (QICC). He/she shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.6.3 **Secretary-Treasurer:** This officer will collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. This officer shall be a voting member of the Joint Conference Committee and of the Credentials Committee. He/she shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may request from time to time.

4.7 Removal and Resignation from Office

4.7.1 **Removal by Vote:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff. The Medical Staff may initiate the removal of any officer if at least twenty-five percent (25%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active staff members casting ballot votes in person with approval by majority vote of the Board.

4.7.2 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer or for failure to meet the attendance requirements as defined in these bylaws.

4.7.3 **Resignation:** Any elected officer 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.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

The Medical Staff shall be organized as a departmentalized staff including the following Departments: anesthesiology, emergency medicine, family medicine, medicine, obstetrics/gynecology, pathology, radiology, and surgery. A Department Chair shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

5.2 Qualifications, Selection, Term, and Removal of Department Chairs

5.2.1 **Qualifications:** All Department Officers must be Members of the Active Medical Staff, have leadership experience by having served on two (2) standing Medical Staff committees, and have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. The Department Chair may have no significant conflict of interest (by serving on the MEC or Board of a hospital not affiliated with the Lake Health). All Department Chairs must disclose any other Conflict of Interest as noted in policy.

5.2.2 **Election Process:** Department Officers shall be elected by simple majority vote of the Active members of the Department.

a. The Nominating Committee shall present a slate of candidates for the position of Department Chair.

b. The list of nominees shall be mailed to all Active Members of the Department at least two (2) weeks in advance of the election. Nominations may also be by petition signed by at least twenty-five percent (25%) of the Active Department Members, but in no case less than three (3) Active Department Members. This petition should be filed with the Secretary-Treasurer of the Medical Staff at least five (5) business days prior to the election. The Nominating committee must determine if the candidate meets the qualifications in section 5.2.1 above before he/she can be placed on the ballot.

If an Active Medical Staff member is contractually obligated to be in-hospital at the time of the vote for Department Chair, he or she must submit in writing the name of the person who will cast their proxy vote to the Medical Staff Office by noon on the day of the meeting. The voting member present at the meeting may receive and cast only one written proxy.

c. The nominee who receives a simple majority of the votes cast at the election, and affirmed by the Board of Trustees, shall be elected as the Department Chair and shall take office on the first day of the next Medical Staff Year.

5.2.3 **Term of office:** Each Department Chair shall serve a term of two (2) years, starting on the first day of the Medical Staff Year after the election, and may serve only two (2) consecutive terms.

5.2.4 **Removal by Vote:** 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. The Active Members of the Department may initiate the removal of any Department Chair if at least twenty-five percent (25%) of the Active Department Members, but in no case than three (3) Active Department Members, sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active Department Members present casting ballot votes with approval by majority vote of the Board.

5.2.5 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being a Department Chair or for failure to meet the attendance requirements as defined in these bylaws.

5.2.6 **Resignation:** Any elected Department Chair 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.

5.2.7 **Filling of Vacancy:** If a Department Chair is removed through this process, or a vacancy occurs for any other reason, the executive committee of the department will choose a new Chair to serve the remainder of the term. If there is no executive committee of the department, the department shall meet within fourteen (14) days to elect a new Chair who will preside through the remainder of the term.

5.3 Responsibilities of Department Chair

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

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

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

d. To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the Medical Staff Department;

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

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 Department or the hospital;

g. To continually assess and support efforts to improve quality, efficiency and clinical documentation reflective of best practices;

h. To coordinate and integrate inter-service and intra-service functions and communication;

i. To develop and implement Medical Staff and hospital policies and procedures that 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 President of the Hospital sufficient numbers of qualified and competent persons to provide patient care and service;

k. To provide input to the President of the Hospital regarding the qualifications and competence of Department or hospital 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 improvement programs as appropriate;

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

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

5.4 Assignment to Department

The MEC will, after consideration of the recommendations of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department. Clinical privileges are independent of Department 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 President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks. The President of the Medical Staff may appoint APPs to any committee; the APP shall vote on these committees, other than the MEC.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff and the Department Chairs. If a Department Chair is not an Active Member, then he/she may attend the MEC meeting in an ex-officio, non-voting capacity. The chair will be the President of the Medical Staff. The non-voting attendees to the MEC shall consist of Hospitalist Medical Director, an APP representative, the President of the Hospital; Senior Vice President of Medical Affairs/Chief Medical Officer (SVPMA/CMO), Vice President Quality Services and the Chief Nursing Officer.

b. Voting: Each Officer has one (1) vote. Each Department Chair shall have one vote for every fifteen (15) Active members, or portion thereof, in that Department.

c. Removal from MEC: A Medical Staff Officer or Department Officer who is removed from his/her position in accordance with Section 4.7 and/or Section 5.2/5.3 above will automatically lose his/her membership on the MEC.

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, Department 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, Departments, 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 that portion of the corporate compliance plan that pertains to the Medical Staff;

o. Hold Medical Staff leaders, committees, and Departments 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.

r. The MEC may develop and adopt policies as necessary to carry out its functions and meet its responsibilities for the proper running of the 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.

6.3 Bylaws Committee

6.3.1 **Composition:** The Bylaws Committee is composed of one member elected from each clinical department at their first departmental meeting of the year when the Officers of the Medical Staff take office. The candidates must be experienced, credible, and knowledgeable of the Bylaws. The Chair of the Bylaws Committee is elected by the Bylaws Committee members at their first meeting.

6.3.2 **Responsibilities:** This committee shall be responsible for writing, accepting proposals for review, and amending Bylaws in order to present to the General Staff Meeting for voting.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting, in the fourth quarter of the Medical Staff year, and at least one (1) other general meeting of the Medical Staff, in the second quarter of the Medical Staff year, shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.

7.1.2 The action of a majority of the members physically or telephonically present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast, except for bylaws amendments which requires a quorum of twenty-five percent (25%) and a two-thirds (2/3rds) vote to pass consistent with Part I, Section 9.2.1of these Bylaws.

7.1.3 Special Meetings of the Medical Staff

a. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The President of the Medical 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 seven (7) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2 Regular Meetings of Medical Staff Committees and Departments

Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall meet at least four (4) times per year. Committees shall meet as needed, unless otherwise stipulated in these bylaws.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee or Department may be called by the committee chair or Chair of the Department thereof or by the President of the Medical Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: A quorum will exist when twenty-five percent (25%) of the Active Members are present when bylaws are being voting upon. A quorum will exist when ten percent (10%) of the Active members are present for all other matters.

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 routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least two (2) members.

7.4.3 Medical Staff committees other than those listed in 7.4.2 above: A quorum will exist of those members present and voting.

7.4.4 Department meetings: A quorum will exist when twenty-five percent (25%) of the Active Members are present.

7.5 Attendance Requirements

7.5.1 Active Members of the Medical Staff must participate in at least fifty percent (50%) of the general medical staff and department meetings in order to retain their Active Status. Associate Members are encouraged to attend meetings of the Medical Staff. Telephonic attendance is acceptable, as long as the confidentiality provisions of the Medical Staff and Hospital are upheld. Failure to maintain these confidentiality provisions will subject the offender to disciplinary action.

a. MEC, Credentials Committee, and Peer Review Committee meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee. This replacement will be automatic, with replacement of the member done in the same manner as initial appointment to the committee.

b. General medical staff meetings and department meetings: Members are encouraged to attend. If there is noted to be less than fifty percent (50%) attendance, then the Member will be placed into the Associate medical staff category.

c. Committees other than those listed in 7.5.1(a) above: Members of these committees are encouraged to attend.

d. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the President of the Medical Staff or the applicable Department Chair 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 seven (7) days prior to the meeting. This notice shall include the date, time, place, issue involved and that 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 termination of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing.

e. Nothing in the foregoing paragraph shall preclude the initiation of summary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.6 Participation by the President of the Hospital

The President of the Hospital or his/her designee may attend any general, committee, or department meeting of the Medical Staff as an ex-officio member without vote.

7.7 Parliamentary Procedure

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 or a parliamentary procedure book approved by the MEC, as noted in the Rules and Regulations, 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 Department or committee not less than seven (7) 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 Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. 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 that 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 Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The committee shall authenticate the minutes and copies thereof shall be available to the MEC. 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, 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 Board. The committee will submit its recommendation to the Board within thirty (30) calendar 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, President of the Hospital, or the President of the Medical 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 2.7.4 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 the discretion of the Medical Executive Committee, 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 bylaws committee, MEC, or by a petition signed by twenty-five percent (25%) of the members of the Active category.

Each active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff if the amendment receives two-thirds (2/3rds) of the votes cast by those members eligible to vote when a quorum of twenty-five percent (25%) is present.

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 MEC may develop and adopt policies as necessary to carry out its functions and meet its responsibilities for the proper running of the Medical Staff.

9.3.2 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.

9.3.3 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 twenty-five percent (25%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.3.4 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote.

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 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 in a substantive way.

Lake Health

MEDICAL STAFF BYLAWS

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

October 10, 2018
Rev. April 29, 2019
Revised November 23, 2020

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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 that have been 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 his/her 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 that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that 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, Department Chair, President of the Hospital, Senior Vice President of Medical Affairs, or hospital Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

2.2 Investigation

If the MEC decides that 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 that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

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

If the investigation is delegated to a committee other than the MEC, 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. 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 President of the Hospital.

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 examination is to be conducted by a practitioner mutually acceptable to the MEC and the practitioner under investigation. 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 that 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.

2.2.1 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 Department Chairs 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 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. Where a bona fide dispute exists as to whether the circumstances have occurred, 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 President of the Medical Staff with the approval of the Senior Vice President of Medical Affairs or President of the Hospital may reinstate the practitioner's privileges or membership after determining that 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 and suspension:** 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 that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs: Whenever a practitioner is sanctioned or barred from 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, with valid Ohio address, is expired, 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 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 **Medical Record Completion Requirements:** A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever he/she fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.5 **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 relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment 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 The Medical Staff Office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 **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 healthcare fraud or abuse, violence, 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.

3.1.7 **Failure to Maintain Collaboration/Supervisory Relationship with a Physician:** The privileges of APPs and AHPs shall be suspended immediately, without right to due process, in the event that the employment of the APP or AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP or AHP with a physician member of the Medical Staff organization is terminated for any reason. The privileges of APPs and AHPs shall terminate if the APP/AHP cannot develop a collaborative/supervisory agreement with another physician on the Medical Staff.

3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. This will be considered a voluntary resignation from the Medical Staff.

3.1.9 **Failure to Participate in an Evaluation:** A practitioner who fails to participate in an evaluation of his/her 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 automatically relinquished all privileges. 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.

3.1.10 **Failure to Become Board Certified:** 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 subject to consideration by the MEC in accordance with Part III, Section 2.4 of these Bylaws.

3.1.11 **Failure to Maintain Board Certification:** A practitioner, who is board certified on approval of these bylaws, who fails to regain their board certification within one (1) recredentialing cycle following a lapse in board certification, will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges unless an exception is granted, for a good cause, by the Board upon recommendation from the MEC subject to consideration by the MEC in accordance with Part III, Section 2.4 of these Bylaws. There is no need to have ABMS maintenance of certification (MOC) or AOA Osteopathic Continuous Certification (OCC).

3.1.12 **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 President of the Medical 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.

3.1.13 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within ninety (90) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.

3.1.14 **Failure to Maintain Qualifications for Privileges:** Whenever a practitioner fails to maintain qualifications for a privilege, that privilege will be automatically suspended until the qualification is restored.

3.1.15 **Failure to Report Changes to Application Questions:** Whenever a practitioner fails to reports changes to the application questions in a timely manner (as noted in Part I, Section 2.6.11 and Part III, Section 3.2.8), the practitioner shall be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges.

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

3.2 Summary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A summary restriction or 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 President of the Hospital determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety; the event, concern, or issue may be clinical or behavioral. Under such circumstances one (1) Medical Staff leader (such as a Medical Staff Officer or Department Chair) in conjunction with one (1) administrator (such as the President of the Hospital; Senior Vice President of Medical Affairs; or administrator on call) restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. 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 restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the President of the Hospital, and the Board. The restriction or 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 that caused the suspension.

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

3.2.2 **MEC Action:** 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 restriction or 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 restriction or 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 (or applicant for the above) shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 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 unfavorable 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 that an application is incomplete or untimely;

j. Determination that 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 that 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 for performance 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 within five (5) years of 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 longer than five (5) calendar days) be given written notice by the President of the Hospital delivered either in person or by certified mail, return receipt requested. This notice shall contain:

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

b. Notice that 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 that 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 President of the Hospital 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 President of the Hospital shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

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

b. A proposed list of witnesses (as known at that 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 that 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 that the other party provide either a list of, or copies of, all documents that will be 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 that 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. This panel will be appointed by the President of the Hospital, in conjunction with the President of the Medical Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. 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. Hearing panel members may be physicians who are not Members of the hospital Medical Staff. 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 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 President of the Hospital 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 President of the Hospital. The President of the Hospital 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, he/she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the President of the Hospital.

5.2 Hearing Panel Chairperson or Presiding Officer

5.2.1 In lieu of a hearing panel chair, the President of the Hospital, acting for the Board and after considering the recommendations of the President of the Medical Staff (or those of the Chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as Presiding Officer. The Presiding Officer should have no previous relationship with either the hospital, organized Medical Staff, or the practitioner. Such Presiding Officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.2 If no Presiding Officer has been appointed, a chair of the hearing panel shall be appointed by the President of the Hospital to serve as the Presiding Officer and shall be entitled to one vote.

5.2.3 The Presiding Officer (or hearing panel chair) shall do the following:

a. Act to ensure that 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 that causes undue delay. In general, it is expected that 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 that pertain 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 he/she feels it is appropriate. Legal counsel to the hospital may advise the Presiding Officer or panel chair.

5.3 Hearing Officer

5.3.1 As an alternative to the hearing panel described above, the President of the Hospital, acting for the Board and in conjunction with the President of the Medical 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 that would 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" or "Presiding Officer" 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 Presiding Officer, 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 Presiding 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 Presiding 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 his/her counsel.

6.2 Pre-Hearing Conference

The Presiding 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 Presiding 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 Presiding Officer, 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 that 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 Ohio.

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 counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may argue the case for his/her client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;

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

6.5.2 Any individuals requesting a hearing who do not testify in 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 Burden of Proof

It is the burden of the MEC (or Board of Trustees) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that he/she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and hospital policies.

6.8 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 with ten (10) business days, following the close of the hearing.

6.9 Official Notice

The Presiding 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 that 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.

6.10 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 Presiding Officer or the President of the Hospital on a showing of good cause.

6.11 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 President of the Medical Staff or President of the Hospital. All members of the hearing panel shall be present, absent good cause, for all stages of the hearing and deliberations.

6.12 Order of Presentation

The Board or the MEC, 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.

6.13 Basis of Recommendation

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

6.14 Adjournment and Conclusion

The Presiding 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.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing or receipt of the transcript, whichever is later, the hearing panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) 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.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the President of the Hospital who shall forward it, along with all supporting documentation, to the Board for further action. The President of the Hospital shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment. If the hearing panel report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below. If the hearing panel report differs from the original MEC or Board recommendation, the MEC or Board may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, or after the MEC or Board makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and shall be delivered to the President of the Hospital or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board.

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 that is 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 that it is new, relevant evidence and that 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 that individual's expense. The review 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 Ohio.

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-minute (30) 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 affected individual and to the chairs of the Credentials Committee and MEC, in person or by certified mail, return receipt requested.

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 that 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 within five (5) years for Medical Staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Fair Hearing and Appeal for Advanced Practice Professionals and Allied Health Professionals

It is noted that 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.

Advanced Practice Professionals and Allied Health Professionals (scrub techs and registered nurse first assistants (RNFAs)) 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 his/her exercise of clinical privileges, the practitioner and his/her collaborating/supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the President of the Medical Staff to discuss the recommendation. The practitioner and the collaborating/supervising physician, if applicable, must request such a meeting in writing to the President of the Hospital within ten (10) calendar days from the date of receipt of such notice. At the meeting, the practitioner and the collaborating/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 collaborating/supervising physician, if applicable, the MEC and the Board.

The practitioner and the supervising physician, if applicable, may request an appeal in writing to the President of the Hospital within 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, if applicable. 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, if applicable, will be notified within ten (10) calendar days of the final decision of the Board.

Lake Health

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

October 10, 2018
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Table of Contents

Section 1. Medical Staff Credentials Committee

1.1 Composition

Voting membership of the Medical Staff Credentials Committee shall consist eight (8) departmental representatives and a representative of the APP community. The departmental representatives, who are not Department Chairs, are recommended by the Department Chair and appointed by the President of the Medical Staff. The Chair of the Credentials Committee shall be elected by the members of the committee; the chair should have significant Credentials Committee experience.

The non-voting members shall be the Senior Vice President of Medical Affairs and the Director of Medical Staff Services. Voting members will be appointed for staggered two (2) year terms. The chair and voting members may be reappointed for additional terms without limit.

1.2 Meetings

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or President of the Medical 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 that are 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 and administrative leaders 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 President of the Hospital or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances only upon written request approved by the President of the Medical Staff, credentials chair or Senior Vice President of Medical Affairs. 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 that he/she has 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;

2.2.2 Have a current state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Ohio. The license must be unrestricted for initial appointment;

2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;

2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to any felony within the last ten (10) years;

2.2.5 For those Practitioners who maintain an office practice, have an office in the Lake Health primary or secondary services areas;

2.2.6 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 seven (7) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association or any foreign board recognized by the American board. Residents in their final year of residency are eligible for privileges, without membership;

2.2.7 A dentist must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.8 An oral and maxillofacial surgeon must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within seven (7) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

2.2.9 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 seven (7) years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine;

2.2.10 A chiropractor must have successful completion of a Council on Chiropractic Education (CCE) accredited chiropractic training program, successful completion of the examination offered by the National Board of Chiropractic Examiners (NBCE), and current licensure to practice as a chiropractor issued by the Ohio State Chiropractic Board. Board certification is required through either the American Board of Chiropractic Acupuncture, the American Chiropractic Rehabilitation Board, and the American Board of Chiropractic Specialties.

2.2.11 A psychologist must have an earned a doctorate degree, (PhD or Psy.D, 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);

2.2.12 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 is required for 1) initial applicants or be actively seeking initial certification and obtain the same by the end of their initial appointment and 2) reapplicants;

2.2.13 An anesthesia assistant 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 an Anesthesiologist Assistant-Certified (AA-C) is required for 1) initial applicants by the end of their initial appointment and 2) reapplicants;

2.2.14 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), or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants and reapplicants;

2.2.15 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program 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) or the American Association of Critical Care Nurses (AACN), the American Academy of Nurse Practitioners (AANP), the National Certification Corporation for Neonatal Nurse Practitioners (NNP-BC) or for Women's Health Care Nurse Practitioner (WHNP-BC), the Pediatric Nursing Certification Board for Certified Pediatric Nurse Practitioner (CPNP) is required for initial applicants and reapplicants;

2.2.16 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 is required for initial applicants and reapplicants;

2.2.17 A radiology assistant (RA) must have current certification and registration in radiography by the American Registry of Radiologic Technologists (ARRT). Successful completion of a radiologist assistant educational program that is recognized by ARRT is required for initial applicants and reapplicants;

2.2.18 A pathology assistant must have successful completion of an NAACLS-accredited pathologist assistant training program, have current certification as a pathologists' assistant (PA) by the American Society of Clinical Pathology (ASCP), and have a current license to practice as a pathologists' assistant issued by the State of Ohio;

2.2.18 A registered nurse first assistant (RNFA) must have successfully completed an approved AORN RNFA training program that meets the AORN standards for RN first assistant education programs. Current certification in perioperative nursing (CNOR) by the Association of Operating Room Nurses (AORN) and current RNFA certification or active participation in the certification process to be achieved within 9 months of eligibility is required for initial applicants. Current certification is required for reapplicants;

2.2.19 A Certified Surgical First Assist must have successful completion of a surgical first assistant education program accredited by the Association of Surgical Technologists or the Commission on Accreditation of Allied Health Education Programs. He/she must have current certification by The National Board of Surgical Technology and Surgical Assisting (NBSTSA), as a certified surgical first assistant CSFA;

2.2.20 Have appropriate written and verbal communication skills;

2.2.21 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.

2.3 In Addition to Privilege-Specific Criteria, the Following Qualifications Must Also be Met and Maintained by All Applicants Requesting Clinical Privileges:

2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.3.2 Possess a current and valid drug enforcement administration (DEA) number, with Ohio address, if applicable. The DEA must be unrestricted for initial appointment;

2.3.3 Possess a valid individual NPI number;

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

2.3.5 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;

2.3.6 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;

2.3.7 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;

2.3.8 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.

2.4 Exceptions

2.4.1 All Practitioners who are current Medical Staff Members, excluding Urgent Care Practitioners, and hold privileges as of June 27, 1994 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements. All Urgent Care Practitioners who are current Medical Staff Members and hold privileges and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

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

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, The Medical Staff Office 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. All applicable fees;

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

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

g. Morbidity and mortality data, when available.

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 will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that 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 that The Medical Staff Office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that 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 The Medical Staff Office 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 Medical Staff Office 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 that he/she is 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 application, The Medical Staff Office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). 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, The Medical Staff Office 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 ten (10) years;

b. Verification of the applicant's past clinical and work experience since the completion of training;

c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, The Medical Staff Office 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. Information from the AMA or AOA Physician Profile, and OIG list of Excluded Individuals/Entities or SAM (System for Award Management);

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

f. 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;

g. Other information about adverse credentialing and privileging decisions;

h. Receipt of three (3) peer recommendations, as directed by the Credentials Committee, chosen from practitioner(s) who have evaluated 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. One reference shall be from someone of the same professional discipline;

h. Information from a lifetime criminal background check for initial application only;

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

j. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, The Medical Staff Office 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 that 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 his/her 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 his/her 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 that may be 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 his/her 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 and peer review information to other hospitals, licensing boards, 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 that 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 section 3.2.5 through 3.2.7 above, if an individual institutes legal action and does not prevail, he/she 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 attestation form of 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 those questions affirmatively and/or provides information identifying a problem with any of those items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

3.3.1 **Credentialing and Privileging 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: credentials chair acting on behalf of the Credentials Committee, Department Chair, the MEC 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 Credentials Committee, Department Chair, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he/she meets 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 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 changed medical schools or residency programs or has gaps;

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

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

h. Applicant has an adverse National Practitioner Data Bank report;

i. 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;

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

k. Applicant has potentially relevant physical, mental, and/or emotional health problems;

l. 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 Credentials Committee, Department Chair, MEC, or Board. The interview may take place in person or by telephone at the discretion of the Medical Staff or the Board. 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 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 that 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 Department Chair for review and recommendation. If designated Category 2, the Medical Staff Credentials Committee reviews the application and forwards the following to the Department Chair:

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.

3.3.4 Department Chair Action

a. All completed applications are presented to the Department Chair for review, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair determines whether the application is forwarded as a Category 1 or Category 2. The Department Chair may obtain input if necessary from an appropriate subject matter expert. If a Department Chair believes a conflict of interest exists that might preclude his/her ability to make an unbiased recommendation he/she will notify the MEC and forward the application without comment.

b. The Department Chair forwards to the Medical Executive 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 to 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.

3.3.5 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 President of the Medical 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 that 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 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 that 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 President of the Hospital to the MEC and to the Chair of each Department 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 Department to which he/she is 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

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 that the practitioner provides effective care that is 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 such as the Vice Chair or previous Chair shall substitute for the Department Chair in the evaluation of current competency of the Department Chair, 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 The Medical Staff Office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to this date the practitioner must return the following to the Medical Staff office:

a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;

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: The Medical Staff Office collects and verifies information regarding each practitioner's professional and collegial activities to include those items listed on the attestation form of the application.

4.2.3 The following information is also collected and verified:

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. Documentation indicating that the applicant has met the continuing education requirements in accordance with the laws of the State of Ohio, in effect at the time of his/her last license renewal, and that the educational activities relate, at least in part, to the privileges being sought;

d. Service on Medical Staff, Department, 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. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations chosen from practitioner(s) who have evaluated 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

k. Malpractice history for the past two (2) years.

4.2.4 Failure, without good cause, to provide any requested information, at least thirty (30) 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, The Medical Staff Office 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 of 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 with the exception of review by the credentials committee. 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 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 physicians serving locum tenens positions, telemedicine physicians, house staff such as residents or fellows moonlighting in the hospital, Advanced Practice Professionals (APPs), or Allied Health Professionals (AHPs) such as registered nurse first assistants (RNFAs) or scrub techs who perform a surgical level of care, 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 that 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 that 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 that 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 that 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. Advance Practice Professionals (APPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the collaboration/supervision of a physician who has been accorded privileges to provide such care. Allied Health Professionals (AHPs) such as scrub techs and Registered Nurse First Assistants (RNFAs) in this category may not exercise independent judgment and work under the direct supervision of a physician who has been accorded privileges to provide such care. The privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the Medical Staff organization is terminated for any reason.

5.7 Special Conditions for Residents or Fellows in Training

5.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the Medical Staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the residency program director. 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 residency program director must communicate periodically with the MEC and the Board about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that 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 will be processed as follows:

a. The hospital uses the credentialing and privileging decision from the distant site if all of the following requirements are met:

i. The distant site telemedicine entity's medical staff credentialing and privileging process and standards meet at least meet the standards stated in the Medicare Conditions of Participation (42 CFR 482.12 (a) and 482.22(a);

ii. The practitioner is privileged at the distant site for those services to be provided at this hospital and provides the hospital with a current list of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity;

iii. The individual distant-site physician or practitioner holds a license issued or recognized by Ohio; and

iv. The hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

5.9 Temporary Privileges

The President of the Hospital, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

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 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 his/her 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.

5.9.3 Termination of temporary privileges: The President of the Hospital, acting on behalf of the Board and after consultation with the President of the Medical 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 effect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the President of the Medical Staff or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

5.9.4 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 his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.10 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 Department 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.

5.11 Disaster Privileges:

5.11.1 If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the President of the Hospital 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 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:

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

b. A current license to practice;

c. Primary source verification of the license;

d. Identification indicating that 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;

e. Identification indicating that 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

f. 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.

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

5.11.3 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.

5.11.4 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 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.

5.11.5 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.

5.11.6 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 Department Chair, with the approval of the MEC, 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 Department Chair will also establish the duration for such FPPE and triggers that indicate 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 that affect 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 acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must arrange for a preceptorship, that is 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 physician practicing outside of the hospital.

If a practitioner has not provided any clinical care within the past five (5) years as determined by the Ohio Medical Board or the MEC, s/he 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 Department Chair 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 for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

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, Department assignment, or clinical privileges by submitting a written request to the Medical Staff office. 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 that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice, through the Medical Staff office, 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 his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

Every practitioner agrees that he/she 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 President of the Hospital or his/her designee shall be responsible for assuring that 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. Actions that must be reported 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. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than one hundred twenty (120) days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. Under such circumstances, the President of the Hospital/ Senior Vice President of Medical Affairs, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed two (2) years except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Section 9. Practitioners Providing Contracted Services

9.1 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.

9.2 Exclusivity policy

Whenever hospital policy specifies that 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.

9.3 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 his/her appointment category as any other applicant or staff appointee.

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

9.5 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 10. Medical Administrative Officers

10.1 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.

10.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities and discharge staff obligations appropriate to his/her staff category in the same manner applicable to all other staff members.

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

10.3.1 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 his remaining in office.

10.3.2 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.

10.3.3 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.

LAKE HEALTH
MEDICAL STAFF RULES AND REGULATIONS
General Staff: April 10, 2019: Board of Trustees: April 29, 2019
Rev. General Staff: October 16, 2019: Board of Trustees: December 6, 2019
Rev. General Staff: April 21, 2021; Board of Trustees: June 28, 2021

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ARTICLE I

INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Trustees, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and Case Management/utilization standards in effect in the Hospital.

ARTICLE II

ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short-term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges. This includes licensed independent practitioners and certified nurse midwives for their own non-Medicare patients.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with the Hospital's Patient Flow Center. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the attending practitioner or his designee shall contact the Hospital's Admitting Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

Admission/Registration personnel will admit patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission, however their condition is not life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

d. **Direct Admissions:** Direct admission patients may be elective, urgent, or emergent. The Hospital "Direct Admission Policy" is to be followed for these admissions.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to the Birthing Center/Labor and Delivery per hospital policy after determination that the patient is stable.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Pregnant patients, greater than twenty (20) weeks' gestation, with a primary obstetrical complaint can have their medical screening exam done in the obstetrics area.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

a. the patient does not have an established relationship with a practitioner, within the past three (3) years outside of that in an unassigned capacity, or does not indicate a preference;

b. the patient's established practitioner does not have admitting privileges; or

c. the patient's injuries or condition fall outside the scope of the patient's established practitioner.

An internal medicine physician, who has accepted an unassigned patient into their practice, is responsible for the care of that patient for only six (6) months. At that point, if the patient returns to the hospital for care, that patient will be considered an unassigned patient.

2.2.2 Unassigned Call Service

a. **Unassigned Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. The MEC, in conjunction with administration, shall determine which specialties shall serve on emergency department unassigned call. Each Medical Staff Department Chair, or his/her designee, shall provide the Medical Staff Office with a list of physicians who are scheduled to take emergency call on a rotating basis. A physician shall serve either on a Department, specialty, or subspecialty call list.

b. **Response Time**: It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, should respond to calls from the Emergency Department within thirty (30) minutes by telephone, and must arrive at the Hospital, if requested to see the patient, to evaluate the patient within one (1) hour for emergent patients or as stipulated by contract or privilege. If the on-call physician does not respond to being called or paged, the physician's Department Chair shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call physician's responsibility to arrange for coverage and officially update the Medical Staff Office if he/she is unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit, regardless of the patient's ability to pay.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered Unassigned.

2.2.5 Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

a. Unassigned call duties should be based on the appointee's clinical core privileges; physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category unless that specialty has been exempted from call based on a decision of the MEC and administration.

b. Unassigned call duties shall be assigned by the Department Chair and approved by the MEC and Board.

c. Unassigned duties may be divided by Department, specialty, or subspecialty.

d. A physician may be excused from Unassigned call roster as long as the remaining members of the specialty agree and absorb the call time of the excused physician.

e. An impairment which is alleged to limit an appointee's ability to provide Unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

f. Department policies concerning Unassigned call, including the frequency of call, must be approved by the Medical Executive Committee and the Board. Generally, call shall be mandated no more often than one (1) in three (3) nights or weekends.

g. Physicians are allowed to take unassigned call at more than one (1) facility at a time as long as they have a back-up plan if there is more than one (1) emergency at different facilities simultaneously.

h. Physician are allowed to perform elective surgery while on unassigned call as long as they have a back-up plan if there is an emergency that requires their attendance while the elective surgery is underway.

2.2.6 Use of the Unassigned Call Roster

The Unassigned call roster may be used as default consultation coverage when a practitioner cannot obtain consultation on his/her patient on a voluntary basis.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet Unassigned call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.3 TRANSFERS

2.3.1 Transfers To or From Other Acute Care Facilities

Transfers to other acute care facilities must comply with EMTALA guidelines as noted in hospital Administrative Policy T-62-1: External (Outside Lake Health) Transfer Procedure.

Transfers to or from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer, unless the risk of transfer is less than the risk of the patient staying at the facility;

b. The patient's condition must meet medical necessity criteria;

c. The patient must require, and the Hospital transferred to must be able to provide either:

   i. a higher level of care or a specific inpatient service not available at the transferring facility,

   ii. or it is done at patient request;

d. Responsibility for the patient must be accepted by a physician with appropriate privileges at the receiving Hospital; and

e. The transfer must be approved by the receiving Hospital representative with authority for accepting transfers.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers per the methods noted in hospital policy.

2.3.3 Transfers That are Delayed

If transfer from the emergency department to another facility is delayed more than four (4) hours, then the unassigned call physician will assume the care of the patient who is boarded in the emergency department.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others.

Acute care admissions of suicidal patients will be accepted subject to bed availability. Other acute care admissions for suicidal patients will not be accepted except for those patients requiring medical stabilization or when transfer to an inpatient psychiatric facility cannot be facilitated. In these instances, once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

The attending practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others.

2.5 PROMPT ASSESSMENT

All new admissions must be personally assessed within the following timeframes:

- Sixteen (16) hours of admission for all new patients admitted through the emergency department,
- Twenty-four (24) hours of admission for all new patients who are directly admitted from the office,
- Four (4) hours for all admissions to the intensive care units.

If a practitioner cannot meet the four (4) hour timeframe for direct evaluation of the patient in the ICU, then a hospitalist will be called to see the patient.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her privileged designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

a. A list of all medications the patient is to take post-discharge;

b. Dietary instructions and modifications;

c. Medical equipment and supplies;

d. Instructions for pain management;

e. Any restrictions or modification of activity;

f. Follow up appointments and continuing care instructions;

g. Referrals to rehabilitation, physical therapy, and home health services; and

h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

ARTICLE III

MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents.

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

- U for Units
- IU for International Units
- QD for Daily
- QOD for Every Other Day
- Use of Trailing Zero (X.0)
- Failure to Use Leading Zero (0.X)
- MS or MSO4 for Morphine Sulfate
- MGSO4 for Magnesium Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses, on informed consents, or on operative procedures.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all surgeries/procedures requiring anesthesia (general, regional, MAC, or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;

d. An age-appropriate social history;

e. A pertinent family history;

f. A review of systems;

g. Cardiorespiratory exams and other relevant physical findings;

h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician or his/her designee.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all invasive procedures performed in the Hospital's surgical suites requiring anesthesia.

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed. In cases of procedures performed by podiatrists and dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

The attending physician, or his/her designee, will record a progress note each day for each significant patient encounter on all acute care hospitalized patients and must indicate that the physician has seen the patient. Progress notes must document the reason for continued hospitalization. All patients in the intensive care units must be seen daily by a physician. Progress notes must be performed three (3) times per week for all rehabilitation patients and at least five (5) times per week on any patients in the geriatric psychiatry unit.. Progress notes documented by non-physicians do not require cosignature.

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery, and in no case later than twenty-four (24) hours after the end of the procedure, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

a. name and hospital identification number of the patient,

b. date and times of the surgery,

c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,

d. the pre-operative and post-operative diagnoses,

e. the name of the procedure performed,

f. a description of the procedure performed,

g. the type of anesthesia administered,

h. findings of the procedure,

i. complications, if any,

j. any estimated blood loss,

k. any specimen(s) removed, and

l. any prosthetic devices, transplants, grafts, or tissues implanted.

3.9 POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:

a. the name of the surgeon(s) who performed the procedure and any assistants,

b. the name of the procedure performed,

c. findings of the procedure,

d. any estimated blood loss,

e. any specimen(s) removed, and

f. the post-operative/procedure diagnosis.

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS

3.10.1 Pre-anesthesia notes

A pre-anesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made by the physician administering or supervising, as applicable, the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location and shall contain the following information:

a. A review of the medical history,

b. An interview and examination of the patient,

c. A documented airway assessment,

d. An anesthesia risk assessment,

e. An anesthesia, drug and allergy history,

f. Performed by an individual, qualified, and privileged to administer anesthesia/sedation, within 48 hours prior to inpatient or outpatient surgery or procedure requiring anesthesia services. (Delivery of the first dose of medications for the purpose of inducing anesthesia marks the end of the 48-hour time frame).

3.10.2 Pre-sedation assessments

Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however a pre-anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia". The pre-sedation assessment shall include the following:

a. Physical examination of the airway (by those qualified and privileged to administer sedation) must be performed within 48 hours of administration of anesthesia/sedation;

b. Assessment of risk to the patient for receiving anesthesia/sedation;(within 30 days/update within 48 hours);

c. Drug and allergy history regarding anesthesia/sedation;(within 48 hours of induction); and

d. Physical condition of the patient prior to induction of anesthesia/sedation;(within 48 hours of induction).

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES

3.12.1 Post-anesthesia notes

A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation. The note shall be entered by an anesthesia provider or by the physician who administered the deep sedation. This note should contain the following information:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

b. Cardiovascular function, including pulse rate and blood pressure;

c. Mental status;

d. Temperature;

e. Pain;

f. Nausea and vomiting; and

g. Postoperative hydration.

3.13 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours after receipt of notification of the consult request. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within thirty (30) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the bylaws will be documented.

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The discharge summary should be completed immediately after discharge, but in no case later than forty-eight (48) days after discharge, transfer, or death.

a. **Content**: A discharge summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the attending physician or their designee and will contain:
    i. Reason for hospitalization;
    ii. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
    iii. Condition of the patient at discharge;
    iv. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
    v. Final diagnoses.

b. **Short-term Stays**: A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician, or designee, enters a final progress note or completes a Discharge Form documenting:
    i. Outcome of the hospitalization;
    ii. The condition of the patient at discharge; and
    iii. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A discharge summary is required on all inpatients who have expired and will include:
    i. Reason for admission;
    ii. Summary of hospital course; and
    iii. Final diagnoses.

d. **Timing**: A Discharge Summary is encouraged to be entered and signed in the medical record immediately after discharge, but in no case later than forty-eight (48) days after discharge, transfer, or death.

Any discharge summary used for readmission purposes should be completed immediately after discharge, but in no case later than forty-eight (48) days after discharge.

3.17 DIAGNOSTIC REPORTS

Diagnostic reports shall be completed in a timeframe consistent with the reading policy, or contract.

3.18 ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals are Physician Assistants (PAs) and Advanced Practice Registered Nurses (certified nurse midwives (CNMs), nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs) and clinical nurse specialists providing direct patient care).

- The collaborating/supervising physician does not need to cosign any history and physical examinations performed by APPs.;
- The collaborating/supervising physician does not need to cosign any consultations performed by APPs.;
- The collaborating/supervising physician does not need to cosign any progress notes performed by APPs. Patients in critical care units must have a progress note performed daily by a physician;
- Routine orders of an Advanced Practice Professional do not need cosignature by a physician. Orders for controlled substances need to be cosigned by a physician if the APP does not have their own independent DEA number;
- Delivery notes done by CNMs do not require cosignature by a physician;
- The collaborating/supervising physician will review and authenticate all discharge summaries prepared by the Advanced Practice Professional.

3.19 MEDICAL STUDENTS AND RESIDENTS IN TRAINING

Medical students and residents in training, who are not moonlighting outside of their training program, must have their:

- History and physical examinations, operative notes, and operative reports cosigned within one calendar day by the attending physician, or their physician designee;
- Discharge summaries cosigned by the attending physician, or their physician designee, within forty-eight (48) days after discharge of the patient;
- Progress notes cosigned within one calendar day, unless the attending physician enters their own independent note for that day; and
- Orders of the resident or fellow do not need to be cosigned.

Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the professional graduate 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.

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 that all supervising physicians possess clinical privileges commensurate with their supervising activities.

3.20 PROVIDER-BASED CLINICS

In provider-based clinics, all office notes must be completed within three (3) days of the visit. A problem list (medications, allergies, and chronic illnesses) must be completed by the end of the first visit.

3.21 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records**: In case of readmission of a patient, all previous records will be made available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.22 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Records Committee.

3.22.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframes noted in the bylaws, Section 2.6.8;

b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;

c. An Admission Prenatal Record with update, or a de novo history and physical, must be entered in the medical record by the attending physician or designated covering practitioner within twenty-four (24) hours after an obstetrical admission;

d. An Operative Report must be entered in the medical record by the performing practitioner immediately, but in no case later than twenty-four (24) hours, following the surgery or procedure;

e. If the Operative Report is not immediately available, a Post-Operative Note must be entered in the medical record by the performing practitioner prior to transfer of the patient to the next level of care;

f. An Inpatient Progress Note must be recorded and authenticated by the attending physician, or designee, each day and for each significant patient encounter on all hospitalized patients;

g. An Emergency Department Record must be completed by the responsible practitioner:

   i. Transferred patient – prior to transfer,

   ii. Admitted patient – within twenty-four (24) hours

   iii. Patient discharged home – within forty-eight (48) hours, unless the ED wants follow-up in the office in a shorter timeframe;

h. A Consultation Note must be completed by the consulting physician, or designee, within twenty-four (24) hours of notification of the consult request;

i. A Discharge Summary must be entered in the medical record by the discharging physician or his/her designee within 48 hours after an inpatient or observation discharge or transfer; or death;

3.22.2 Policy on Incomplete Records

All practitioners will be held to the Administrative policy on Incomplete Chart Control: I-40-1.

3.23 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.24 COPY FUNCTIONALITY FOR DOCUMENTATION WITHIN THE ELECTRONIC HEALTH RECORD (EHR)

3.24.1 Copy Functionality

The purpose of the health record is to provide a basis for planning patient care and for the continuity of care. Each record should provide documentary evidence of the patient's medical evaluation, treatment, and change in condition as appropriate. The purpose of this policy is to provide guidance on the use of copy functionality when documenting in the Electronic Health Record (EHR). For the purpose of this rule, copy shall be understood to include cut/paste, copy forward, cloning, and any other intent to move documentation from one part of the record to another.

Providers or other individuals permitted to document in the EHR ("Providers" hereafter) must avoid indiscriminately copying and pasting another provider's documentation as well as the process of copying forward information from previous notes, without clear attribution in an effort to increase documentation in a current visit. Indiscriminate use of copying and pasting lengthens the note, may lead to fraudulent provider billing, adds redundant information that may be unnecessary, and may adversely impact quality and patient safety. Inappropriate use of copy functionality may be deemed to be pre-documentation or falsification. The following procedure shall be used:

a. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.

b. If any information is imported or reused from a prior note, the provider is responsible for its accuracy and medical necessity. A provider may not copy another practitioner's note.
c. Providers are responsible for correcting any errors identified within documentation.
d. Providers must notify the Director of Health Information Management (HIM) immediately regarding any error(s) in the source note. All notes from the original source that contain errors must be corrected.
e. Providers are responsible for citing and attributing as applicable all lab data, pathology, and radiology reports.
f. Providers are responsible for clearly identifying who performed each service documented within the note. When entering patient data into the medical record that the provider did not personally take or test, the provider must attribute the information to the person who did.
g. If the provider references a form or other entries within the record (e.g., review of system form), he/she must reference the form or other entry with sufficient detail to uniquely identify the source. Example: See review of systems dated 1/1/18.
h. Providers are required to document in compliance with all federal, state, and local laws and Medical Staff Rules and Regulations.
i. Once a note has been signed as final, additional information may only be added as an addendum.
j. Failure to comply with this procedure subjects the provider to corrective disciplinary action.

3.24.2 Medical Record Copy Function Sanction Policy

When practitioners fail to comply with the procedure noted above, the following will occur:

a. Inappropriate copying will be referred to the Director of Health Information Management for review, validation and facility-wide trending.
b. The Chairman of the Medical Records Committee is responsible for reviewing all substantiated inappropriate use of copy functionality and facility wide trending reports. This Committee Chairman will work with the respective Department Chairman and shall make recommendations on disciplinary action in which continued inappropriate use of copy technology is identified.
   Failure to comply with the organizational policy regarding copy functionality will be deemed a violation of the Medical Staff Code of Conduct.

3.25 ORGANIZED HEALTH CARE ARRANGEMENT

a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of [Hospital] are deemed to be members of, and a part of, an *Organized Health Care Arrangement* ("OHCA") as that term is defined within HIPAA. This designation is intended to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with Lake Health and the hospital's medical staff. Except for non-compliance remedies set forth in the HIPAA regulations, no member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

b. The members hereby adopt the Lake Health Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the joint Notice of Privacy Practices.

c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as

those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, though any portal that is not solely operated by Lake Health, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Lake Health information through a portal maintained by the member.

d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE IV

STANDARDS OF PRACTICE

4.1 ADMITTING, ATTENDING AND DISCHARGING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges.

a. Admitting Physician. The admitting physician, or designee, is responsible for completion of the history and physical examination.

b. Attending Physician. The attending physician, or designee, will be responsible for:
   i. the medical care and treatment of each patient in the Hospital;
   ii. making daily rounds;
   iii. the prompt, complete, and accurate preparation of the medical record; and
   iv. necessary special instructions regarding the care of the patient.

c. Discharging Physician. The discharging physician, or designee, is responsible for completion of the Discharge Summary.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Service, a note covering the transfer of responsibility will be entered in the medical record by the attending physician.

4.2 ALTERNATE COVERAGE

Each physician shall provide the Medical Staff Services Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who shall be responsible for the care of their patients in the Hospital when the physician is not available.

4.3 RESPONDING TO CALLS AND PAGES

a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes to calls from the Hospital's patient care staff regarding their patient.

b. Physical Response: Practitioners are expected to respond in person within one (1) hour to evaluate emergent requests from staff. If not available within one (1) hour, the practitioner should provide for back-up response.

4.4 ORDERS

4.4.1 General Principles

Orders are to follow Hospital policy.

4.4.2 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal orders are given directly practitioner-to-hospital staff; telephone orders are given practitioner-to hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy.

b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal/telephone orders must be signed within twenty-four (24) hours by the ordering practitioner or another practitioner involved in the patient's care.

e. Orders for cancer chemotherapy may not be given verbally.

f. Verbal/telephone orders may be given only by practitioners privileged at the hospital or working under training protocols.

4.4.3 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete

c. The identity of the patient is clearly documented; and

d. The facsimile contains the name of the ordering practitioner, his address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law.

4.4.4 Cancellation of Orders Following Surgery or Transfer

All previous medication orders are canceled when the patient:

a. goes to surgery,

b. is transferred to or from a critical care area,

c. is transferred to/from the Psychiatric unit or Rehabilitation unit to an acute care area, or

d. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.5 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policy Pharmacy Policy PH-2.5-10: Medication Ordering.

4.5 CONSULTATION

a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges. The attending physician, or designee, will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his/her patient. This request shall specify:

   i. the reason for the consultation, and

   ii. the urgency of the consultation (STAT – in a timeframe determined by conversation between the referring physician and the consultant; TODAY – to be done before midnight; and routine – within 24 hours).

b. All consultations will be for "consultation and treatment" unless otherwise noted.

c. All STAT and TODAY consultations should be communicated practitioner-to-practitioner.

d. Nurse practitioners and physician assistants may initiate and receive consultations. All consultation requests should be noted in the medical record.

e. Consultants may order consultations with other specialties without informing the attending physician.

f. APRNs and physician assistants:

i. may perform the consultation with the knowledge and collaboration of their collaborating/supervising physician.
ii. may order diagnostics and therapeutics before discussing the case with the consultant.

g. If the full consultation report is not immediately available, then the consultant, or designee, shall document their assessment and plan in the medical record at the completion of the consultation.

h. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to her manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained. Mandatory consultation in the ICU will be managed according to Medical Staff policy MS-37-1: ICU Admission Policy.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician, or designee, within four (4) hours following admission.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by a physician, Advanced Practice Professional or a senior nurse (administrative coordinator or nurse manager). A registered nurse may pronounce death in a hospice patient. Whoever declares death must note the time of death in the medical record.

The attending physician is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner, not to exceed forty-eight (48) hours after pronouncement of death. In cases of death within the emergency department the attending physician, or the coroner if there is no primary care physician, will be responsible for certifying the cause of death and completing the Death Certificate in a timely manner, not to exceed forty-eight (48) hours after pronouncement of death.

4.7.2 Organ Procurement

When death is imminent, physicians should follow Hospital policy on organ procurement.

4.8 AUTOPSY

It is the responsibility of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest. For all autopsies done in the hospital, a provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within sixty (60) days unless an explanatory note is written. When autopsies are performed off-site, a provisional diagnosis and the complete autopsy report will be obtained as soon as possible.

4.9 SUPERVISION OF / COLLABORATION WITH ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership.

4.9.2 Guidelines for Supervising / Collaborating with Advanced Practice Professionals

a. The physician(s) is(are) responsible for managing the health care of patients in all settings with the exception of the non-Medicare patients of certified nurse midwives.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defined by state law.

c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the Advanced Practice Professional.

e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to present to the hospital within sixty (60) minutes when needed by the Advanced Practice Professional, unless a shorter timeframe is required as noted in privileging documents.

f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician(s).

g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.

i. The supervising/collaborating physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.

j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and one or more alternate supervising physician(s).

4.9.4 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Services Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional, the supervising/collaborating physician, and all alternate supervising/collaborating physicians. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.

4.9.5 Supervising/Collaborating Physician

An Advanced Practice Professional may not provide services to patients if the supervising/collaborating physician, or alternate physician, is more than one (1) hour travel time from the Hospital. A physician may not supervise more Advanced Practice Professionals than allowed by State law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.9.6 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 3.18.

4.9.7 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Services Office, or
b. provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

4.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties, including hand hygiene.

4.11 EVIDENCE-BASED ORDER SETS

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The Medical Executive Committee may adopt evidenced-based order sets upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

ARTICLE V

PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies on Futile Treatment Guidelines F-60-1 and Resuscitation: Patient Withdrawal of Life Sustaining Treatment R-60-1 delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital policy on Resuscitation: Patient Withdrawal of Life Sustaining Treatment R-60-1 delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy on Disclosure of Medical Errors and Unanticipated Outcomes Guidelines: D-14-1 delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Hospital policy on Restraint Use: Violent or Destructive Patient Behavior: R-61-1 delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Hospital policy on Advance Directives A-61-1 delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

A complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition must be completed for each patient receiving general/regional/MAC anesthesia. Only anesthesiologists, certified registered nurse anesthetists, anesthesia assistants, or physicians privileged to perform deep sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

Moderate and deep sedation is performed under the authority of the anesthesia department.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. The Hospital policy on "Universal Protocol" shall be followed.

ARTICLE VII

RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The policy on "Medical Staff Code of Conduct" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the "Health Policy for Practitioners".

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include: spouses, domestic partners, parents, parents-in-law, children, stepchildren, siblings, siblings-in-law, grandparents, aunts, uncles, nieces and nephews.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the hospital policy "Release of Medical Records" regarding access to medical records of themselves or family members. Practitioners may view their own records at any time. Practitioners may only view the records of family members after written authorization of the patient, or other person authorized to sign for the patient.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on TB testing, influenza vaccination, and any testing/vaccinations as noted in policy.

ARTICLE VIII

ORGANIZATION AND FUNCTIONS OF THE STAFF

8.1 ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff shall be organized as a departmentalized staff including the following Departments: anesthesiology, emergency medicine, family medicine, medicine, obstetrics/gynecology, pathology, radiology, and surgery. A Department Chair shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

8.2 RESPONSIBILITIES FOR MEDICAL STAFF FUNCTIONS

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 8.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, Department Chair, hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

8.3 DESCRIPTION OF MEDICAL STAFF FUNCTIONS

The medical staff, acting as a whole or through committee, participates in or has oversight over the following activities:

8.3.1 Governance, direction, coordination, and action

a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from Sections, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the Board.

8.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

   i. Medical assessment and treatment of patients

   ii. Use of medications

   iii. Use of blood and blood components

   iv. Operative and other procedures

   v. Education of patients and families

   vi. Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations

   vii. Appropriateness of clinical practice patterns

   viii. Significant departures from established pattern of clinical performance

   ix. Use of developed criteria for autopsies

   x. Sentinel event data

   xi. Patient safety data

   xii. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient

   xiii. Findings of the assessment process relevant to individual performance; and

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

8.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the medical staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

8.3.4 Credentials review (see Part III: Credentials Procedures Manual)

8.3.5 Information Management

a. Review and evaluate medical records to determine that they:

i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

8.3.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

8.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

8.3.8 Bylaws review

a. Conduct periodic review of the medical staff bylaw, rules, regulations, and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations, and policies.

8.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

8.3.10 Infection Prevention and Control Oversight

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:

   i. Review of cumulative microbiology recurrence and sensitivity reports;

   ii. Review of prevalence and incidence studies, as appropriate; and

   iii. Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biennially.

8.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by TJC and DNV;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to The Joint Commission Patient Care Standards and DNV Medication Management standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

   i. Prescribing/ordering of medications;

   ii. Preparing and dispensing of medications;

   iii. Administrating medications; and

   iv. Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

8.3.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the impaired practitioner's Department Chair and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Practitioner Health Committee does not alter the primary responsibility of the Department Chair] for clinical performance within that chair's Section;

d. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible; and

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

8.3.13 Utilization Management

a. Study recommendations from medical staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate Section or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the medical staff [Peer review] committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, medical staff, and administration in matters of privileged communication and legal release of information.

ARTICLE IX

MEDICAL STAFF COMMITTEES

9.1 GENERAL LANGUAGE GOVERNING COMMITTEES

The following shall be the standing committees of the Medical Staff: Executive, Credentials, Bylaws, Practitioner's Health, Nominating, Medical Staff Quality Oversight, Education, and Graduate Medical Education. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff and the President of the Hospital, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical Staff members may be appointed to the Quality Improvement Coordinating Committee and the Ethics Committee. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

9.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

9.3 CREDENTIALS COMMITTEE

Description of the credentials committee is in Part III: Credentials Procedures Manual; Section 1.

9.4 PEER REVIEW COMMITTEE(S)

9.4.1 Composition: There may be one (1) or more peer review committees as determined by the MEC.

a. There shall be an Active Member from each Department appointed by the President of the Medical Staff, based on recommendations from the Department Chairs. This committee shall meet at least four (4) times per year.

b. Departments Chairs may develop department peer review committees under the guidelines developed by the Medical Staff Quality Oversight Committee (MSQOC).

9.4.2 Responsibilities: The committee(s) shall be responsible for those functions described in section 8.3.2 a-d above.

a. The Medical Staff Quality Oversight Committee shall 1) review cases involving multiple departments and 2) set policy and procedure for all peer review committees. There may also be departmental peer review committees.

b. Departments may also do primary case review.

9.5 NOMINATING COMMITTEE

9.5.1 Composition: The Nominating Committee shall consist of five (5) Active Members who are elected by the Staff at the Interim meeting.

9.5.2 Responsibilities: It shall be the function of this committee to offer one or more nominees for each office of the Staff, and the AMA Organized Medical Staff Section (OMSS) representative and alternate; however, no physician shall be nominated for more than one office or position.

9.6 PRACTITIONER'S HEALTH COMMITTEE

9.6.1 Composition: The committee shall consist of no less than seven (7) members of the medical staff, a majority of which, including the chairman, shall be physicians. Except for initial appointments, each member shall serve a term of two (2) years and can serve an unlimited number of terms, and the terms shall be staggered to achieve continuity. Insofar as possible, members of this committee shall not serve as participants on other peer review or quality assurance committees while serving on this committee

9.6.2 Responsibilities: The Practitioner's Health Committee may receive reports related to the health, well-being, or impairment of Medical Staff members, and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action to the President of the Medical Staff, and to the Board of Trustees. The committee shall also consider general matters related to the health and well-being of the Medical Staff, and, with the approval of the Medical Executive Committee, develop educational programs or related activities. The committee shall meet on call of the chairman. It shall maintain records of its proceedings and shall report on its activities on a routine basis to the Medical Executive Committee. The Practitioner's Health Committee is deemed a peer review committee whose actions are intended to be confidential and protected from discovery, and whose participants are intended to be covered by the statutory immunity afforded peer review committee participants.

9.7 EDUCATION COMMITTEE

9.7.1 Composition: The Education Committee shall consist of seven (7) or more members of the medical staff with all major services represented. The members will be appointed by the President of the Medical Staff with the approval of the Medical Executive Committee. The Director of Medical Education shall be a member of the Committee and will serve as Chairman.

9.7.2 Responsibilities: The committee will meet as necessary to develop educational programs according to the OSMA Accreditation Body requirements, and submit a report in writing to the Medical Executive Committee. A summary report will be given to the medical staff at appropriate meetings. The committee will participate in the identification of quality issues and develop continuing medical education programs which are to have expected outcomes affecting these quality issues, consistent with OSMA accreditation requirements. The committee will meet as necessary to develop and plan educational activities according to the OSMA Accreditation Body requirements, and submit a report in writing to the Medical Executive Committee.

9.8 GRADUATE MEDICAL EDUCATION COMMITTEE

9.8.1 Composition: The Graduate Medical Education Committee (GMEC) consists of the following members:

- Chair of Graduate Medical Education Committee
- Director of the Office of Graduate Medical Education (DME)
- Patient Safety Officer
- Residency Program Directors from each Department of the Medical Staff
- Peer-selected Resident Physicians
- Three subspecialty Program Directors
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA)
- Quality
- Pharmacy
- IT and ENR
- Hospital Administration CEO, CFO
- Chair of the Committee will also serve as the ACGME Designated Institutional Official (DIO)

The minimum voting membership of the GMEC is determined by the Accreditation Council for Graduate Medical Education (ACGME), and specified in the ACGME Institutional Requirements. In addition to the minimum voting members specified in each revision of the ACGME Institutional Requirements, other voting members are appointed by the Chairman of the Graduate Medical Education upon the approval of the Medical Executive Committee.

9.8.2 **Responsibilities:** The Committee meetings are open to all Program Directors or Division Chiefs of Hospital-sponsored ACGME approved residency training programs, and to site Directors of residency programs identified as Major Participating sites. The Committee will provide a means of communication between the Medical Staff, the Board of Trustees, and the Office of Graduate Medical Education of the Hospital, and monitor and advised on graduate medical education issues. The responsibilities of the Committee are defined by the Accreditation Council for Graduate Medical Education, and include the following:

a. To establish institutional policies for graduate medical education;
b. To serve as a liaison between residency program directors and the administrators of other institutions participating in programs sponsored by Lake Health;
c. To regularly review all residency training programs to ensure compliance with institutional policies and the requirements of their ACGME review committees;
d. To establish and implement policies and procedures to ensure due process in connection with the discipline of residents;
e. To ensure appropriate and equitable funding for resident positions, including benefits and support services;
f. To establish and implement policies and procedures for the discipline of residents and the adjudication of complaints and grievances relative to the graduate medical education programs;
g. To ensure appropriate working conditions for residents.

ARTICLE X

CONFIDENTIALITY, IMMUNITY, RELEASES, AND CONFLICT OF INTEREST

10.1 CONFIDENTIALITY OF INFORMATION

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

10.2 IMMUNITY FROM LIABILITY

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or Medical Staff. No representative of this healthcare organization acting in good faith and without malice shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

10.3 COVERED ACTIVITIES

10.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 RELEASES

When requested by the President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

10.5 CONFLICT OF INTEREST

A member of the Medical Staff requested to perform a Board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.