# AMENDED AND RESTATED
# BYLAWS OF
# THE MEDICAL STAFF
# OF
# ASCENSION
# BRIGHTON CENTER FOR RECOVERY

## Brighton, Michigan

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**Amended and Restated**
**Bylaws Of**
**The Medical Staff**
**Of**
**Ascension**
**Brighton Center for Recovery**

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**AMENDED AND RESTATED BYLAWS**

**THE MEDICAL STAFF OF**
**ASCENSION**
**BRIGHTON CENTER FOR RECOVERY**

**PREAMBLE**

Ascension Brighton Center for Recovery is a nonprofit corporation organized under the laws of the State of Michigan. Herein referred to as the "Center", the purpose of which is to serve as a chemical dependency recovery center providing hospital inpatient, outpatient and center-based patient care and education.

The Medical Staff of the Center ("Medical Staff"), is responsible for the quality of medical care provided in the Center, including diagnosis, treatment and rehabilitation of chemical dependency patients in the Center, for the ethical conduct and professional practice of the members of the Medical Staff and accounting for such care, conduct and practices to the Ascension Health System ("AH") Southeast Michigan Board (referred to as the "SMB"). The Medical Staff carries out its duties subject to the ultimate authority of the SMB.

The cooperative efforts of the Medical Staff, the Director of the Center and the SMB are necessary to fulfill the obligations of the Medical Staff to patients. Therefore, the practitioners and professionals practicing at the Center will organize themselves into a Medical Staff conformity within these Bylaws.

**DEFINITIONS**

As used in these Bylaws, the following terms have meanings ascribed to them unless the context clearly provides a different meaning:

"SMB" means Southeast Michigan Board, the governing body of the Center.

"Allied Health Practitioners" means all licensed practitioners who hold dependent privileges and provide direct patient care services in the Center and its Outpatient Programs, under the supervision of a Medical Staff member with clinical privileges. Allied Health Practitioners are designated, credentialed and privileged according to these Bylaws and approved by the SMB. Types of Allied Health Practitioners include: physician assistants, nurse practitioners, certified registered nurses, clinical nurse specialists and licensed social workers. Allied Health Practitioners are not members of the Medical Staff. They must be employed by or have contracts with the Center, or they may be employed, contracted or sponsored

by members of the Medical Staff. Allied Health Practitioners are not entitled to the rights, privileges and responsibilities of Medical Staff membership.

"Adjunct Professional Staff" is limited to doctored leveled scientists, including by way of example, psychologists and PhD's.

"Consulting" Medical Staff - The Consulting Medical Staff shall consist of physicians, dentists and podiatrists who are qualified to provide consulting services in conjunction with an Active Medical Staff member. Consulting Medical Staff members shall provide consultations within their areas of specialty or training at the request of an Active Medical Staff member and, where appropriate, may provide emergency service care, but they shall not be eligible to admit patients. Consulting Medical Staff members shall not be eligible to vote or hold office in the Medical Staff. They shall not be required to attend Medical Staff meetings.

"Credentials Committee" of the Center reports to the Quality Committee/Joint Conference Committee of the SMB in accordance with the Center's Bylaws, and consists of the Chief Medical Officer, Chief Nursing Officer and Facility Director.

"Center" means Ascension Brighton Center for Recovery.

"Center Policies" means, collectively, all rules, regulations and policies of the Center other than the Rules and Regulations referred to in Article 15 of the Bylaws, which are held electronically in PolicyStat.

"Facility Director" means the Director of the Center who is appointed by the SMB.

"TJC" means The Joint Commission, an independent accreditation organization or any successor organization.

"Judicial Review Committee" means the Judicial Review Committee established by Section 11.4 of these Bylaws to conduct appellate review hearings in accordance with Article 11.

"Chief Medical Officer" means the person appointed in accordance with Article 13 of these Bylaws and at the same time serving as Medical Director and (unless the context requires a different meaning) shall include the person so appointed as the "Interim Chief Medical Officer" while serving as Chief Medical Officer in the Chief Medical Officer's absence.

"Medical Staff means all licensed independent practitioners which include; physicians, psychiatrists and adjunct professional staff who are authorized by law to practice within the State of Michigan and privileged to attend patients in the Center, subject to the Medical Staff Bylaws, and is synonymous with "Medical Staff Division".

"Medical Staff Executive Committee" means the Medical Staff Executive Committee established by Section 7.2 of these Bylaws.

"Practitioner" means a licensed physician who holds an M.D. or D.O. Degree, or other adjunct professional staff who is licensed to treat patients independently.

"Professional Expectations Standards" means the professional expectations standards in effect from time to time at the hospitals and medical centers that are part of Ascension Health and reviewed annually by the Chief Medical Officers of such hospitals and medical centers.

"Research Committee and Institution Review Board" means the Research Committee and Institutional Review Board referred to in Section 7.3 of these Bylaws.

"Quality Improvement/Utilization Review Committee" means the Quality Improvement/Utilization Review Committee established by Section 7.4 of these Bylaws.

"Rules and Regulations means the Rules and Regulations adopted by the Medical Staff in accordance with Article 15 of these Bylaws, as amended and in effect from time to time.

As used in these Bylaws, masculine pronouns are used to include both masculine and feminine genders. All references to "days" or "months" are to calendar days or months unless another meaning is specified. References to "articles" and "sections" are to articles and sections of these Bylaws unless otherwise stated. The headings to articles and sections are for convenience and shall not be used to interpret these Bylaws.

## Article 1 – Name

The name of this organization is the Medical Staff of Ascension Brighton Center for Recovery, herein referred to as the Medical Staff of the Center.

## Article 2 - Purpose

**The purpose of this organization is:**

**2.1** To ensure that all patients admitted to or treated in the Center receive high quality medical and behavioral care consistent with community standards.

**2.2** To ensure that high quality professional clinical care is provided by all Practitioners and Allied Health Practitioners authorized to practice or render services in the Center. This purpose will be fulfilled through (a) the appropriate delineation of clinical privileges that each Practitioner or Allied Health Practitioner may exercise in the Center and (b) an ongoing review and evaluation of each Practitioner's and Allied Health Practitioner's performance and ethical conduct in the Center.

**2.3** To provide an appropriate educational setting that will maintain scientific standards and lend itself to continuous advancement in professional knowledge and skills.

**2.4** To provide a means whereby issues concerning or affecting the Medical Staff and the Center can be discussed by the Medical Staff with the SMB, the Chief Medical Officer and the Director of the Center.

## Article 3 – Medical Staff Membership

**Nature of Medical Staff Membership**:

**3.1** **Privilege:** Membership on the Medical Staff of the Center is a privilege which shall be extended only to professionally competent individuals who continuously meet the responsibilities, qualifications, standards and requirements set forth in these Bylaws and the Credentialing Policy of AH without regard to race, color, creed, sex or national origin.

**3.2** **Qualifications for Membership**:

**3.2.1** Only individuals licensed to practice in the State of Michigan who satisfy the eligibility requirements set forth in these Bylaws and the Credentialing Policy of AH shall be qualified for membership on the Medical Staff. Specifically, it is the policy of the Center that only physicians, psychiatrists, dentists, podiatrists, psychologists and PhD's, who meet the following criteria initially and on an ongoing basis will be eligible for appointment and reappointment to the Medical Staff.

**3.2.1.1** Understand that the Center is a healthcare organization that is sponsored by AH and that it is a faith-based and value-driven organization which provides holistic care with a multidisciplinary approach guided by a Catholic ethic which is expressed through the Ethical and Religious Directives for Catholic Health Care Services and agree to conduct themselves in a manner consistent with those principles; and

**3.2.1.2** Are aware of the importance of caring for persons who are disadvantaged, which is fundamental to the mission of Ascension Health's health care ministry. Applicants must be reasonably willing to provide care for such persons; and

**3.2.1.3** Are willing, if appointed to the Medical Staff, to participate in an orientation to Ascension Brighton Center for Recovery and their particular Unit Orientation at the Center; and

**3.2.1.4** Where applicable, have a current and unrestricted: (i) Michigan controlled substance license, and (ii) DEA registration, and (iii) NPI; and

**3.2.1.5** Have a current and unrestricted Michigan professional license; and

**3.2.1.6** Have successfully completed an approved residency training program approved by the Accreditation Council for Graduate Medical Education of the American Osteopathic Association in the specialty in which they seek clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education leading to certification by the American Board of Foot and Ankle Surgery, or the American Board of Medical Specialties, being Board Certified in their particular specialty; and

**3.2.1.7** Board Certification is required to exercise clinical privileges. If Board Certification has expired, the Medical Staff member may request a waiver as provided under section 3.2.1.17 or request Affiliate or Emeritus Medical Staff membership. Upon the Board Certification expiration, a grace period of up to one year may be granted upon request. Recent graduates of approved

residencies must become Board Certified in their primary specialty by the appropriate specialty/subspecialty Board of the American Board of Medical Specialties, the American Osteopathic Association, as applicable, within three years of being considered fully Board eligible.

**3.2.1.8** Provide a current complete and accurate Curriculum Vitae, along with a letter requesting staff privileges; and

**3.2.1.9** Have and maintain professional liability insurance with minimum coverage limits consistent with current AH standards; and

**3.2.1.10** Are not currently, excluded and precluded from participation in Medicare, Medicaid, or other federal or state governmental health care programs; and

**3.2.1.11** Satisfy the quality, cost and population health standards adopted by the Medical Staff, and the applicable clinical departments.

**3.2.1.12** Satisfy other eligibility requirements for the membership and clinical privileges sought; and

**3.2.1.13** Agree to fulfill all responsibilities regarding emergency call as established by the department and approved by the Medical Executive Staff Committee and Board; and

**3.2.1.14** Participate in peer review (focused, ongoing or periodic) of professional competence, conduct, and skill, including quality, cost, and population health objectives; and

**3.2.1.15** Provide a signed statement from an Active Staff member of the same specialty (same privileges) who has agreed to cover them for patient care at the Hospital; and

**3.2.1.16** Must inform the Medical Staff Office within 14 days of any sanction, restriction, or revocation, of federal, state, or DEA licensure or registration. Restriction or revocation of clinical privileges at another facility must also be reported within 14 days to the Medical Staff Office. Failure to report any of the above actions could result in suspension or revocation of Medical Staff membership.

**3.2.1.17** Members of the Active, Consulting, or Associate Medical Staff who do not meet the criteria for advancement to or retention of their applicable Medical Staff designation shall be reviewed by the Qualifications and Credentials Committee. After review, the Qualifications and Credentials Committee may recommend in writing to the Medical Staff Executive Committee that a waiver be granted for a member based upon his/her commitment to the Hospital and Medical Staff, as reflected by the member's involvement in teaching, committee work, or other activities which support the center. The Board shall have final approval of such a waiver. If such a waiver is granted by the Board, the member shall have all the rights and responsibilities of the applicable Medical Staff designation approved by the Board, subject to such conditions as the Board may establish. The member shall continue to have the burden of demonstrating current clinical competency for any requested clinical privileges.

**3.3** **Acceptance of Membership** on the Medical Staff shall constitute the staff member's agreement that he or she will abide by the Principles of Medical Ethics of the American Medical Association, the Ethics of the American Osteopathic Association, or the code of Ethics of the American Dental Association

and that in care for patients within this institution, he or she will strictly abide by the Ethics and Religious Directives for Catholic Health Services, dated November 1994 or as the same may be amended and approved by the Committee on Doctrine of the National Conference of Catholic Bishops, as the same are appended to and made part of the Bylaws. When doing business for or representing the Center, Medical Staff members shall abide by the Ascension Health Standards of Conduct.

**3.4** **Rights of Applicant**: No person shall be denied Medical Staff membership, clinical privileges or the right to provide medical or professional services because of race, creed, sex, color, national original or age. However, the right to provide medical or professional services and to obtain and exercise clinical privileges shall be limited to those services authorized by the person's license and as provided by these Bylaws.

**3.5** **Duration and Conditions of Membership Appointment:**

**3.5.1** **General** – Initial appointments and reappointments to the Medical Staff shall be made by the Board. Except as otherwise provided in these Bylaws, the Board shall act on appointments, reappointments or revocation of appointments only after there has been a recommendation from the Medical Executive Staff Committee as provided in these Bylaws. In addition, every member shall pledge that the member will not receive from, or pay to, any other Practitioner or Professional, directly or indirectly, any part of a fee received for professional services.

3.5.2 Duration: Initial appointments and reappointments shall be for a period of not more than two years.

**3.5.3** **Term of Appointment** – All initial appointments to the Active Staff shall be provisional as provided in these Bylaws. These staff members shall be assigned to a department where their performance shall be monitored by the Chair of the Department or his/her representative, to determine their eligibility for nonprovisional staff membership and for exercising the clinical privileges granted to them. Failure to advance to nonprovisional staff status within seven years of Initial appointment shall be deemed a voluntary relinquishment of Staff.

**3.5.4** **Privileges Conferred** – Appointment to the Medical Staff shall confer only the clinical privileges that are conferred by the SMB on recommendation of the Center's Credentials Committee in accordance with these Bylaws.

## Article 4 – Divisions of the Medical Staff

The Medical Staff shall consist of the Medical Staff Division. Allied Health Practitioners are not members of the Medical Staff. They may be employed by or have contracts with the Center, or they may be employed, contracted or sponsored by members of the Medical Staff. Allied Health Practitioners are not entitled to the rights, privileges and responsibilities of Medical Staff members.

**4.1** **Medical Staff Division**: The Medical Staff Division shall consist of Practitioners who are members of the Active Medical Staff or the Adjunct Professional Staff.

**4.1.1** **Active Medical Staff**- The Active Medical Staff shall consist of physicians who, by training, education and experience are qualified to assume and discharge primary responsibility for the care of patients and regularly use the facilities of the Center. They shall assume all functions and responsibilities of membership on the Active Medical Staff, including where appropriate, admitting patients and consultation assignments. Members of the Active Medical

Staff shall be eligible to vote and to hold office and shall be required to attend Medical Staff meetings.

**4.1.2** **Consulting Medical Staff** - The Consulting Medical Staff shall consist of physicians, dentists and podiatrists who are qualified to provide consulting services in conjunction with an Active Medical Staff member. Consulting Medical Staff members shall provide consultations within their areas of specialty or training at the request of an Active Medical Staff member and, where appropriate, may provide emergency service care, but they shall not be eligible to admit patients. Consulting Medical Staff members shall not be eligible to vote or hold office in the Medical Staff. They shall not be required to attend Medical Staff meetings.

**4.1.3** **Associate Medical Staff** - The Associate Medical Staff shall consist of physicians, dentists and podiatrists who are qualified to provide special services to the Center under contract with the Center. Those services shall be delineated in contract between the Associate Medical Staff member and the Center and shall be approved by the Chief Medical Officer and the Director of the Center. Associate Medical Staff members shall not be eligible to vote or hold office in the Medical Staff and shall not be required to attend Medical Staff meetings. They may provide consultations within their areas of specialty or training at the request of an Active Medical Staff member and, where appropriate, may provide emergency service care.

**4.1.4** **Adjunct Professional Staff** – The Adjunct Professional Staff shall consist of doctoral level scientists, whose fields of expertise are required by the Medical Staff for patient care. Wherever required by law or regulation, Adjunct Professional Staff must possess appropriate licensure and/or national credentials relative to their specialties. Adjunct Medical Staff members shall not be eligible to admit patients or to vote or hold office in the Medical Staff but may attend Medical Staff meetings by invitation of the Active Medical Staff.

**4.1.5** **Affiliate Medical Staff**- The Affiliate Medical Staff shall consist of Medical Staff members who seek a professional association with the Center but do not seek to exercise clinical privileges. They must have achieved board certification but are not required to maintain board certification and must meet all other qualifications for active staff membership. They may no request any admitting or other privileges. They shall be appointed to a specific department, shall be required to pay dues, but shall no be eligible to vote or hold office. They may attend Medical Staff meetings but are not required to do so. Membership on the Affiliated Medical Staff may be terminated at any time. As Affiliate Staff members do not exercise clinical privileges, any termination of membership shall not entitle the member to the hearing rights set forth in these Bylaws.

**4.1.6** **Emeritus Medical Staff** – Members of the Medical Staff who retire from the active practice at the Center may be transferred to Emeritus status upon application to the Chief Medical Officer and with the approval of the Executive Committee and board. Such members shall not pay dues, shall not be eligible to vote or hold office, and not chair a department or standing committee. They may not admit patients. They are encouraged to attend staff and departmental meetings but are not required to do so. Appointment shall be on a permanent basis, shall not require than active medical license or board certification be maintained, and hence not require reappointment review. Membership on the Emeritus Medical Staff is an honor. In reviewing the request for Emeritus status, the Credentials Committee shall take into

consideration duration of medical staff membership and contributions to patient care, medical education, and institutional improvement. The Credentials Committee and Board have discretion over whether to grant membership to any individual. Denial of membership, or termination of membership, shall not give rise to any of the procedural rights described in these Bylaws or other Medical Staff documents, including the right to request a hearing and appeal.

**4.2 Allied Health Practitioners** - The SMB, upon recommendation of the Center's Medical Executive Committee, will determine the types of Allied Health Practitioners that may request authorization to provide direct patient care services at the Center, under supervision of a Medical Staff member with clinical privileges. The AH Department of Human Resources, AH Medical Staff Services, the Chief Medical Officer and/or the Chief Nursing Officer shall review and approve qualifications, clinical duties and responsibilities of each Allied Health Practitioner through the hiring, appointment, reappointment and privileging process.

Allied Health Practitioners are not members of the Medical Staff. They are not eligible to vote or hold office. They may attend Medical Staff Meetings by invitation of an Active Medical Staff member.

## Article 5 – Officers of the Medical Staff Division

**5.1 Officers** - The sole officer of the Medical Staff Division shall be the Chief Medical Officer, or the Interim Chief Medical Officer acting on behalf of the Chief Medical Officer. The Chief Medical Officer shall be the Chief of the Medical Staff Division.

**5.2 Eligibility for Appointment** - The Officers of the Medical Staff Division shall be members of the Active Medical Staff at the time they are appointed and shall remain members in good standing at all times during his/her term of office. Failure to maintain such status shall create an immediate vacancy in the office in question.

**5.3 Term of Office** - Officers of the Medical Staff Division shall serve a term of one year from the date of appointment of (if sooner) until the next annual meeting of the Medical Staff or a success is appointed. The Director of the Center may remove officer from office at any time with cause.

**5.4 Duties of Officers:**

**5.4.1 Chief Medical Officer** – The Chief Medical Officer shall be appointed by the Facility Administrative Director and Vice-President of the SMB Behavioral Health Service Line and shall have all the duties and responsibilities assigned to the Chief Medical Officer in the Center Bylaws, these Bylaws and Rule and Regulations or delegated by the SMB. In addition, the Chief Medical Officer shall serve as an ex officio member with vote of all committees of the Medical Staff and the Medical Staff Division.

The Chief Medical Officer shall serve as an *ex officio* member of the SMB . In addition, the Chief Medical Officer shall be the Chief of the Medical Staff to:

**5.4.1.1** Act in coordination and cooperation with the Director of the Center and the members of the Medical Staff in all matters of mutual concern within the Center and serve as an active member of the executive team at the Center.

**5.4.1.2** Call and preside at regular and special meetings of the Medical Staff

**5.4.1.3** Be responsible for enforcement of the appropriate sections of the Center

Bylaws, the Center Policies, these Bylaws and the Rules and Regulations and implementation of sanctions where indicated

**5.4.1.4** Represent the views, policies, needs and grievances of the Medical Staff through the Director of the Center to the SMB.

**5.4.1.5** Unless otherwise made a member, serve as an *ex officio* member of any committee (except the Judicial Review Committee) whose jurisdiction involves operation of the Center and performance of the Medical Staff members.

**5.4.1.6** Be responsible for the educational training of the Medical Staff as required and be responsible for regularly scheduled review and evaluation of the clinical work of the members of the Medical Staff.

**5.4.1.7** Coordinate the Quality Review activities and Quality Review for all Medical Staff. Fulfill the Medical Staff's accountability to the Quality Committee of the SMB and the SMB for the medical and chemical dependency care rendered to patients in the Center.

**5.4.1.8** Participate in the annual evaluation and updating of the Professional Expectation Standards.

**5.4.1.9** Designate a secretary from time to time to keep and maintain accurate and complete minutes of all Medical Staff meetings and all correspondence.

**5.4.1.10** Present candidates for initial appointment and/or reappointment as Active Medical Staff to the Credentials Committee.

**5.4.1.11** To provide ongoing education, training, support and guidance in the concepts and methods of Quality Improvement problem-solving and to help define and implement FPPE and OPPE activities for the Medical Staff.

**5.4.2** **Interim Chief Medical Officer** - The Interim Chief Medical Officer shall be appointed by the Board of Trustees to serve as the Chief Medical Officer in the Chief Medical Officer's absence or when the Chief Medical Officer's personal interest, conflict of interest or like circumstances make his participation inappropriate. During such times, the Interim Chief Medical Officer shall have the same duties and responsibilities as the Chief Medical Officer, including but not limited to the following:

**5.4.2.1** Coordinate the Quality Review activities and Quality Review for all Medical Staff

**5.4.2.2** Participate in the annual evaluation and updating of the Professional Expectation Standards

**5.4.2.3** Fulfill the Medical Staff's accountability to the Quality Committee of the SMB and the SMB for the medical and chemical dependency care rendered to patients in the Center

**5.4.2.4** Designate a secretary from time to time to keep and maintain accurate and complete minutes of all Medical Staff meetings and all correspondence.

**5.4.2.5** Responsible for regularly scheduled review and evaluation of the clinical work of the members of the Medical Staff

**5.4.2.6** Present candidates for initial appointment and/or reappointment as Active Medical Staff to the Credentials Committee

## Article 6 – Staff Meetings

**6.1 Medical Staff/Allied Health Practitioner Meetings:**

**6.1.1 Regular Medical Staff Meetings and Notice** – The Medical Staff Division shall meet on the call of the Chief Medical Officer monthly, with a minimum of 4 meetings. Written notice of date, time, place and purpose of each such meeting shall be given by electronic transmission before the meeting by or at the direction of the Chief Medical Officer. Notice of a meeting waived must be in writing (which includes a waiver by electronic transmission).

**6.1.2 Quorum** - The presence of 50% of the total membership of the Medical Staff/Allied Health Practitioner shall constitute a quorum for the transaction of business at any meeting.

**6.1.3 Attendance Requirement** – Except as otherwise specifically provided in these Bylaws, each member of the Medical Staff shall be required to attend 50% of all meetings each year. The failure to satisfy that requirement shall be grounds for corrective action.

**6.1.4 Vote** - Except as otherwise specifically provided in these Bylaws, each member of the Active Medical Staff shall be entitled to vote at any meeting.

**6.2 Medical Executive Staff Meetings:**

**6.2.1 Meetings and Notice** – - Meetings of the Medical Executive Staff shall be held in January, April, July and October, with January serving as the Annual Meeting. These meetings shall be held at such day and hour as the Chief Medical Officer shall designate in the call and notice of the meeting.

The first meeting shall be designated as the Medical Staff Division's Annual Meeting. Written notice of date, time, place and purpose of each such meeting shall be given by electronic transmission before the meeting by or at the direction of the Chief Medical Officer. Notice of a meeting may be waived in writing (which includes a waiver by electronic transmission) before or after the meeting. Attendance at a meeting will constitute waiver of notice of the meeting.

**6.2.2 Attendance Requirement** – Each member of the Medical Executive Staff shall be required to attend 50% of all regular meetings each year. The failure to satisfy this requirement shall be grounds for corrective action.

**6.2.3 Quorum** –A quorum of the Medical Executive Staff Committee shall be 50% of the voting members including at least one Medical Staff Officer.

**6.2.4 Vote** – Only members of the Active Medical Staff shall be entitled to vote at any regular or special meeting of the Medical Executive Staff Meetings.

**6.3 Special Meetings**- The Chief Medical Officer or the Medical Executive Staff Committee may call a Special Meeting of the Medical Staff at any time. A special meeting may be used to resolve conflicts between the Executive Committee and the Medical Staff.

**6.3.1** Special Meetings of the Medical Staff may be requested at any time by the Hospital Director or the Chief Medical Officer.

**6.3.2** The Chief Medical Officer must call a Special Meeting within 30 days after receipt by him/her of a written request for same, signed by not less than (3) three of the Active Medical Staff and stating the purpose for the meeting.

**6.3.3** The Medical Executive Staff Committee shall designate the time and place of any Special Meeting.

**6.3.4** Written or printed notice at the direction of the Chief Medical Officer or other persons authorized to call a meeting stating the place, day and hour of any Special Meeting of the Medical Staff shall be mailed or electronically transmitted to each member of the Active Medical Staff not less than seven days before the date of such meeting. The notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at his/her address as it appears on the records of the Hospital or confirmed delivered by electronic mail. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

**6.3.5** No business shall be transacted at any special meeting except that stated in the notice of the meeting.

**6.4** **Quorum**-The presence of 50% of members of the total membership of the Active Staff at any Special Meeting shall constitute a quorum for the purposes of amendment of these Bylaws, Rules and Regulations.

**6.5** **General Education** - The Administration of the Center or the Ascension Health System will sponsor at least one educational program on physician health and wellbeing each year for the general medical staff.

## Article 7 –Committees

**7.1** **Standing Committees** – The Chairs and members of the following standing committees shall be appointed by the Chief Medical Officer. The Chief Medical Officer shall consider the recommendations of the Chair when appointing members to that Chair's committee. All standing committees will have defined charters that outline the committee composition, roles, function, responsibilities and reporting structure. These charters will be approved by the Medical Executive Staff Committee. The standing committees shall be:

**7.2** **Medical Executive Staff Committee:**

**7.2.1** **Composition** - The Medical Executive Staff Committee shall consist of all members of the Active Medical Staff and Adjunct Professional Staff who are employed full time by the Center. The Chief Medical Officer shall be the Chairman of the Medical Executive Staff Committee. (Committee of the Whole)

**7.2.2** **Duties** -The duties of the Medical Executive Staff Committee shall be:

**7.2.2.1** To represent and act on behalf of the Medical Staff between Medical Staff meetings, subject to limitations as may be imposed by these Bylaws:

**7.2.2.2** To recommend directly to the SMB on the following matters:

- The Medical Staff's structure
- The process used to review credentials and define privileges
- Qualifications and criteria for membership and clinical privileges related to identified quality, cost, and population health objectives.
- The delineation of privileges for each Medical Staff member, and
- Medical Staff membership

**7.2.2.3** The Medical Executive Staff Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the Qualifications and Credentials Committee, recommend initial departmental assignments for all Medical Staff members.

**7.2.2.4** To fulfill the Medical Staff's accountability to the SMB by receiving, reviewing and acting upon reports of committees, departments and other groups assigned Medical Staff activities.

**7.2.2.5** To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff

**7.2.2.6** To provide liason between the Medical Staff, Facility Director and the SMB.

**7.2.2.7** To recommend action to the Facility Director on matters of a medico-administrative nature and hospital management affairs.

**7.2.2.8** To assist in the coordination of the activities and policies of the various departments

**7.2.2.9** To implement and formulate policies of the Medical Staff not otherwise the responsibility of the departments

**7.2.2.10** To report at each Quarterly Medical Staff Meeting; and

**7.2.2.11** To review and recommend Departmental Rules and Regulations to the SMB for approval

**7.2.2.12** To provide oversight for the review and improvement of patient satisfaction and patient safety

**7.2.2.13** Monitors the accuracy and quality of history and physical examinations

**7.2.2.14** To provide oversight and determine the circumstances under which consultation or management by a physician is required

**7.2.2.15** To review and comply with any residency review citations in Graduate Medical Education programs of the ACGME, AOA, American Dental Association Commission or Dental Accreditation, and/or the Council on Podiatric Medical Education.

**7.2.2.16** To provide a forum for the discussion of findings of clinical and non-clinical concerns to ensure that a program of Continuous Quality Improvement receives adequate support and direction

**7.2.2.17** To develop and implement Quality Improvement/Clinical Excellence plans and evaluate such plans at least annually.

**7.2.2.18** To provide oversight for the review and improvement of patient satisfaction and patient safety

**7.2.3** **Infection Control Duties** – The Medical Executive Staff Committee may appoint a member of the Nursing Department as "Infection Control Officer . This appointment will go before the SMB for approval and/or acknowledgment of this recommendation. The Infection Control Officer will be responsible for the day-to-day performance and oversight of the duties enumerated in Section 7.2 of the Bylaws. The Infection Control Officer shall report to the Medical Staff Executive Committee respecting such matters as requested by the Medical Staff Executive Committee at least once each calendar quarter.

**7.2.4** **Pharmacy and Therapeutic Duties** – The Medical Staff Executive Committee may delegate to the Chief Medical Officer or his designee, responsibility for the day-to-day performance and oversight of the duties enumerated in Section 7.2 of the Bylaws. The Chief Medical Officer shall report to the Medical Staff Executive Committee respecting such matters as requested by the committee at least twice each calendar year.

**7.2.5** **Meetings** – The Medical Staff Executive Committee shall meet regularly and maintain a permanent record of its proceedings and actions.

**7.3** **Research Committee and Institutional Review Board**: The officers of the Medical Executive Staff Committee shall function as the oversight body for research and review acting through the Ascension Health Institutional Review Board, who will have authority to approve such research projects as are carried out at the Center.

7.4 **Quality Committee/Utilization Review Committee**:

**7.4.1** **Composition** – The Quality Committee shall consist of members of the Center's Clinical Leadership Team and Health Information Department. The Chief Medical Officer shall appoint the Medical Staff representatives. Appointments may be staggered so that experienced committee members are always present.

**7.4.2** **Duties** – The duties of the Quality Committee shall be:

**7.4.2.1** To provide a forum for the discussion of findings of clinical and non-clinical Concerns to ensure that a program of Continuous Quality Improvement receives Adequate support and direction;

**7.4.2.2** To provide ongoing education, training, support and guidance to all departments in the concepts and methods of Quality Improvement problem-solving and to help define and implement FPPE and OPPE activities for the Medical Staff.

**7.4.2.3** To develop and implement Quality Improvement/Clinical Excellence plans and evaluate such plans at least annually.

**7.4.2.4** To review annually third party payer requirements for medical staff participation and necessary Quality Improvement targets to be submitted on behalf of the organization.

**7.4.3** **Meetings** – The Quality Improvement/Utilization Review Committee shall meet at least once each calendar quarter, maintain a written record of proceedings and activities and report thereon to the Medical Executive Staff Committee.

## Article 8 – Procedures For Appointment And Reappointment of Privileges

**8.1** **Initial Appointment of Privileges**:

**8.1.1** Applications for positions of employment at the Center shall be made online through the Ascension Website. It is the responsibility of the Human Resources Department and the Credentialing Verification Specialist/Behavioral Health Associates within the Ascension Corporate Medical Staff Services to compile all background verification as required.

**8.1.2** The applicant shall make an appointment with Ascension Corporate Medical Staff Services to receive application and supply all supporting information and documentation as required. The Initial Appointment packet will be returned to Corporate Medical Staff Services when

completed. The application shall be accompanied by proof of Professional Liability Insurance against such risks and with such limits and deductibles as The Center requires at that time.

**8.1.3** Upon completion of Verification by Corporate Medical Staff Services, the Initial Application for Privileges will be electronically presented to The Center's Credentials Committee for approval of privileges at The Center. Upon approval of privileges, Credentials Committee will then present the approved Initial Appointment to the Medical Staff Committee. Upon approval of the Medical Staff Committee, the Initial Application will be presented at the monthly Joint Conference Committee/Quality Committee of the Southeast Michigan Board.

**8.1.4** The SMB may elect to:

**8.1.4.1** Accept the recommendation of the Center's Credentials Committee to appoint the applicant to the Medical Staff, or;

**8.1.4.2** Reverse the recommendation of the Center's Credentials Committee. If the SMB decision is to reverse an unfavorable recommendation and to appoint the applicant to the Medical Staff, such decision is final.

**8.1.4.3** Modify the request for clinical privileges that are a part of the application for membership to the Medical Staff, conforming them to the applicant's credentials. Clinical privileges are governed further by these Bylaws.

**8.1.5** If the JCC of the SMB renders an approval: Upon approval at the SMB, the Center's Medical Staff Office will notify Corporate Medical Staff Services of the SMB approval. They, in turn will notify Ascension Human Resources Department and the Recruiting Office for additional and final processing. The applicant shall be required to become familiar with and abide by The Bylaws of the Center and the Rules and Regulations and;

**8.1.5.1** The Ethical Religious Directives of the US Conference of Catholic Bishop;

**8.1.5.2** Any statement of ethics or principles applicable to the applicant's profession;

**8.1.5.3** The principles of professional ethics of the professional organization to which the applicant aspires or belongs;

**8.1.5.4** All pertinent statutes and regulations of the State of Michigan and the United States.

**8.1.5.5** The Center's Policies and statement of ethics;

**8.1.5.6** Regulatory Accreditation and Payer Requirements at the Center and;

**8.1.5.7** Quality of Care Expectations for Medical Staff at the Center (including such things as care protocols, documentation, communication and quality improvement programs at The Center).

**8.1.6** If the SMB makes a decision adverse to an applicant who is a Practitioner, with respect to either appointment or clinical privileges, the Chief Medical Officer shall promptly notify the applicant of such adverse decision and the grounds therefore by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived any rights under these Bylaws. The fact that the adverse decision has been held in abeyance shall not be deemed to confer privileges. If the SMB makes an adverse decision regarding clinical privileges regarding an applicant who is an Allied

Health Practitioner, the decision is final, and the applicant shall have no recourse under these Bylaws.

**8.1.7** After the practitioner's rights under these Bylaws have been exhausted or waived, the decision of the SMB is final. The SMB may also defer final determination by referring the matter back to the Center's Credentials Committee for further consideration. Any such referral back shall state the reasons, shall set a time limit of 120 days by which the Center's Credentials Committee shall make a new recommendation to the SMB and may include a directive to conduct an additional interview with the Practitioner to clarify issues that are in doubt. At its next regular meeting and after receipt of a new recommendation and new evidence in the matter, if any, the SMB shall make a decision either to appoint the Practitioner to the Medical Staff or to deny the application.

When the SMB adverse decision is final, it shall give notice to the Practitioner of such adverse decision through the Director of the Center, the Chief Medical Officer and the Chairman of the SMB by certified mail, return receipt requested, addressed to the Practitioner.

**8.1.8** If an application is denied, another application for Medical Staff membership shall not be accepted or processed until 12 months have elapsed from the date of the denial, which shall be the date that the action denying the application becomes final; *provided, however,* that a new application may be submitted before the expiration of the 12 months if the SMB, within its sole discretion, determines that there has been a significant change in circumstances since the most recent denial.

8.2 Reappointment of Privileges:

**8.2.1** The Corporate Medical Staff Services Office shall, during the 90 days prior to the expiration of the practitioner's reappointment period, shall verify and compile all pertinent information, licensing and/or certification as is necessary and shall present the completed Reappointment of Privileges application to the Center's Credentials Committee. The Center's Credentials Committee shall meet and review such Reappointment information. Upon approval of privileges, Credentials Committee will then present the approved Reappointment of Privileges to the Medical Staff Committee. Upon approval of the Medical Staff Committee, their recommendation of Reappointment of Privileges will be presented at the monthly Joint Conference Committee/Quality Committee of the SMB.

The Joint Conference Committee/Quality Committee of the SMB shall review all pertinent information, as provided to the Committee by the Center's Credentials Committee, on members of the Medical Staff/Allied Health Practitioner, for the purpose of making recommendations for Reappointment to the Medical Staff and for the granting of clinical privileges for an additional two years. Notification of the Southeast Michigan Board's decision shall be given the Center by way of electronic mail.

**8.2.2** The SMB may elect to:

**8.2.2.1** Accept the recommendation of the Center's Credentials Committee to reappoint the applicant to the Medical Staff, or;

**8.2.2.2** Reverse the recommendation of the Center's Credentials Committee. If the SMB decision is to reverse an unfavorable recommendation and to reappoint the applicant to the Medical Staff, such decision is final.

**8.2.2.3** Modify the request for clinical privileges that are a part of the application for membership to the Medical Staff, conforming them to the applicant's credentials. Clinical privileges are governed further by these Bylaws.

**8.2.3** For each recommendation where the reappointment and granting of clinical privileges is not recommended by the Center's Credentials Committee, the reasons shall be clearly defined and relayed to the SMB. Each Medical Staff member's clinical privileges are to be granted upon reappointment based upon each member's professional competence and clinical judgment in the treatment of patients, ethics and conduct, attendance at Medical Staff meetings and participation in its affairs, compliance with Center's Bylaws and Rules and Regulations, mental competence, cooperation with Center personnel, prudent and efficient use of the Center's facilities for patients, relationships with other Practitioners, Allied Health Practitioners, and professionals and the general attitude towards patients, the Center and the public.

In making a recommendation to the SMB, the Chief Medical Officer will review at least the following:

**8.2.3.1** The Medical Staff member's individual file and request for reappointment.

**8.2.3.2** The Medical Staff member's activities since his last appointment, which shall include (without limitation) the following: (a) participation in Medical Staff activities, (b) continuing medical education credits at a level determined by the Medical Staff Executive Committee, (c) evaluation of whether the member's performance (measured or evaluated in methods, outcomes, complications and other recognized evaluation criteria) meets the standards annually established by the Medical Executive Staff Committee, (d) other comments and evaluations that may be relevant to the Chief Medical Officer's and/or Credentials Committee's review of the member's qualifications for reappointment (disciplinary actions taken, suspensions or curtailments of privileges) and (e) evidence that the member's physical and mental health are satisfactory.

**8.2.4** If the applicant for reappointment does not meet the qualifications for Medical Staff membership or provide the necessary information, the application for reappointment will not be processed, and he/she will not be entitled to a fair hearing or any rights and due process provided under these Bylaws. The applicant agrees to hold harmless the Credentials Committee, the Medical Executive Staff Committee and others involved in the application process. Allied Health Practitioners desiring to remain associated with the Medical Staff shall submit a comparable reappointment form containing information pertinent to the professional and function of the applicant.

**8.2.5** The Chief Medical Officer shall forward his/her recommendation to the Joint Conference Committee/Quality Committee of the SMB, which shall adopt, reject or defer the recommendation for further consideration. The JCC/Quality Committee shall then forward its recommendation for or against reappointment to the SMB, along with all pertinent

documentation and the reasons for its recommendation. Notification of the decision shall be given to the Center by way of electronic mail.

**8.2.6** The JCC/Quality Committee of the SMB shall either grant or deny reappointment and clinical privileges of each member of the Medical Staff whose application is presented to it for consideration. When the recommendation is adverse to the applicant with respect to reappointment of clinical privileges, the Chief Medical Officer shall promptly so notify the applicant by certified mail, return receipt requested.

**8.2.7** If the SMB denies reappointment of clinical privileges to a Practitioner, such denial shall not become effective until the Practitioner has exercised or has been deemed to have waived his rights under these Bylaws. If the SMB denies clinical privileges to an Allied Health Practitioner, such denial shall be final and the Allied Health Practitioner shall have no recourse under these Bylaws.

**8.3** **Identification of a Physician's Physical or Mental Illness or Life Crisis**

**8.3.1** A physician may refer himself or herself, or be referred by another physician, staff member or other source by calling the CMO, or his designee, and submitting a report verbally or in writing. The CMO will maintain an anonymous summary of the referrals received and report to the Credentials Committee and the Medical Staff Executive Committee every six months.

**8.3.2** The CMO, or his designee, will review the information and investigate the matter fully to evaluate the credibility of the referral.

**8.3.3** The CMO, or his designee, will take action, as appropriate, upon completion of this investigation.

**8.3.4** This action may include:

**8.3.4.1** CMO may meet personally with the physician or designate another appropriate person to do so.

**8.3.4.2** CMO may review all documents or interview any and all individuals involved in the incident(s) or who may have information relevant to the investigation.

**8.3.4.3** CMO may require that the physician undergo a complete medical exam, so long as the exam is related to the performance of the physician's clinical privileges and medical staff duties.

**8.3.4.4** CMO may require the physician to undergo a drug test to determine if the physician is currently using drugs illegally.

**8.3.4.5** CMO may refer the affected physician to the appropriate professional, internal or external, for diagnosis and treatment of the condition or concern.

**8.3.4.6** CMO will document all of these activities, and that of his designee, carefully and confidentially.

**8.3.4.7** CMO or his designee will report any instances in which a physician provides unsafe treatment to the Credentials Committee and the Medical Staff Executive Committee.

**8.3.5** Monitoring and Evaluation

**8.3.5.1** The Administration of the Center will provide information to the physician as it relates to their illness as needed.

**8.3.5.2** Once a physician has been identified as having a physical illness, mental illness or a life crisis, a treatment process and time frame will be discussed and agreed upon with the physician and the CMO or his designee. This will include reports from the treating professional. If it is determined that the physician's physical or mental illness affects his/her ability to treat patients, their privileges will be referred to the Credentials Committee for review.

**8.3.5.3** If the problem that is affecting a physician is determined to be an impairment and is classified as a disability under the ADA, the following will occur:

**8.3.5.3.1** It will be determined if a reasonable accommodation can be made for the physician and if the physician would be able to competently and safely perform his/her clinical privileges and the duties and responsibilities of the medical staff.

**8.3.5.3.2** Whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, disruptive, or alter the nature of the hospital's operations or the provision of patient care.

**8.3.5.3.3** Whether the impairment constitutes a "direct threat" to the health and safety of the physician, patients, employees or others within the hospital

**8.3.5.3.4** If there is a reasonable accommodation that can be made, the CMO or his designee, will attempt to work out a voluntary agreement with the physician, so long as it does not create an undue hardship upon the hospital. The Facility Director will be informed of attempts to work out an agreement and approve any agreement before it becomes final or effective. The hospital will report to the Department of Commerce for Health Facilities as outlined in the Health Professional Licensure and Discipline Laws.

**8.3.5.4** The Facility Director and the Chief Medical Officer, or his designee, will monitor the patient care activities of the affected physician.

**8.3.5.5** All information gathered by the process will be kept strictly confidential in the Administration Office in a separate locked file. The Administration and the Chief Medical Officer, or his designee, will maintain confidentiality except as required by law, ethical obligation or when the safety of a patient is threatened.

**8.3.5.6** This reporting policy will be reviewed yearly.

**8.4** **Leave of Absence**:

**8.4.1** A Medical Staff member may obtain a leave of absence for a period of not more than 12 months by submitting written notice to the Chief Medical Officer or the Director of the Center, stating the period of and reasons for the requested leave. The Medical Staff member shall also submit a request for a leave of absence to the Ministry Service Center, completing all documentation required for said leave. Under extenuating circumstances and with the approval of the Medical Staff Executive Committee, the leave of absence may be extended for up to 12 additional months, but not beyond the Medical Staff member's then current period of appointment. During the leave of absence, the Medical Staff member shall apply for reinstatement when appropriate, and will not have clinical privileges and staff responsibilities. In

anticipation of returning to work, the Medical Staff Member shall obtain a return to work approval from the Medical Staff Member's physician and notify the Chief Medical Officer of the intended return to work date. The Ascension Occupational Health Office, when in receipt of the Medical Staff member's return to work letter, will process the return to work through the Ministry Service Center. When the Chief Medical Officer has received the approval of return to work, the Medical Staff member shall then be reinstated with privileges and staff responsibilities of the Center.

**8.4.2** Failure without good cause to request reinstatement or extension of leave of absence or to provide a requested summary of activities, shall result in the automatic termination of Medical Staff membership, privileges and responsibilities. A request for Medical Staff membership subsequently received from a Medical Staff member so terminated shall be submitted and processed in the manner provided for initial appointments to the Medical Staff.

**8.5 Reinstatement of Privileges**

**8.5.1** If a physician had their privileges limited or restricted during their treatment process, a Review will be completed to determine if the physician has completed his/her rehabilitation and/or treatment. At this time the physician may request to have their privileges reinstated.

**8.5.2** The physician must submit a report from the treating physician to the CMO or his designee. The letter shall include:

**8.5.2.1** If the physician is participating in a treatment or rehabilitation program

**8.5.2.2** If the physician is in compliance with all of the terms of the program

**8.5.2.3** If the physician is attending rehabilitation meetings regularly (if appropriate)

**8.5.2.4** To what extent the physician's behavior and conduct are monitored

**8.5.2.5** Whether in the opinion of the treating physician or director if the physician is rehabilitated

**8.5.2.6** Whether an aftercare program has been recommended to the physician and a description of the program

**8.5.2.7** Whether in the opinion of the treating physician or director if the physician is capable of resuming medical practice and providing continuous, competent care to patients.

**8.5.3** The Chief Medical Officer, or his designee, has the right to obtain another opinion if needed.

**8.5.4** If all the information given indicates that the physician is rehabilitated and capable of resuming care of patients, the CMO or his designee may request the following:

**8.5.4.1** The affected physician must identify a physician who is willing to assume responsibility for the care of their patients in the event of their inability or unavailability to treat patients.

**8.5.4.2** The affected physician may be required to obtain periodic reports for the CMO or his designee, from his/her primary care physician, during a specified time frame.

**8.5.4.3** The affected physician must agree to submit an alcohol or drug screening test (if appropriate) at the request of the CMO or his designee.

**8.5.5** The affected physician's privileges will be monitored by the Chief Medical Officer or a physician appointed by the Chief Medical Officer. The Medical Staff Executive Committee will determine the nature and timeframe of the monitoring after review of the circumstances.

**8.6 Responsible Persons**

Chief Medical Officer

Medical Executive Staff Committee

## Article 9 – Clinical Privileges

**9.1 Application for Clinical Privileges:**

A qualified, licensed employee, making up the Adjunct Professional staff and/or Allied Health Staff of the Center may be granted specific clinical privileges, and may/may not be a member of the Center's Medical Staff by virtue of their licensing. Such privileges may be granted by the SMB upon recommendation of the Credentials Committee and the Chief Medical Officer for a two-year period.

**9.2 Clinical Privileges Restricted:**

**9.2.1** Except as provided in Sections 9.3 and 9.4, every Practitioner and Allied Health Professional practicing at the Center by virtue of Medical Staff membership and/or grant of privileges shall be entitled to exercise only those clinical privileges specifically granted by the SMB.

**9.2.2** Each application for appointment to the Medical Staff shall contain a request for the specific clinical privileges requested by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Chief Medical Officer. The applicant shall have the burden of establishing his qualifications and competency in the requested clinical privileges.

**9.2.3** Periodic redetermination of clinical privileges and the increase and curtailment of the same shall be based upon the direct observation of care provided, review of the records of patients treated in the Center or other hospitals or treatment centers and review of the records of the Medical Staff that document the evaluation of the individual's participation in the delivery of medical and professional care.

**9.2.4** The scope of practice of members of the Medical Staff shall be based upon the individual's training, experience, judgment and demonstrated competence and shall be delineated in a manner consistent with Section 9.2. Medical Staff members shall exercise judgment within the areas of their competence provided that the SMB shall have the ultimate authority for the quality of care. Only a member of the Medical Staff with admitting privileges shall be permitted to admit patients to the Center.

**9.2.5** When Medical Staff members desire to delegate certain practices to certain external professional personnel, the Medical Staff Executive Committee reviews and recommends to the SMB.

**9.2.6** A Medical Staff member, either in connection with reappointment or at any other time, may request that his staff category, assignment, or clinical privileges be changed or modified by submitting a written request to the Chief Medical Officer along with appropriate documentation of education, training and experience. Such information shall be processed in the same manner as provided for application for appointment and reappointment. If an Active Medical Staff member voluntarily resigns from the Active Medical Staff, such member must submit a written

notification thirty (30) days prior to resignation to the Chief Medical Officer. The thirty (30) day requirement may be waived at the discretion of the Chief Medical Officer.

**9.3** **Temporary Privileges:** Upon receipt of a clean application for Medical Staff membership from an appropriately licensed Practitioner or an appropriately licensed, certified or registered Allied Health Professional, the Chief Medical Officer and/or the Director of the Center, on the basis of information then available that reasonably may be relied upon with respect to the credentials, competence and ethical standing of the applicant, may grant temporary clinical privileges to the applicant for a period of not more than 90 days. If at that time the application is not complete, an extension may be granted under the conditions aforementioned for a period not to exceed 90 days. In exercising such privileges, the applicant shall act under the supervision of the Chief Medical Officer, or in his absence or at his/her direction, any qualified Practitioner on the Active Medical Staff.

**9.3.1** The Chief Medical Officer shall notify Corporate Medical Staff Services that an applicant has been designated for temporary privileges. Corporate Medical Staff Services will assure primary source verification for the following has been completed:

- Validated government picture ID
- Current Licensure
- Education, training experience
- Board certification, if board certified
- Professional liability insurance
- National Practitioner's Data Bank (NPDBP) results from query, as applicable
- Medicare/Medicaid sanctions
- Ability to perform privileges requested

**9.3.2** Corporate Medical Staff Services will forward the appropriate forms to the Center within three (3) business days, as well as copies of primary source verified information.

**9.3.3** Corporate Medical Staff Services is responsible to verify current competence using the Clinical Competence Questionnaire and ensure that temporary privileges are properly documented within the credentials file.

**9.3.4** The Director of the Center, on recommendation of the Chief Medical Officer, may grant temporary consulting privileges for the medical evaluation and treatment of a specific patient or group of patients pursuant to the same verification process.

**9.3.5** At any time, the Chief Medical Officer may suspend a Practitioner's or an Allied Health Professional's temporary privileges effective immediately. The Chief Medical Officer shall assign a qualified member of the Medical Staff to assume responsibility for the care of a terminated Practitioner's patient(s) until discharged from the Center. The wishes of the patient(s) shall be considered, where feasible, in the selection of such substitute practitioner. In all such cases, the Chief Medical Officer shall promptly notify the Director of the Center of the actions that he/she has taken.

**9.3.6** The granting, exercise or termination of temporary privileges shall not confer on the affected Practitioner or Allied Health Professional any vested rights for the continuation of such privileges, nor shall the practitioner or professional be entitled to any procedural rights set forth in these Bylaws.

**9.3.7** The applicant bears the burden of demonstrating that there are no current or previously successful challenges to his licensure or registration and that he/she has not been subject to involuntary termination of Medical Staff membership, or the involuntary limitation, reduction, denial or loss of clinical privileges, at another health care facility.

**9.3.8** Practitioners appointed to any committee established by or as provided in these Bylaws, who are not Medical Staff members, shall be granted temporary Medical Staff membership without privileges for the purpose and duration of committee membership. The granting or termination of temporary Medical Staff membership of such practitioners shall not be deemed to create any rights or privileges set forth in these Bylaws, including the right to a hearing pursuant to Article 12. Termination of a Practitioner's membership on any such committee immediately shall terminate the practitioner's temporary Medical Staff membership.

**9.3.9** It is the intent of the Medical Staff that practitioners who are granted temporary Medical Staff membership, under the supervision of the Chief Medical Officer, shall have immunity from liability to the fullest extent permitted by law in the conduct and performance of their responsibilities as committee members with availability of peer review, if necessary. It is also the intent of the Medical Staff that the proceedings and records of such committees that have the responsibility of evaluation and improvement of the quality of care rendered in the Center shall be privileged to the fullest extent permitted by law.

**9.4** **Emergency Privileges**: In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and any Practitioner or Allied Health Professional, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Center necessary for that purpose, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the privileges necessary to continue treatment of the patient. If such privileges are denied, or the Practitioner does not request such privileges, the patient shall be reassigned to a member of the Active Medical Staff by the Chief Medical Officer or in his/her absence, by the Director of the Center. To the extent feasible, such assignment shall be in accordance with the wishes of the patient. For the purpose of this section, "emergency" is defined as "a sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

In the event the Emergency Disaster or Management Plan is activated, and the Center is unable to manage immediate patient care needs, the Chief Medical Officer, or a designee may (but is not required to) grant emergency disaster clinical privileges. The individual who grants disaster clinical privileges shall be responsible to ascertain that the practitioner granted such privileges is duly licensed in his or her profession, as evidenced by one of the following: (a) a current picture/hospital ID card; (b) a current license to practice; (c) a valid picture ID issued by a state, federal or regulatory agency; (d) identification as a member of a Disaster Medical Assistance Team; (e) identification indicating that the individual is authorized by a governmental entity to render patient care in disaster circumstances; or (f) presentation

by current hospital or medical staff members(s) with personal knowledge regarding the practitioner's identity and profession.

The individual practitioner will be assigned duties, as needed, under the direction of the Chief Medical Officer, or a member of the Medical Staff designated by the Chief. The individual's status as an emergency disaster clinical provider shall be evident throughout the emergency.

A credentialing process for individuals granted emergency disaster clinical privileges will be undertaken at the earliest possible time using the process outlined in these Bylaws.

**9.5 Responsible Persons**

Chief Medical Officer
Medical Executive Staff Committee

## Article 10 – Corrective Action

**10.1 Procedure:**

**10.1.1** Whenever the activities, performance, competency or professional conduct of an Practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, disruptive of the operations of the Center or contrary to the Center's Bylaws, the Rules and Regulations or the Professional Expectations Standards, any member of the Medical Staff or the Director of the Center may request corrective action against the Practitioner. All requests for corrective action shall be in writing, shall be presented to the Chief Medical Officer and shall be supported by references to the specific activities or conduct that constitute the grounds for the request. When acting on a request for corrective action, the Chief Medical Officer may, in his/her sole discretion, request information by written communication from or the personal appearance of individuals. Initiation of corrective action does not preclude immediate action or imposition of summary suspension nor does it require immediate action or summary suspension.

**10.1.2** The Chief Medical Officer shall make sufficient inquiry to satisfy that the question raised is credible and if so, shall forward it to the Medical Executive Staff Committee. All such activities shall constitute a lawful peer review investigation. The Medical Staff Executive Committee shall review the matter and determine whether to conduct further peer review or to direct the matter to be handled pursuant to another policy or procedure. In making such determination, the Medical Staff Executive Committee may discuss the matter with the Practitioner. The Chief Medical Officer shall keep the Director of the Center fully informed of all action taken in connection with an investigation.

**10.1.3** Once a determination has been made to initiate an investigation, the Medical Executive Staff Committee shall either investigate the matter itself or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the Practitioner being investigated, but may include individuals not on the Medical Staff. Whenever the question raised involves clinical competence, the ad hoc

committee shall include a professional of comparable knowledge and experience (e.g. physician, dentist or podiatrist).

**10.1.4** The investigating individual or committee shall meet with the Practitioner. At such meeting, the Practitioner shall be informed of the general nature of the concerns raised against him/her and shall be encouraged to discuss, explain or refute the concerns. This meeting shall be preliminary in nature, and no procedural rules provided in these Bylaws with respect to hearing shall apply hereto.

**10.1.5** The investigating individual or committee shall make reasonable efforts to conclude the investigation and issue a report within thirty (30) days of initiating the investigation, provided that an outside review is not necessary. When an outside review is determined to be necessary, the investigating individual or committee shall make reasonable efforts to conclude the investigation and issue a report within thirty (30) days of receiving the results of the outside review. The time frames herein are intended to serve as guidelines. In the event that an investigating individual or committee is unable to complete the investigation and issue a report within these timing guidelines, he/she or it will inform the Practitioner of the reasons for the delay and the anticipated timeframe he/she or it expects to complete the investigation and issue a report.

**10.1.6** At the conclusion of the investigation, the investigating individual or committee shall prepare a report of his or its findings, conclusions, and recommendations and submit the report to the Medical Staff Executive Committee.

**10.1.7** The Medical Staff Executive Committee shall review the report in executive session, and shall, after due consideration of the report, recommend to accept, dismiss or modify the request for action or make any other recommendations that it deems necessary or appropriate. Corrective action may include (but is not limited to) revocation, reduction or suspension of clinical privileges; suspension or expulsion from the Medical Staff; a letter of warning, admonition or reprimand; a term of probation; or requirements for monitoring or consultation. The Chief Medical Officer shall promptly notify the Practitioner of the Medical Staff Executive Committee's recommendations by certified mail, return receipt requested.

Unless otherwise provided in these Bylaws, any recommendation by the Medical Staff Executive Committee that, if adopted by the SMB, will adversely affect a Practitioner's status as a member of the Medical Staff or his exercise of clinical privileges as set forth in these Bylaws shall entitle the affected Practitioner to the procedural rights provided in these Bylaws.

**10.2** **Summary Suspension:**

**10.2.1** The SMB, the Medical Executive Staff Committee, the Director of the Center or the Chief Medical Officer, shall have authority to summarily suspend a Practitioner's Medical Staff membership or all or any portion of the Practitioner's clinical privileges. Such suspension may be imposed only when the Practitioner willfully disregards the Center's Policies, these Bylaws, the Rules and Regulations or the Professional Expectations Standards; whenever the Practitioner's conduct requires immediate action to protect the health or safety of any individual; or substantial evidence exists that the Practitioner has committed acts of an illegal or unethical nature, which are of such gravity that, if proven, would justify revocation or permanent

suspension of Medical Staff membership, privileges, professional licensure or prescribing authority. The individual taking such action shall immediately notify the affective Practitioner in person, if possible and confirm such in writing within three (3) days or immediately notify the Practitioner in writing if such Practitioner is not present. Such summary suspension shall become effective immediately. The Practitioner may be given the opportunity to voluntarily refrain from exercising privileges pending further review. Any summary suspension imposed by the Chief Medical Officer must be sustained, modified or voided by the Director of the Center within twenty-four (24) hours of imposition.

**10.2.2** Within five (5) business days after a summary suspension, the Center's Credentials Committee shall meet to review and consider the suspension. The affected Practitioner shall be given an opportunity to discuss the matter at the meeting. The Credentials Committee may recommend continuation, modification or termination of the suspension, including any further or additional corrective action. This meeting shall not constitute a hearing under Article 11 and the provisions of Article 11 do not apply. If the Credentials Committee's decision is other than to rescind the action in total within fourteen (14) days of imposition, the Practitioner may be entitled to request and receive a hearing pursuant to Article 11. The terms of the summary suspension, as affirmed or as modified by the Credentials Committee, shall remain in effect pending resolution of the matter in accordance with Article 12.

**10.2.3** Immediately upon imposition of summary suspension, the Chief Medical Officer shall have authority to provide for the care and treatment of the suspended practitioner's patient(s) in the Center at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of an alternate Practitioner.

**10.3 Automatic Suspension:**

**10.3.1 Licensure** – If a Practitioner's license, certificate or other legal credential authorizing him/her to practice in Michigan is expired, denied, suspended, revoked or voluntarily relinquished, his/her Medical Staff membership and privileges immediately and automatically shall be relinquished.

**10.3.2 DEA Registration** – A Practitioner, whose DEA registration certificate or Michigan Controlled Substance License is revoked, limited or suspended, shall automatically be divested of his/her right to prescribe medication covered by such certificate, registration and/or license, as of the date of such action becoming effective and throughout its term.

**10.3.3. Failure to Satisfy Special Appearance Requirements** – Failure of a Practitioner to appear at any meeting with respect to which he was given special notice shall result in an automatic suspension of all or such portion of the Practitioner's clinical privileges upon recommendation of the Chief Medical Officer or the Director of the Center or as the SMB may direct, unless excused by the SMB upon showing of good cause. Such suspension shall remain in effect until the matter is resolved by subsequent action by the SMB or through corrective action, if necessary.

**10.3.4 Conviction of Felony** – A Practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony in any6 jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon

such conviction whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action by the SMB or through corrective action, if necessary.

**10.3.5** **Medical Records** – A Practitioner will be considered to have voluntarily relinquished the privileges to admit new patients, schedule new procedures, or make new consults whenever he fails to complete medical records within the timeframes established by the Center. This relinquishment of privileges shall not apply to patients already admitted or already scheduled at the time of relinquishment or to emergency patients. The relinquished privileges automatically will be restored upon completion of the medical records and compliance with medical records policies.

**10.3.6** **Excluded Providers** – A Practitioner who becomes an excluded provider from Medicare/Medicaid, Tricare or other federal programs, or is listed with the Health and Human Services Office of the Inspector General as an excluded provider shall automatically be considered to have relinquished his/her membership and clinical privileges as of the date such action becomes effective.

**10.4** **Corrective Action for Allied Health Practitioners**: Whenever the activities or professional conduct of any Allied Health Practitioner are considered to be lower than the standards or aims of the Medical Staff, disruptive of the operations of the Center or contrary to the Center's bylaws, the Center Policies, these Bylaws, the Rules and Regulations, or the Professional Expectations Standards, the Director of the Center and the Chief Medical Officer may request corrective action against the Allied Health Practitioner. All such requests shall be in writing, shall be presented to the SMB and shall describe in reasonable detail the activities or conduct that constitute the grounds for the request. The SMB shall take such corrective action against such Allied Health Professional as it considers appropriate after investigating the facts (including any evidence or response presented by the accused Allied health Practitioner) and giving due consideration thereto and such other information as it considers appropriate in the circumstances.

## Article 11 – Hearing and Appellate Review Procedures

**11.1** **Request for Hearing:**

**11.1.1.** **Notice of Decision** – The applicant or the Medical Staff member shall be given prompt notice by certified mail, return receipt requested, in all cases where the body or individual with authority has taken or is recommending any of the actions enumerated in Section 11.1.2 as constituting grounds for a hearing. Notice shall advise that an action has been proposed or has been taken, reasons for the action, that the applicant or the Medical Staff member has a right to a hearing under these Bylaws, and that such applicant or Medical Staff member shall have no less than thirty (30) days after the date of the receipt of such notice within which to request a hearing by the Judicial Review Committee. A copy of the Medical Staff bylaws should be provided with the notice. The request for a hearing shall be sent to the Director of the Center by certified mail, return receipt requested. If the applicant or Medical Staff member does not request a hearing within the time and manner provided in this section, he/she shall be deemed to have accepted the action involved and waives any right to hearing and/or appellate review, which action thereupon shall become effective immediately.

**11.1.2** **Grounds for Hearing** – Any one or more of the following actions shall constitute grounds for a hearing under this article.

**11.1.2..1** Suspension of Medical Staff membership, expulsion from the Medical Staff, suspension or termination of clinical privileges

**11.1.2.2** Denial of Medical Staff membership

**11.1.2.3** Denial of requested advancement in Medical Staff division membership

**11.1.2.4** Denial of Medical Staff reappointment

**11.1.2.5** Demotion to lower Medical Staff category

**11.1.2.6** Denial of requested clinical privileges

**11.1.2.7** Reduction in clinical privileges

**11.1.2.8** Suspension of clinical privilege

**11.1.2.9** Imposition of consultation requirement for greater than fourteen (14) days as well as consideration of other trigger issues.

**11.2** **Date, Time and Place of Hearing** – Upon receipt of a request for hearing, the Facility Director of the Center shall deliver the request to the Vice-President of the Ascension Behavioral Health Service Line and to the SMB. The Vice President of the Ascension Behavioral Health Service Line shall arrange for a hearing to be held not less than thirty (30) days after the date of receipt by the Director of the Center's timely request for hearing.

**11.3** **Notice of Hearing** – The notice of hearing shall state, in clear and concise language:

**11.3.1** The time, place and date of the hearing

**11.3.2** A list of proposed witnesses (as known at that time, but is subject to modification) who will give testimony or evidence in support of the proposed or taken action.

**11.3.3** The names of the hearing panel members, if known and presiding officer, if applicable and known.

**11.3.4** A statement of the specific reasons for the recommendation or action, as well as a list of patient records and/or information supporting the recommendation. This statement and the list of supporting patient records and other information may be amended or updated at any time, even during the hearing, so long as the additional material is relevant to the continued appointment of clinical privileges of the individual requesting the hearing, and both the individual and his/her counsel, as applicable, have sufficient time to study the additional information and respond to it.

**11.4** **Judicial Review Committee** – When a hearing is requested, the SMB shall appoint a Judicial Review Committee with members of not less than three (3) individuals. No individual appointed to the Committee 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 Center or an affiliate shall not preclude any individual from serving on the Committee. Committee members need not be members of the Center's Medical Staff. When the issue before the Judicial Review Committee is a question of clinical competence, all Committee members shall be clinical practitioners. Committee members need not be clinicians in the same specialty as the individual requesting the hearing.

**11.5** **Failure to Appear** – Failure without good cause of the person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved, which shall become final and effective immediately.

**11.6** **Postponements and Extensions** – Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by any party to the proceedings, but shall only be permitted by the Judicial Review Committee, or its chairman acting on its behalf, upon a showing of good cause.

**11.7** **Decision of the Judicial Review Committee** – Within thirty (30) after final adjournment of the hearing (provided that, if the member is currently under suspension, this time shall be twenty (20) days), the Judicial Review committee shall deliberate outside the presence of any other person. The Committee shall deliver a written report of its findings and decision to the SMB. The report shall contain a clear and concise statement of the reasons for the committee's decision. At the same time, a copy of the report and decision shall be delivered to the person who requested the hearing by certified mail, return receipt requested.

**11.7.1** **Appeal of Decision**– The decision of the Judicial Review Committee shall be referred to the SMB for final decision, subject only to the right of appeal provided in Section 11.9

**11.8** **Hearing Procedure**:

**11.8.1** **Personal Presence Required** – Under no circumstances shall the hearing be conducted without the personal presence of the person requesting the hearing, unless he/she has waived such appearance or has failed without good cause to appear after appropriate notice.

**11.8.2** **Representation** – The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on conduct or professional competence. Accordingly, neither the person requesting the hearing, nor the Medical Staff Division nor the SMB shall be represented in any phase of the hearing or appeals procedure by an attorney unless the Judicial Review Committee or the SMB, in its discretion, permits both sides to be represented by legal counsel. The person requesting the hearing shall be entitled to be accompanied and represented at the hearing by a practitioner who is licensed to practice in the State of Michigan but is not a member of the bar of any state. The SMB shall appoint a representative from the Medical Staff Division to present its recommendations and to examine witnesses.

**11.8.3** **Presiding Officer** - The Chairman of the Judicial Review Committee shall preside at its meetings. The Chairman shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard, to present all oral and documentary evidence and ensure that decorum is maintained. The Chairman shall determine the order of procedure during the hearing and shall have the authority to make rulings on all questions that pertain to matters of law and to the admissibility of evidence.

**11.8.4** **Record of Hearing** – The Judicial Review Committee shall maintain a record of the hearing by having present a court reporter to make a record of the hearing or by recording. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents of the State of Michigan.

**11.8.5** **Rights of Both Sides** – At the hearing, both sides shall have the right to call and examine witnesses, to introduce exhibits, to cross-examine any witness and to rebut any evidence. If the

person who requested the hearing does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination.

**11.8.6** **Admissibility of Evidence** – The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the chairman 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. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems it appropriate.

**11.8.7** **Official notice** – The Chairman shall have the discretion to take official notice of any technical or scientific matters relating to the issues under consideration that could have been judicially noticed by the courts of the State of Michigan. Participants in the hearing shall be informed of the matters to be officially noticed or to refine the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

**11.8.8** **Basis of Decision** – The decision of the Judicial Review Committee shall be based on the evidence produced at the hearing.

**11.8.9** **Burden of Proof** – The person who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse determination, recommendation, or action lacks any factual basis or that such basis or the conclusions drawn there from are unreasonable.

**11.8.10** **Adjournment and Conclusion** –The Chairman of the Judicial Review Committee may adjourn and reconvene the hearing at the convenience of the participants without special notice. Upon conclusion of the presentation of all oral and written evidence, the hearing shall be closed.

**11.9** **Appeal to the Southeast Michigan Board:**

**11.9.1** **Time for Appeal** – Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the person who requested the hearing, or the body whose decision prompted the hearing, may request review by the SMB. The request shall be in writing and delivered to the Director of the Center in person or by certified mail, return receipt requested. The request shall include a brief statement of the reasons for the appeal. If review is not requested within such thirty (30) day period, both sides shall be deemed to have accepted the decision of the Judicial Review committee, which thereupon shall become final and immediately effective.

**11.9.2** **Grounds for Appeal** – The grounds for appeal to the SMB shall be (a) substantial failure of the Judicial Review committee to comply with the procedures required by this Article or by these Bylaws, in the conduct of hearings, and decisions upon hearings, so as to deny a fair hearing or, (b) the decision of the Judicial Review committee is arbitrary and capricious and is not supported by substantial evidence.

**11.9.3** **Time, Place and Notice** – if a decision is timely appealed to the SMB under this Article, the SMB, within twenty-one (21) days after receipt of such notice of appeal, shall schedule and arrange for such review. The SMB shall cause the applicant or member to be given notice of the time, place and date of the review by certified mail, return receipt requested. The date of the

review shall not be less than fifteen (15) nor more than sixty (60) days from the date on which the SMB receives the request for review; provided, however, that when the request is from a member who is under a suspension then in effect, the review shall be held as soon as arrangements reasonably may be made and not more than ten (10) days from the date on which the SMB receives the request for review. The time for review may be extended by the Director of the Center or the SMB for good cause.

**11.9.4 Nature of Review** – The proceedings by the SMB shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the SMB, in its discretion, may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided in case of the hearing before the Judicial Review Committee. Each party shall have the right to present a written statement in support of its position on appeal, and the SMB in its sole discretion may allow each party or representative personally to appear and make oral argument and may limit such oral argument as to time and issues. At the conclusion of oral argument, the SMB, at a time convenient to itself, shall conduct its deliberations outside the presence of the parties and their representatives. The SMB may affirm, modify or reverse the decision of the Judicial Review Committee or refer the matter to the Judicial Review Committee for further review and consideration.

**11.9.5 Final Decision** – Within twenty-one (21) days after the conclusion of the proceedings before the SMB, the SMB shall render a final decision in writing and shall deliver copies of the decision to the parties, the Active Medical Staff and the Director of the Center by certified mail, return receipt requested.

**11.9.6 Further Review** – Except when the matter is referred to the Judicial Review Committee for further review and consideration in accordance with Section 12.3.4, the final decision of the SMB shall be effective immediately and shall not be subject to further review. If the matter is referred back to the Judicial Review Committee in accordance with Section 12.3.4, the committee shall promptly conduct its review and report the results of its reconsideration to the SMB not more than 30 days after such referral except as the parties otherwise stipulate.

**11.9.7 Right to One Hearing Only** – Except as otherwise provided in this Article, no applicant or member shall have any right to more than one hearing before the SMB on any single matter that may be subject of an appeal without regard to whether such subject is the result of action by the Judicial Review Committee or the SMB, or both of them.

## Article 12 – Immunity From Liability

Members of the Medical Staff shall be immune from all civil liability to the fullest extent permitted by law when acting within the scope of their duties, functions and responsibilities as well as all activities identified in or relating to the provisions of the Center Bylaws, the Center Policies, these Bylaws, the Rules and Regulations and the Professional Expectation Standards.

## Article 13 – Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles expressed in these Bylaws, subject to the approval of the Board of Trustees of the SMB. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and embody the level of practice that is to be required of each practitioner and professional in the Center. **The Rules and Regulations** shall incorporate the Professional Expectations.
**See Exhibit A**

## Article 14 - Amendments

A proposed amendment to these Bylaws may be referred by any member of the Medical Staff or by the SMB to the Medical Executive Staff Committee. The Medical Executive Staff Committee shall review and make recommendations on all proposed Bylaws changes. A proposed amendment shall be submitted and read at any meeting of the Medical Staff. The amendment shall not be voted upon until a meeting of the Medical Staff after the meeting at which the amendment is submitted and read. An amendment shall be adopted by the affirmative vote at least 51% of the members of the Medical Staff present and entitled to vote. An amendment so adopted shall be effective if approved by the SMB.

**14.1** Any member of the Medical Staff may propose an amendment. Such proposals shall be presented in writing to the Medical Executive Staff Committee. After their review and recommendations, if supported by the Medical Executive Staff Committee, the proposed amendment shall be submitted to all members of the Medical Staff by the Secretary of the Medical Staff at least 14 days prior to the regular or Special Meeting at which action is to be taken. Such submission shall constitute written notice. The Chief Medical Officer shall report on the proposed amendment at the meeting. Discussion shall be entertained and amendments accepted from the floor. To be adopted, the entire amendment shall require a simple majority vote of the Active and Provisional Active Medical Staff at the meeting. Amendments so adopted shall become effective when approved by the Southeast Michigan Board.

**14.2** The Medical Executive Staff Committee may provisionally adopt and approve a Bylaw, Rule and Regulation, or policy, as is necessary to comply with State and Federal laws or regulations. Any such amendment will be reviewed at the next TriAnnual Staff meeting and submitted to the Board for approval.

**Exhibit A**

**Ascension Brighton Center for Recovery**
**Medical Staff Rules and Regulations**

1. **Elements of the Medical Record**

The attending practitioner (physician, oralmaxillo facial surgeon, podiatrist), is responsible for the preparation of a medical record for each patient which contains sufficient information to identify the patient, support the diagnosis with appropriate documentation and respond to queries regarding documentation of results accurately, and facilitate the continuity of care among health care providers. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated with the practitioner's signature, either electronically or in writing. New entries to the medical record may not be created by cloning or cutting and pasting. Cloning (which is language or documentation identical to a previous entry) is unacceptable for the medical record. Cutting and pasting (which is electronic duplication of a previous entry) is unacceptable for the medical record.

Specifically, each medical record will contain at least the following:

a. The patient's name, address, date of birth and the name of the legally authorized representative;
b. The patient's legal status, for patients receiving mental health services;
c. Pertinent and emergency care provided to the patient prior to arrival;
d. The findings of the patient's assessment;
e A statement of the conclusions or impressions drawn from the medical history and physical examination;
f. The diagnosis or diagnostic impression;
g. The reason(s) for admission or treatment;
h. The goals of treatment and the treatment plan;
i. Evidence of known advance directives;
j. Evidence of informed consent for treatment and for which informed consent is required;
k. Diagnostic and therapeutic orders;
l.. All diagnostic and therapeutic procedures and tests performed and results;
m. Progress notes made by the medical staff and other authorized individuals;
n. All reassessments including change in code status;
o. Response to the care provided;
p. Consultation reports

**1.1** In circumstances where the patient's life is in jeopardy and suitable signatures cannot be immediately obtained from parents, guardian or next of kin, appropriate medical interventions should none the less be performed. These circumstances should be fully explained in the patient's medical record.

**1.2** Diagnostic, consultation and therapeutic orders for treatment shall be in writing, dated and timed. A telephone/verbal order shall be considered to be in writing if dictated

to, entered into the EMR/HER and transcribed to the physician's order form by any of the following:

- Registered Nurse
- Registered Pharmacist
- Physician Assistant
- Registered Dietician
- Nurse Practitioner

The order must be authenticated by the responsible physician or his/her designee within 48 hours. All telephone/verbal orders are to be signed by the person by whom it was dictated. The person who receives the telephone/verbal order must also indicate the name of the practitioner.

2. **Orders:**

**2.1** All orders for medication and treatment shall be entered into the medical record (written or electronic). Written records must be legible and signed by the physicians or non-physician practitioners, or *pharmacist delegated for medication management therapy, responsible for the care of the patient. The physicians shall authenticate the order and include their contact number.

* consistent with state law, a practitioner may delegate to a license or unlicensed individual (who is otherwise qualified by education, training or experience) the performance of selected acts, tasks or functions, where the acts, tasks or functions fall within the scope of practice of the practitioner's profession and will be performed under the practitioner's supervision.

Verbal or telephone orders shall be entered into the record if dictated to a nurse, medical assistant, pharmacist, registered or certified respiratory therapist, physical therapists, dieticians, residents, or any other appropriate healthcare provider. The recipient of the verbal or telephone order shall repeat the order back to the physician and sign the order. The practitioner or practitioner designee, shall authenticate the order within 30 days of discharge.

**2.2** Orders not legible or improperly entered into the electronic records will not be carried out by the nurse until clarification has been obtained from the practitioner. This clarification may be oral, but shall be subsequently verified and signed by the practitioner. The terms "renew", "repeat", "continue orders" are unacceptable.

**2.3** Cutting and pasting (which is electronic duplication of a previous entry) is unacceptable for the medical record.

3. **History and Physical Examination:**

It is the policy of Ascension Brighton Center for Recovery that all patients receive a physician examination as part of their admission to any level of programming.

**3.1** Patients admitted to the detox or residential level of care will have a history and physical completed within 24hrs of their admission. If a patient is being readmitted

within 30 days of a prior admission, a readmit note will be written in place of a History and Physical.

**3.2** If the patient was sent as a transfer from another medical facility a copy of the history and physical will be obtained from the facility and placed in the record. It is the responsibility of the Medical Staff to ensure the patient receives a history and physical examination meeting standards of Ascension Brighton Center for Recovery.

**3.3** Any patient requesting to be seen by the Staff Physician or any patient who is exhibiting signs/symptoms of disease or physical problems as observed by the Ascension Brighton Center for Recovery Treatment Team will be assessed by nursing staff. After consult with a physician, it will be determined if the patient needs to be seen by the physician.

**3.4** Patients admitted to the halfway houses or outpatient level of care from an outside facility or referral source will be required to have a history and physical from their outpatient provider completed prior to entering.

**3.5** The History should include, but is not limited to:

a) Precipitating event that brought the patient into the Ascension Brighton Center for Recovery.
b) Patient's alcohol and drug history, including any alcohol and/or drug related problems, treatment history, experience with 12 Step Recovery and past history of significant morbidity during withdrawal (e.g. seizures, delirium, etc)
c) Past medical and surgical history (including significant injuries).
d) Personal/family history.
e) Past psychiatric diagnoses and treatment, if available.
f) Current medications (including allergies).
g) Gynecological and obstetrical history (female).
h) Review of systems, including:
    i. Eyes
    ii. Ears, nose, throat
    iii. Cardiovascular
    iv. Respiratory
    v. Gastrointestinal
    vi. Genitourinary
    vii. Breasts/Skin
    viii. Musculoskeletal
    ix. Neurological
    x. Psychiatric
    xi. Endocrine
    xii. Hematologic
    xiii. Allergic Immunologic

**3.6** The Physical Examination should include, but is not limited to, pertinent examination of the following systems:

a) General Appearance
b) Eyes
c) Ears, Nose and Throat
d) Neck
e) Cardiovascular
f) Respiratory
g) Breast examination, as indicated
h) Gastrointestinal (including rectal examination as indicated)
i) Genitourinary
    i. Pelvic examination in females, if indicated
    ii. Testicular examination in males, if indicated
j) Lymphatic System
k) Integument
l) Neurologic
m) Psychiatric
n) Musculoskeletal

It is assumed that rectal and genitourinary examinations are performed by the patient's Primary Care Physician and need not be repeated unless indicated during treatment.

4. **Clinical Observations**:

**4.1** All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication means to establish authorship by written or electronic signature.

**4.2** While in Detox, patients shall be seen daily. Patient progress notes shall be recorded upon each visit and shall give a pertinent chronological report of the patient's course in the hospital and shall reflect any change in condition and/or results of treatment. Each of the patient's clinical problems shall be clearly identified in the progress notes, correlated with the specific orders, as well as the results of tests and treatments.

**4.3** Nursing notes shall be informative and descriptive of nursing care given and include information and observation of significance, so that they contribute to the continuity of the patient's care. All shift entries are to be authenticated either electronically or in writing with: first initial, last name, nursing classification, date and time.

**4.4** Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations shall be kept on file in the Health Information Management Department (Medical Records).

**4.5** Disagreements between physicians and departments, with any action or report from another physician or department, should be handled by face-to-face discussion, telephone conversation or in a written email or memo to the responsible person. Writing on the report or in the medical record is not an appropriate method of disagreement and/or conflict resolution.

**4.6** Medical reports from pharmacy, radiology, laboratory and all other departments that are part of the active medical record should not be defaced or altered.

5. **Diagnoses:**

Final diagnoses shall be recorded in full without the use of symbols and abbreviations, dated and signed by a credentialed physician at the time of discharge of all patients.

6. **Integrated Discharge Summary**:

A Discharge Summary shall be electronically entered on all patients' medical records. The Discharge Summary, located within CDHR, shall recapitulate the reason for hospitalization, significant findings and diagnoses, medications received and treatment rendered, condition of the patient at time of discharge and specific instructions given with regard to medication, physical activity, diet and follow up care.

When preprinted instructions are given to the patient, such instructions should be on file in the medical record and held in the Health Information Management Department.

7. **Patient Death Notation:**

In the event of patient death, a final note should be added to the record either as a final progress note or as a separate discharge summary. This final note shall include events leading to death, if known.

8. **Unsigned Documents**:

In the event that a document in the medical record remains unsigned 7+ days, the physician will receive a copy of their unsigned document report from Health Information Management team.

9. **Incomplete Summary:**

In the event that the Discharge Summary remains incomplete, the physician will receive a copy of their Incomplete IDS report from Health Information Management team.

**9.1** If a document in the medical record remains incomplete or unsigned for 14+ days, the CMO will receive an email alerting them that there is documentation that may become delinquent, or 30 days incomplete. The Unsigned document 14+ days BPR is also updated indicating that there are documents that have not been completed/signed in 14+ days.

**9.2** If a document in the medical record remains incomplete or unsigned for 31+ days, the CMO will receive an email that there is documentation that is delinquent. The document will be counted towards the number of delinquent for that month and reported to the Quality Team. The delinquent 31+ days BPR is also updated indicating that there are documents that are delinquent.

At 31+ Days unsigned, the medical record is delinquent and reported on the 31+ Day Delinquent BPR Unsigned Document Slide, the CMO is also notified.

**10. Chronic Delinquency:**

If a physician remains delinquent more than 31 days and becomes chronically delinquent, he/she will receive notification from the CMO, or his designee, that he/she must appear before the Medical Executive Staff Committee or provide a written performance improvement plan.

**11. Physician LOA When in Delinquency:**

When a physician leaves on vacation or leave of absence, and appropriately notifies the Medical Staff Administrative Assistant, the process outlined above stops and his/her status remains exactly where it was upon notification of his/her leave. Upon his/her return, the status resumes where it left off. In other words, if a physician has incomplete records eight days old, prior to a properly notified vacation or leave of absence, the record will still be considered eight days old until the physician returns from vacation or leave of absence.

**12. Patient Release of Information:**

Written consent of the patient, or his/her legally qualified representative, is required for release of medical information (ROI) to persons not otherwise authorized to receive this information, and/or when a patient wishes to see his/her hospital medical record or procure copies of same. If the patient wishes to view his/her record only and has completed and ROI for himself/herself, an appointment can be made during normal business hours of the Health Information Department. Psychiatric medical records are the exception, and are released only to a licensed psychiatrist or psychologist with an ROI from the patient.

**13. Medical Records/Health Information Safekeeping:**

**13.1** Medical Records may be removed from Ascension Brighton Center for Recovery's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed from the hospital.

**13.2** In the case of readmission of a patient, all previous medical records shall be available for the use of the attending physician, electronic or otherwise. This shall apply whether the patient be attended by the same physician or another.

**13.3** Unauthorized removal of patient records from Ascension Brighton Center for Recovery by a physician is grounds for suspension of the physician for a period to be determined by the Executive Committee of the Medical Staff.

**13.4** Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research. Confidentiality shall be preserved. All such projects shall be approved by the Facility Director before records can be studied.

Subject to the discretion of the Chief Medical Officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

**14. Quality of Care:**

All medical staff members have the responsibility to ensure that care provided to patients at Ascension Brighton Center for Recovery is of the highest quality. This shall be accomplished through the appropriate utilization of resources, timely order of diagnostic evaluations and consultations and recognition of the participation in ongoing quality improvement initiatives. Utilization of inpatient care protocols, clinical pathways and standing orders is encouraged.

**15. Conduct of Care:**

**15.1** A general consent form signed by, or on behalf of, every patient admitted to Ascension Brighton Center for Recovery must be obtained at the time of admission. When so notified, it shall, except in emergency situations, be the physician's responsibility to obtain proper consent before the patient is treated.

**15.2** If a patient is intoxicated, or otherwise unable to sign an authorization for treatment, consent may be obtained within 24 hours.

**15.3** If a nurse has sufficient reason to doubt or question the care provided to a patient has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the Leader of the department wherein the practitioner has clinical privileges.

**15.4** All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the State of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

**16. Medical Orders:**

a) Antibiotics and sulfa medications ordered without time limitations of dosage shall automatically be discontinued after 120 hours (5 days).
b) Drugs shall not be discontinued without notifying the physician.
c) Medication orders shall be written legibly or entered electronically into the EHR. The order shall include: date and hour written, name of medication, dosage (preferably in the metric system), route of administration and signature of physician.
d) All P.R.N. medication orders shall include the maximum frequency of dosage, as well as the intended use of the drug.

**17. TB Testing:**

Annual TB testing, which is mandated by MIOSHA, is required of all physicians and allied practitioners. Testing may be done at Ascension Brighton Center for Recovery or may be administered and read by another institution; however, it is the responsibility of each physician and practitioner to see that the test results are forwarded to the Ascension Brighton Center for Recovery Lead Infection Control Officer, who maintains record of same. The Lead Infection Control Officer will forward all information regarding The Center's TB testing to the Ascension Providence Park Occupational Health Office for duplicate recordkeeping.

**18. Resident Physician Rotation:**

Residents will be part of an established, contracted GME residency program within Ascension. Residents will abide by the hospital bylaws, general rules and regulations, as well as department specific rules and regulations. On all rotations, the resident is under the direct supervision of the attending physician (s). Patients will have the opportunity to decline resident care and will have their wishes respected.

The resident may write H&P's, discharge summaries, progress notes and consults at the discretion of the attending physician, with review and co-signature of the attending physician. The attending physician shall be notified of all admissions and significant changes in the patient's condition. Residents may write diagnostic and therapeutic orders after reviewing the case with the attending physician.

The Chief Medical Officer of contracted educational facility will be responsible for the overall educational experience of the residents, as well as coordinating communications between the residency program and Ascension Brighton Center for Recovery. Residents and students in the program will be scheduled with the medical staff monthly.

**19. Physician Policy of Conduct**

a) All individuals within the hospital must be treated with courtesy, respect and dignity. Physicians and other independent practitioners are expected to conduct themselves in a professional and cooperative manner, even in situations of disagreement and frustration.
b) Disruptive conduct may include, but is not limited to, behavior such as:
    i. Verbal or physical attacks leveled at medical staff, patients or hospital employees.
    ii. Inappropriate comments made in official documents that impugn the quality of hospital care or attack members of the hospital staff.
    iii. Non-constructive criticism that attempts to intimidate, belittle or imply incompetence.
    iv. Refusal to cooperate with assignments or departmental affairs or to do so in a disruptive manner.
c) Any physician, patient, visitor or hospital employee may report potentially disruptive conduct. The report shall be submitted to the Chief Medical Officer and forwarded to the Facility Director and respective Department Leader involved.
d) A report will be investigated by the Chief Medical Officer. The individual initiating such report must be appraised and the accused party must be questioned

before any action is taken. Reports which are not founded may be dismissed by the Chief Medical Officer.

e) The first incident of disruptive behavior warrants a discussion with the offending physician. The Chief Medical Officer shall emphasize that such conduct is inappropriate and must cease. The initial approach shall be collegial and designed to be helpful to both the physician and hospital. The Facility Director will be informed in writing of the meeting and of any action required with a copy sent to the accountable individual. Following the above, if the report has merit, the person who initiated the report will be apprised that such action has been taken but the specifics will not be divulged.

f) If it appears to the Chief Medical Officer that a pattern of disruptive behavior is developing, the Facility Director shall meet with and advise the physician that such conduct is intolerable and must stop. The involved physician may submit a rebuttal to the charge, which will be maintained as a permanent part of the record.

g) If such behavior continues, the Facility Director and the Chief Medical Officer will again meet with and advise the physician that such conduct will not be tolerated and must stop. This meeting is not a discussion but rather constitutes the physician's final warning. It shall be followed with a letter reiterating the warning.

h) Additional occurrences will result in medical staff membership suspension by the Medical Executive Staff Committee and/or other disciplinary action as determined by the Medical Executive Staff Committee.

## 20. Guidelines for Physicians and Health Care Workers Treating Family Members

**27.1** Physicians and healthcare workers should avoid treating themselves and immediate family members.

**27.2** A Physician or health care worker's emotional proximity to patient may result in a loss of professional objectivity.

## 21. Adoption and Approval

The Rules and Regulations shall be considered an Appendix A to the Medical Staff Bylaws according to Article 13 of the Amended and Restated Bylaws of the Medical Professional Staff of Ascension Brighton Center for Recovery. The Medical Executive Staff shall adopt and amend rules and regulations for the proper conduct of the work of the medical staff. Such Rules and Regulations shall become effective when approved by the Southeast Michigan Board.

In the adoption of additions/amendments to these Rules and Regulations, the Medical Executive Staff Committee will work to resolve all conflicting issues related to a rule, regulation or policy update/amendment in the best interest of Ascension Brighton Center for Recovery, its patients and the medical staff.

Each active staff member has a right to discuss a conflict with the Medical Executive Staff Committee , regarding an issue with a newly adopted rule, regulation or policy amendment to these Rules and Regulations:

- The active staff member is encouraged to initially attempt to resolve the issue/concern with his/her Chief Medical Officer
- If this is unsuccessful, he/she may request a meeting with the Medical Executive Staff Committee to discuss the issue. This must be accomplished through a written request provided to the Facility Director two weeks in advance of a regular meeting of the Medical Executive Staff Committee to schedule this concern.

If an issue arises regarding a current Medical Staff Rule and Regulation process/policy, the active staff member may submit a petition signed by a least 10% of all active staff members requesting a review/challenge to the process as follows:

- Upon receipt of the petition, the Medical Executive Staff Committee will schedule an Ad Hoc Committee to review with the petitioners and further clarify and discuss the issue.
- The meeting will be scheduled within 30 days of the regularly scheduled Medical Executive Staff Committee meeting at which the petition is reviewed.
- The Ad Hoc Committee shall be comprised of active Medical Staff members and Medical Executive Staff Committee members as selected by the Facility Director.
- The Ad Hoc Committee will work to achieve resolution of the conflict presented in the petition.

If the processes outlined above fail to provide a resolution to the conflict, the active staff member may communicate his/her concerns to the Southeast Michigan Board in writing. In the event this level of appeal occurs, the Facility Director shall also provide a written summary of the conflict resolution process to the Southeast Michigan Board.

The Southeast Michigan Board may seek to resolve the conflict through informal discussions. If this is unsuccessful in resolving the conflict, the Facility Director or the Chair of the SMB, or his/her designee, may request a formal conflict resolution process.

The formal conflict resolution process will begin with a meeting of the Conflict Committee within 30 days of the initiation of the formal conflict resolution process to address the conflict. The Conflict Committee shall be comprised of equal representatives of the active medical staff, the Medical Executive Committee and the Southeast Michigan Board. The Facility Director and the Chief Medical Officer may also be present as determined by the SMB Chair.

| ASCENSION | **Southeast Michigan Hospital Board of Trustees**<br>**Joint Conference Committee (JCC)**<br>**Wednesday, January 23, 2019 0700 – 0900**<br>Skype Conference Call 248-564-3118 ID#: 41255333<br>Phone Conference only |
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| | Following approval of minutes, Marita Grobbel recommended a "time-saver" to members of JCC. Those reporting are to verbalize only those complicated cases and to request approval only at the end of their reports | **APPROVED BY JCC** |

| **REVIEW AND APPROVAL OF CREDENTIALING MATERIALS<br>-BRIGHTON CENTER FOR RECOVERY-** | | |
|---|---|---|
| **AGENDA ITEM** | **ACTION** | **FOLLOW-UP (WWW)** |
| **NEW APPLICANTS NPP (Type 1)** | There was nothing to report from the Brighton Center for Recovery | None |
| **NEW APPLICANTS PHYSICIAN (Type 1)** ***(None)*** | | |
| **NEW APPLICANTS NPP (Type 2)** ***(None)*** | Amended and Restated Bylaws of the Medical Staff of Ascension Brighton Center for Recovery. | **APPROVED BY JCC** |
| **NEW APPLICANTS PHYSICIAN (Type 2)** ***(None)*** | | |
| **REAPPOINTMENT NPP (Type 1)** | | |
| **REAPPOINTMENT Physician (Type 1)** | | |
| **REAPPOINTMENT NPP (Type 2)** ***(None)*** | | |
| **REAPPOINTMENT Physician (Type 2)** ***(None)*** | | |

| **REVIEW AND APPROVAL OF CREDENTIALING MATERIALS<br>-ASCENSION MACOMB OAKLAND HOSPITALS -** | | |
|---|---|---|
| **NEW APPLICANT NPPs (TYPE 1)** | | **APPROVED BY JCC** |