Ascension Providence Rochester Hospital
Medical Staff Bylaws
May 1, 2024

MEDICAL STAFF BYLAWS

Part I: Governance

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Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at Ascension Providence Rochester Hospital in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the hospital Board of Trustees.

1.2 Authority

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

1.3 Definitions

"Non-Physician Practitioner or NNP" means those individuals eligible for privileges but not staff membership who are physician assistants (PAs), or advance practice registered nurses (APRNs) such as nurse midwives, certified registered nurse anesthetists (CRNAs), clinical nurse specialists or nurse practitioners.

"Non-Physician Practitioner or NNP" means those individuals eligible for privileges who are not staff Members or Non-Physician Practitioners who are qualified by academic education and clinical experience or other training to provide patient care services in a clinical or supportive role. Non-Physician Practitioner (NPP) provide services only under supervision of a Member of the Medical Staff.

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

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

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

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

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

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

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

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

"Good Standing" means having no adverse actions, limitations, or restriction on privileges or medical staff membership at the time of inquiry based on a reason of competence or conduct.

"Governing Body", "Board of Trustees" or "Board" means the Board of Trustees of Ascension Providence Rochester Hospital.

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

"Hospital" means Ascension Providence Rochester Hospital.

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

"Medical Staff or "Staff" means an individual who is either a medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, or podiatrist who have obtained membership status and have been granted privileges that allow them to attend patients and/or to provide other diagnostic, therapeutic, teaching or research services at the Hospital.

"*Medical Staff Bylaws"* means these Bylaws covering the operations of the Medical Staff of Ascension Providence Rochester Hospital.

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

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

"Member" is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been granted this status by the Board of Trustees of Ascension Providence Rochester Hospital.

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

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

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

"Practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist,

oral and maxillofacial surgeon, podiatrist, clinical psychologist, advanced practice professional, or Non-Physician Practitioner (NPP) who has been granted clinical privileges.

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

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

“Representative” or “Hospital Representative” means the Board of Trustees and any trustee or committee thereof; the Hospital President or his or her designee; other employees of the Hospital; a Medical Staff organization or any member, officer, clinical division or committee thereof; and any individual appointed or authorized by any of the foregoing Representatives to perform specific functions related to gathering, analysis, use of dissemination of information.

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

"Telemedicine" means the exchange of medical information from one site to a distant site via electronic communications for improving and facilitating patient care, treatment, and services.”

“Written” means documented through entry in an electronic format or on paper.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the hospital.

2.2 Qualifications for Membership

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

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, color, sex, , religion, age, height, weight, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) except for temporary, emergency and disaster privileges. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months. A 60-day extension may be granted for completion of the reappointment process if: (1) A national or state emergency has officially been declared. “or” (2) Ascension Providence Rochester Hospital has activated its emergency management plan.

2.5 Medical Staff Membership and Clinical Privileges

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

2.6 Medical Staff Members Responsibilities

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

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

2.6.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on-call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.

2.6.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by any of the Officers of the Medical Staff, Hospital President, and/or their Department Chief when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's or practitioner's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment.

2.6.5 Each staff member and practitioner with privileges must abide by the Medical Staff bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital, including the Ethical and Religious Directives for Catholic Health Care Services.

2.6.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount, sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the President or designee immediately of any and all malpractice claims filed in any court of law against the Medical Staff member.

2.6.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and his/ her credentials.

2.6.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to Medical Staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

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

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

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

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

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

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

2.7 Medical Staff Member Rights

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

2.7.2 Each staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.7.3 Each staff member in the Active category may initiate a call for a general staff meeting, to be held within ninety (90) days, to discuss a matter relevant to the Medical Staff by presenting a petition signed by thirty percent (30%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.7.4 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by thirty percent (30%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.

2.7.5 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by thirty percent (30%) of the members of the Department. Upon presentation of such a petition the Department Chief will schedule a Department meeting.

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

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

2.8 Staff Dues

Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.9 Indemnification

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

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

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

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

At least twenty-four (24) patient contacts per two (2) years (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic), **OR**

Have attended at least twenty (20) Medical Staff or hospital meetings per two (2) years.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the Medical Staff and hospital, the member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

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

b. Vote on all matters presented by the Medical Staff, Department and committee(s) to which the member is assigned; and

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

3.1.3 Responsibilities

Members of this category shall:

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

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

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

3.2 The Associate Category

3.2.1 Qualifications

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

3.2.2 Prerogatives

Members of this category may:

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

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

c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees. May vote on matters that come before their Department that do not require a ballot.

3.2.3 Responsibilities

Members of this category shall have the same responsibilities as Active Category Members.

3.3 The Associate Without Clinical Privileges Category

3.3.1 Qualificaitons:

The Associate Without Clinical Privileges Category is for those physicians who do not wish to exercise any inpatient privileges. Applicants must have an existing arrangement for referral of their patients to a hospitalist group at APRH or an appropriately privileged physician with admitting privileges at APRH

3.3.2 Prerogatives:

The Associate Without Privileges category allows the following:

a. Visit their patients socially in the hospital and follow progress of patient through discharge
b. Access to the inpatient medical record of your patient
c. Order outpatient ancillary tests/services and obtain results
d. May attend medical staff/department meetings of which they are a member. CME educational programs and other medical staff functions
e. Members of this category shall not have the ability to admit patients, write orders, make medical chart entries, or otherwise engage in any form of active medical management.

3.4 Honorary Recognition

Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. Practitioners granted Honorary Recognition shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned. Honorary recognition does not require recredentialing.

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

4.1 Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.1.3 Secretary-Treasurer

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing of the Active category and be actively involved in patient care in the hospital, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. Qualifications for the positions of Chief of Staff also includes having previously served as a Department Chief or Medical Staff Officer. Qualifications for the other Officer positions includes having previously served as a Department Officer, Medical Staff Officer, or Division/Section Chief. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria. The immediate past Chief of Staff, who does not serve as a Medical Staff Officer, attains his/her position by automatic succession from the office of Chief of Staff.

4.2.2 Officers and MEC at-large members may not simultaneously have a conflicting interest on another non-Ascension Providence Rochester Hospital Medical Staff or in a facility or organization that is directly competing with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

4.3 Election of Officers

4.3.1 The Nominating Committee shall nominate two (2) candidates for each of the positions of Chief of Staff, Vice Chief of Staff and Secretary-Treasurer. The names of the nominees will be announced at least thirty (30) days prior to the election.

4.3.2 A petition signed by at least fifteen (15) Members of the Active staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office by October 15th prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.

4.3.3 Ballots will be mailed to all Active Members by October 30th. Elections shall take place by ballots cast by Active Medical Staff Members returned to the Secretary-Treasurer on or before November 15th. The nominee(s) who receives a majority of votes cast will be elected. In the event that no candidate receives a majority vote, the MEC will make arrangements for a repeat vote(s) between the two (2) candidates receiving the highest number of votes.

4.3.4 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position.

4.4 Term of Office

All officers serve a term of two (2) years. They shall take office on January 1st following their election. An individual may be reelected for one additional successive term. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office and Vacancies in the Position of MEC At-Large Member

The MEC shall fill vacancies of Office or in the position of MEC At-Large Member during the Medical Staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the term.

4.6 Duties of Officers

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

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

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

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

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

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

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

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

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

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

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

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

l. Perform such other duties and exercise such authirty commensurate with the office as are set for in the Medical Staff Bylaws; and

m. Authorize payments of Medical Staff funds in the absence of the Secretary-Treasurer.

4.6.2 **Vice Chief of Staff:** In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.3 **Secretary/Treasurer:** This officer will collaborate with the hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. S/he shall perform such further duties to assist the Chief of Staff as may be requested from time to time.

4.6.4 **MEC at-large members:** These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.

4.7 Removal and Resignation from Office

4.7.1 **Removal by Vote:** Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct or statements that damage the hospital, its goals, or programs. The Medical Staff may initiate the removal of any officer if at least thirty percent (30%) of the Active members sign a petition advocating for such action. A majority vote of the MEC may also initiate the removal of any officer. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active staff members casting ballot votes.

4.7.2 **Automatic Removal:** Automatic removal shall be for failure to meet or maintain any of the qualifications for being an Officer, as noted in Part I, Section 4.2.1.

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

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The Medical Staff shall be organized into departments. The Medical Staff may create clinical divisions within a department in order to facilitate Medical Staff activities. A list of departments organized by the Medical Staff and formally recognized by the MEC is listed in the Organization and Functions Manual which is part of the Rules and Regulations.

The MEC, with approval of the Board, may designate new Medical Staff departments or divisions or dissolve current departments or divisions as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Department Chiefs, Department Vice Chiefs

5.2.1 All Department Officers must be Members of the Active Medical Staff, be in good standing, have relevant clinical privileges, be actively practicing in the hospital, and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. Department Chiefs must have had some previous leadership experience. Department Officers may not simultaneously have a conflicting interest on another non- Ascension Providence Rochester Hospital Medical Staff or in a facility or organization that is directly competing with the Hospital. Noncompliance with this requirement will result in the officer being automatically removed from office.

5.2.2 Department Officers shall be elected by majority vote of the Active members of the Department, subject to ratification by the MEC. In the event that no candidate receives a majority vote, the Department will make arrangements for a repeat vote(s) between the two (2) candidates receiving the highest number of votes.

a. Each Department Chief, Department Vice Chief shall serve a term of two (2) years commencing on January 1 and may be elected to serve one additional successive term.

b. If the post of Officer of a Department is vacated, an election shall be held within fourteen (14) days to elect a new Officer who will preside through the remainder of the term.

5.2.3 A petition signed by five (5) Active Members of the Department may initiate a recall election. Department Officers may be removed from office by the MEC if two-thirds (2/3) of the voting members of the department recommend such action.

5.2.4 Department Officers will be removed from office automatically if they fail to maintain the qualifications for the position.

5.2.5 If a Department Chief is removed through this process, or a vacancy occurs for any other reason, the Department Vice Chief will assume the position of Department Chief and serve the remainder of the unfinished term. This will create a vacancy in the position of Department Vice Chief.

a. If there is more than six (6) to the unexpired term, the new Department Chief will hold an election for the position of Department Vice Chief, to fill the position for the remainder of the unexpired term.

b. If there is difficulty getting candidates to run for the position of Department Vice Chief, or if there is less than six (6) months to the vacancy, then the Department Chief will appoint a Department Vice Chief to the position for the remainder of the unexpired term.

5.3 Responsibilities of Department Chief

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

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

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

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

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

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

g. To integrate the Department into the primary functions of the hospital;

h. To coordinate and integrate interdepartmental and intradepartmental services and communication;

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

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

k. To provide input to the President regarding the qualifications and competence of Department or service personnel who are not LIPs but provide patient care, treatment, and services;

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

m. To maintain quality control programs as appropriate;

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

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

5.4 Assignment to Department

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

Section 6. Committees

6.1 Designation and Substitution

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

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff, the Immediate Past Chief of Staff, the Department Chiefs and Vice Chiefs of the following Departments (Family Medicine, Internal Medicine, Surgery, Pediatrics, and Obstetrics and Gynecology), elected representatives from the following Departments (Anesthesiology, Emergency Medicine, Pathology, Psychiatry, and Radiology), the chair of the Credentials Committee, and three (3) At-Large Members. A majority of the MEC must be physicians who are actively practicing in the Hospital.

The chair will be the Chief of Staff. The non-voting attendees to the MEC shall consist of the President, Chief Medical Officer (CMO),Chief Nursing Officer (CNO) and the Division Chiefs.

b. Removal from MEC: A Medical Staff Officer, MEC At-Large Member, or Department Officer who is removed from his/her position in accordance with Section 4.7, Section 7.5.1.a and/or Section 5.2 above will automatically lose his/her membership on the MEC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

r. The MEC is empowered to authorize use of Medical Staff funds, for non-budgeted items, up to ten percent (10%) of the Medical Staff budget on an annual basis, without requiring full Medical Staff approval.

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

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

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

7.1.2 The action of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

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

7.2 Regular Meetings of Medical Staff Committees and Departments

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

7.3 Special Meetings of Committees and Departments

A special meeting of any committee, Department, or Division may be called by the committee chair or Chair or of the Department/Division thereof or by the Chief of Staff.

7.4 Quorum

7.4.1 Medical Staff Meetings: Those eligible Medical Staff members present and voting on an issue.

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

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

7.5 Attendance Requirements

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

a. MEC, Credentials Committee, and Peer Review Committee meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held on an annual basis. Failure to meet the attendance requirement will result in replacement on the committee.

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

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

7.6 Participation by the President

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

7.7 Robert's Rules of Order

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

7.8 Notice of Meetings

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

7.9 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

7.10 Rights of Ex Officio Members

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

7.11 Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chief shall authenticate the minutes. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee as composed in the Board bylaws. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

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

8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of Part I of these bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

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

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

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Initiation by MEC. Proposed amendments to these bylaws may be originated by the MEC. When originated by the MEC, the amendment shall be sent to the Bylaws Committee for review and appropriate terminology. The amendment shall then be sent back to the MEC for approval. Once approved by the MEC, the amendment will be sent to the Medical Staff for review and then for vote.

9.2.2 Initiation by the Medical Staff. Proposed amendments to these bylaws may be originated by a petition signed by thirty percent (30%) of the Members of the Active category.

9.2.2 Approval Process. Each Active member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the Medical Staff shall receive at least two (2) weeks advance notice of the proposed changes. The amendment shall be considered approved by the Medical Staff: if the Medical Staff receives a simple majority of the votes cast by those members eligible to vote.

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

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

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

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

9.3.3 In addition to the process described in 9.3.2 above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by thirty percent (30%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

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

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

9.3.6 The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations.

Ascension Providence Rochester Hospital

MEDICAL STAFF BYLAWS

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

Table of Contents

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

1.1 Criteria for Initiation

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

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

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

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

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

Section 2. Investigations

2.1 Initiation

2.1.1 Whenever the MEC receives information that a Practitioner's activities or professional conduct may not adhere or comport with the standards or aims set forth in the Bylaws, or with any Hospital rule, regulations, policies, or professional standards, the MEC may consider whether corrective action is appropriate in accordance with the Medical Staff Accountability Policy.

2.1.2 A request for an investigation must be submitted in writing by a Medical Staff officer, Medical Staff committee chair, Department Chief, President, CMO, or hospital Board chair to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons and notify the practitioner.

2.2 Investigation

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

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

If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals and to interview any witnesses, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the President/CMO. The investigating body may also require, with the approval of the Chief of Staff and the President/CMO, the practitioner under review to undergo a physical and/or mental fitness-for-duty examination and may access the results of such examination(s). The investigating body shall notify the practitioner in question of the allegations that form the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including but not limited to suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

a. Litigation seems likely;

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

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

d. A conflict arises or seems likely as in matters involving a member of the MEC or a member of the Board where other reasonably perceived conflicts of interest may arise, which may taint the MEC's investigations into the practitioner.

2.3 MEC Action

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

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

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

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

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

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

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

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

h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

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

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

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

3.1.1 **Licensure**

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

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

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

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

3.1.3 **Controlled Substances**

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

b. **Probation:** Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical Record Completion Requirements:** A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever s/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

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

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within sixty (60) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.

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

3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.9 **Failure to Participate in Required Testing:** A practitioner who fails to participate in required testing, as noted in Part I, Section 2.6.4, and authorizes release of this information to the MEC, shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.

3.1.10 **Failure to Become Board Certified:** A practitioner who fails to become board certified in compliance with these bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges.

3.1.11 **Failure to Maintain Board Certification:** Except as provided in Part III section 2.4.1 , a practitioner who fails to regain their board certification within one year following a lapse in board certification, will be deemed to have immediately and voluntarily relinquished his or her medical staff appointment and clinical privileges unless an exception is granted, for a good cause, by the Board upon recommendation from the MEC.

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

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

3.2 Summary Restriction or Suspension

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

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the President, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

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

3.2.2 **MEC Action:** As soon as practicable and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the practitioner with notice of its decision.

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

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

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

a. Denial of Medical Staff appointment or reappointment;

b. Revocation of Medical Staff appointment;

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

d. Involuntary reduction or revocation of clinical privileges;

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

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

4.2 Hearings Will Not Be Triggered by the Following Actions

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

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

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

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

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

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

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

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

i. Determination that an application is incomplete or untimely;

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

k. Decision not to expedite an application;

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

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

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

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

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

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

r. Any recommendation voluntarily accepted by the practitioner;

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

t. Change in assigned staff category;

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

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

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

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

4.3 Notice of Recommendation of Adverse Action

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

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

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

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

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

4.4 Request for Hearing

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

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the President shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

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

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

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

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

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

4.6 Witness List

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

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed. This panel will be appointed by the Hospital President, in conjunction with the Chief of Staff. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

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

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

5.2 Hearing Panel Chairperson or Presiding Officer

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

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

5.2.3 The presiding officer (or hearing panel chair) shall do the following:

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

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

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

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

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

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

h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

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

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

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

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

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

b. Reports of experts relied upon by the MEC;

c. Copies of redacted relevant committee minutes;

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

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

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

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

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

6.2 Pre-Hearing Conference

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

6.3 Failure to Appear

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

6.4 Record of Hearing

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

6.5 Rights of the Practitioner and the Hospital

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

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

b. To introduce exhibits;

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

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

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

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

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

6.6 Admissibility of Evidence

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

6.7 Burden of Proof

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

6.8 Post-Hearing Memoranda

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

6.9 Official Notice

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

6.10 Postponements and Extensions

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

6.11 Persons to be Present

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

6.12 Order of Presentation

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

6.13 Basis of Recommendation

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

6.14 Adjournment and Conclusion

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

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

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

Section 7. Appeal to the Hospital Board

7.1 Time for Appeal

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

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

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

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

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

7.3 Time, Place, and Notice

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

7.4 Nature of Appellate Review

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

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

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

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

7.5 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the chairs of the credentials committee and MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current member or a physician or dentist with privileges without membership, that individual may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this hospital unless the Board advises otherwise.

7.7 Fair Hearing and Appeal for Those with Privileges Without Medical Staff Membership and Who are Not Physicians or Dentists

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

Clinical psychologists, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), scrub techs, and registered nurse first assistants (RNFAs) are not entitled to the hearing and appeals procedures set forth in the Medical Staff bylaws. In the event one of these practitioners receives notice of a recommendation by the Medical Executive Committee that will adversely affect his/her exercise of clinical privileges, the practitioner and his/her supervising physician, if applicable, shall have the right to meet personally with two physicians and a peer assigned by the Chief of Staff to discuss the recommendation. The practitioner and the supervising physician must request such a meeting in writing to the President within ten (10) calendar days from the date of receipt of such notice. At the meeting, the practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected practitioner, the MEC and the Board.

The practitioner and the supervising physician may request an appeal in writing to the President within 10 days of receipt of the findings of the review body. Two members of the Board assigned by the chair of the Board shall hear the appeal from the practitioner and the supervising physician. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The practitioner and the supervising physician will be notified within ten (10) calendar days of the final decision of the Board.

Ascension Providence Rochester Hospital

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

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Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Medical Staff credentials committee shall consist of at least ten (10) members of the Active Medical Staff who are experienced leaders that are not Department Chiefs with at least one representative from each of the following departments (Internal Medicine, Family Medicine, Surgery, Obstetrics and Gynecology, Emergency Medicine, Radiology, and Anesthesia). The Chief of Staff will appoint the Chair; the Chair must have been on the Credentials Committee for at least two (2) years or have previous MEC experience. The Chief of Staff will appoint the other members, based on the recommendation of the Department Chief.

Members will be appointed for staggered three (3) year terms. The chair will be appointed for a one (1) year term. The chair and members may be reappointed for additional terms without limit. The committee may also invite members such as representatives from hospital administration and the Board.

1.2 Meetings

The Medical Staff credentials committee shall meet at least four (4) times per year and on call of the chair or Chief of Staff.

1.3 Responsibilities

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

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

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

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

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

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

1.4 Confidentiality

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

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

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

Only upon written request approved by the Chief of Staff, President, credentials chair or Chief Medical Officer (CMO). Review of such files will be conducted in the presence of the Medical Staff service professional, Medical Staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

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

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

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

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

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

2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony, relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence in any jurisdiction, or abuse (physical, sexual, child or elder) within the last seven (7) years;

2.2.5 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or any foreign board acknowledged by the American board, or other board certification organization acceptable to the MEC, and be currently board certified or become board certified within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, or any foreign board acknowledged by the American board;

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

2.2.7 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery, or any foreign board acknowledged by the American board;

2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Foot and Ankle Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;

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

2.2.10 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants or be actively seeking initial certification and obtain the same on the first examination for which eligible and reapplicants.

2.2.11 An anesthesia assistant must have successfully completed a graduate level degree program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or any of the commission's successor organizations, which qualifies the candidate to sit for the National Commission for Certification of Anesthesiologist Assistants (NCCAA) examination. Current certification by the National Commission for the Certification of Anesthesiologist Assistants (NCCAA) as an Anesthesiologist Assistant-Certified (AA-C) is required for initial applicants and reapplicants.

2.2.12 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB), or be actively seeking initial certification and obtain the same on the first examination for which eligible is required for initial applicants and reapplicants.

2.2.13 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body is required for initial applicants or be actively seeking certification and obtain the same on the first examination for which he/she is eligible and reapplicants.

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

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

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

2.2.17 Have appropriate written and verbal communication skills;

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

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

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

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

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

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

2.3.3 Possess a valid NPI number;

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

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

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

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

2.3.8 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.4 Exceptions

2.4.1 All practitioners who are current Medical Staff members and/or hold privileges as of June 16, 2000 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

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

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff office. Upon receipt of the request, the Medical Staff office will provide the applicant an application package, which will include a complete set or overview of the Medical Staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

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

d. All applicable fees;

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

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

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

h. Morbidity and mortality data, when available.

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

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the Medical Staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for Medical Staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the Medical Staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

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

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

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

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

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

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

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

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

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

g. Other information about adverse credentialing and privileging decisions;

h. Two (2) peer recommendations, as selected by the credentials committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges;

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

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

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

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

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

3.2 Applicant's Attestation, Authorization, and Acknowledgement

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

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

3.2.2 Consents to appear for any requested interviews in regard to his/her application.

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

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

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

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

c. Professional and ethical qualifications;

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

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

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

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

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

Notwithstanding section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, s/he shall reimburse the hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

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

a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

b. Has your license to practice or registration in any state ever been relinquished, denied, challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?

c. Have you ever been asked to surrender your professional license?

d. Have you ever been suspended, sanctioned, excluded, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?

e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

f. Has your DEA certificate ever been relinquished, limited, denied, suspended, or revoked?

g. Is your DEA certificate currently being challenged?

h. Have you ever been named as a defendant in any criminal proceedings or been arrested (excluding misdemeanor arrests that did not result in convictions) or charged with a crime?

i. Has your employment, Medical Staff membership, or clinical privileges ever been terminated, reduced, suspended, diminished, revoked, refused, or limited at any hospital, physician group practice or other health care facility, whether voluntarily or involuntarily?

j. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before a hospital's or health facility's Board made a decision?

k. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

l. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?

m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?

n. If you are not currently board certified, please answer i. through iv. below (if board certified skip to (o) below):

    i. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

    ii. If not certified, have you applied for the certification exam?

    iii. Have you ever been accepted to take the certification exam?

    iv. If yes, what dates are you scheduled to take the certification exam?

o. Have any professional liability claims or suits ever been filed against you or are any presently pending?

p. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).

q. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?

r. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?

s. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?

t. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?

u. Have you ever been terminated, resigned or non-renewed from any healthcare employment or from a group practice?

3.3 Application Evaluation

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

Type 1: A completed application that does not raise concerns as identified in the criteria for Type 2. Applicants in Type 1 will be granted Medical Staff membership and/or privileges after review and action by the following: Department Chief, credentials chair acting on behalf of the credentials committee, the MEC and a Board committee consisting of at least two individuals.

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

a. The application is deemed to be incomplete;

b. The final recommendation of the MEC is adverse or with limitation;

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

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

e. Applicant has had two (2) or more malpractice cases filed within the past five (5) years, an unusual pattern of malpractice cases, or one final adverse judgment or settlement in a professional liability action in excess of $150,000;

f. Applicant changed medical schools or residency programs or has unverifiable or unexplained gaps in training or practice;

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

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

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

j. Applicant has an adverse National Practitioner Data Bank report related to behavior;

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

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

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

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

3.3.2 Applicant Interview

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

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview within forty-five (45) days of completion of his or her application will be deemed a withdrawal of the application.

3.3.3 Department Chief Action

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

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

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

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

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

iv. Comments to support these recommendations.

3.3.4 Medical Staff Credentials Committee Action

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

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

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

c. Comments to support these recommendations.

3.3.5 MEC Action

If the application is designated Type 1, it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing, as noted in Part I, Section 7.4.2. The Chief of Staff has the opportunity to determine whether the application is forwarded as a Type 1, or may change the designation to a Type 2. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

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

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

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

d. Comments to support these recommendations.

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

3.3.6 Board Action:

The Board reviews the application and votes for one of the following actions:

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

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

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

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

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

3.3.7 **Notice of Final Decision:** Notice of the Board's final decision shall be given, through the President to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which s/he is assigned, the clinical privileges s/he may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

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

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

Section 4. Reappointment

4.1 Criteria for Reappointment

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

4.2 Information Collection and Verification

4.2.1 **From appointee:** On or before six (6) months prior to the date of expiration of a Medical Staff appointment or grant of privileges, a representative from the Medical Staff office notifies the practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least five (5) months prior to this date the practitioner must return the following to the Medical Staff office:

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

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

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

d. Each medical staff applicant and members has an ongoing duty to immediately report (within 30 business days) to Chief Medical Officer relevant facts and documents: regarding the institution of disciplinary proceedings or taking of action by any health facility (including HMOs), professional society or licensing authority of any state or nation; fine, limitation, suspension, revocation or resignation of clinical privileges at any health facility; censure, reprimand, suspension, restriction, probation or limitation of professional licensure by the licensing authority of any state or nation; or censure of any kind by any professional organization. Failure to inform the Chief Medical Officer shall result in an immediate administrative suspension pending further review the CMO and the MEC.

4.2.2 From internal and/or external sources: The Medical Staff office collects and verifies information regarding each practitioner's professional and collegial activities to include those items listed in Section 3.2.8, items a. to y.

4.2.3 The following information is also collected and verified:

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

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

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

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

e. Timely and accurate completion of medical records;

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

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

h. Verification of current licensure;

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

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

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

4.2.4 Failure, without good cause, to provide any requested information, at least ninety (90) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the Medical Staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

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

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

Section 5. Clinical Privileges

5.1 Exercise of Privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be Clinical Psychologists, Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), physicians serving short locum tenens positions, telemedicine practioners, or house staff such as fellows moonlighting in the hospital, or Non-Physician Practitioner (NPP)s (Non-Physician Practitioner (NPP)) such as registered nurse first assistants (RNFAs) or scrub techs who perform a surgical level of care, or others deemed appropriate by the MEC and Board.

5.2 Requests

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

5.3 Basis for Privileges Determination

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

5.3.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:

a. Review the community, patient, and hospital need for the privilege and reach agreement with management and the Board that the privilege is approved to be exercised at the hospital;

b. Review with members of the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);

c. Meet with management to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information, and staffing plans; and

d. Work with management to ensure that any/all exclusive contract issues, if applicable are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee and appropriate Department or subject matter experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

i. For the development of criteria, the Medical Staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate. The requesting practitioner may be requested to provide a full briefing concerning the new technique or procedure including names of other hospitals in which it is used, any peer-reviewed research, any product literature or educational syllabus and the names of any residency or other training directors responsible for providing training in this area;

ii. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director; and

iii. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the credentials committee who has no vested interest in the issue.

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

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

5.4 Special Conditions for Dental Privileges

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

5.5 Special Conditions for Podiatric Privileges

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

5.6 Special Conditions for Practitioners Eligible for Privileges Without Membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for Medical Staff membership, with the exception that such individuals are not eligible for membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Clinical psychologists can exercise their independent judgment only within the areas of their professional judgment when privileges are granted. Advance Practice Professionals (Non-Physician Practitioner (NPP)) such as Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. Non-Physician Practitioner (NPP)s (Non-Physician Practitioner (NPP)) such as scrub techs and Registered Nurse First Assistants (RNFAs) in this category may not exercise independent judgment and work under the direct supervision of a physician who has been accorded privileges to provide such care. The privileges of these Non-Physician Practitioner (NPP) and Non-Physician Practitioner (NPP) shall terminate immediately, without right to due process, in the event that the employment of the APP or AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP or AHP with a physician member of the Medical Staff organization is terminated for any reason.

5.7 Special Conditions for Residents or Fellows in Training

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

5.7.2 The CMO must communicate periodically with the MEC and the Board about the performance of residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.8 Telemedicine Privileges

Applicants seeking clinical privileges to perform solely telemedicine services may but need not. be processed pursuant to the complete privileging procedures described in Part Ill, Section 3 above. Alternatively, in the case of applicants who intend to provide such telemedicine services under a written agreement between the hospital and a distant-site hospital or telemedicine entity. the recommendations of the Department Chair. Medical Staff Credentials Committee. and MEC to approve, modify, or deny the applicant's request for privileges pursuant to Section 3 may be made in reliance upon the privileging decisions of the distant-site hospital or telemedicine entity with whom the Hospital has a written agreement for telemedicine services.

Upon confirmation that an applicant's request for telemedicine privileges complies with the terms of the written agreement between the Hospital and the distant-site hospital or telemedicine entity. including clinical privileges criteria adopted by the Medical Staff. the privileging decisions made by a distant-site hospital or telemedicine entity may be relied upon when the Department Chair, Medical Staff Credentials Committee and MEC make their respective recommendations for approval, modification, or denial of clinical privileges pursuant to Section 3, provided that a written agreement between the Hospital and distant-site hospital or telemedicine entity ensures the following:

5.8. The distant-site hospital is a Medicare participating hospital or the distant-site telemedicine entity provides written assurances that its credentialing and privileging process and standards meet the Medicare Conditions of Participation for Hospitals:

5.8.2 The distant-site hospital or distant-site telemedicine entity, as applicable. meets all other pertinent accreditation requirements to which the hospital may be subject:

5.8.3 The practitioner is privileged at the distant-site hospital or distant-site telemedicine entity and a current list of equivalent privileges is provided:

5.8.4 The distant-site practitioner holds a current license issued or recognized by the State of Michigan:

5.8.5 The practitioner meets the professional liability insurance requirements established by the hospital: and

5.8.6 That upon being granted clinical privileges. the hospital provides the distant-site hospital or telemedicine entity evidence of an internal review of the practitioner's clinical performance for use in the practioners periodic appraisal and at a minimum, the information must include all adverse events resulting from the telemedicine services provided by the distant-site practitioner as well as the registered complaint.

5.9 Temporary Privileges

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

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

5.9.2 Clean Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include 1) complete application 2) fully verified application, 3) positive recommendation from the Department Chief, and 4) positive recommendation from the Credentials Committee. Additionally, the application must meet the criteria for Type 1, expedited credentialing consideration as noted in section 3 of this manual.

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

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

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

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

5.11 Disaster Privileges:

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

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

b. A current license to practice;

c. Primary source verification of the license;

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

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

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

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

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

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

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

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

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

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

- FPPE 1 – Initial evaluation and appointment.
- FPPE 2 – Event triggered evaluation.

6.2 Ongoing Professional Practice Evaluation (OPPE)

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

6.3 Physician Re-Entry

A practitioner who has not provided acute inpatient care within the past two (2) years who requests clinical privileges at the hospital must complete a formal process to assess and confirm clinical competence as determined by the Department Chief and Credentials Committee.

If a practitioner has not provided any clinical care within the past five (5) years as determined by the Michigan medical licensing board or the MEC, is required to complete a formal re-entry process through an ACGME or AOA accredited residency program. The practitioner must assume responsibility for any financial costs required to fulfill these requirements. If additional formal training is required, a description of the preceptorship or training program, including details of monitoring and consultation must be written and submitted for approval to the Department Chief and credentials committee and MEC. At a minimum, the preceptorship or training program description must include the following:

a. The scope and intensity of the required activities;

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

6.4 Low/No Volume Practitioners

For low/no volume practitioners who do not utilize APRH with sufficient frequency to allow for an adequate evaluation of current clinical competence, the practitioner will be responsible for providing alternative information for review that will allow an informed decision about the practitioner's current competence. This may include information from their primary hospital where they have significant volume relating to their privileges, similar data from a managed care plan, and/or an evaluation from a chief of service and/or peer references specific to the privileges being exercised at APRH.

The appropriate Peer Review or Credentialing Committee will make a recommendation to the Medical Executive Committee (MEC) regarding whether the low volume/no volume information provided is adequate to establish current competence.

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

7.1 Reapplication After Adverse Credentials Decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the Medical Staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for Modification of Appointment Status or Privileges

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

7.3 Resignation of Staff Appointment or Privileges

A practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chief or Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of Administrative Remedies

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

7.5 Reporting Requirements

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

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than ninety (90) days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. Under such circumstances, the President/CMO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the Chief of Staff stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

8.2 Termination of Leave

At least forty-five (45) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

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

Section 9. Practitioners Providing Contracted Services

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

9.2 Exclusivity policy

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

9.3 Qualifications

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

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

9.5 Effect of Contract or Employment Expiration or Termination

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

Section 10. Medical Administrative Officers

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

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

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

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

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

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

Ascension Providence Rochester Hospital

MEDICAL STAFF RULES AND REGULATIONS

Organization and Functions Manual

Table of Contents

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The Medical Staff shall be organized as a departmentalized staff including the following departments: Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, and Surgery. A Department Chief shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.1.1. Divisions within a department may be formed with the approval of the parent department. Divisions may elect a division chief at their discretion. Meetings are held informally, and attendance is not required. Division recommendations or concerns should be forwarded to the parent department for resolution.

1.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, Department Chief, hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

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

1.3.1 Governance, direction, coordination, and action

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

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

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

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

e. Inform the Medical Staff of the accreditation and state licensure status of the hospital;

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

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

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

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

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

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

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

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

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

i. Medical assessment and treatment of patients

ii. Use of medications

iii. Use of blood and blood components

iv. Operative and other procedures

v. Education of patients and families

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

vii. Appropriateness of clinical practice patterns

viii. Significant departures from established pattern of clinical performance

ix. Use of developed criteria for autopsies

x. Sentinel event data

xi. Patient safety data

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

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

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

1.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the Medical Staff's and administration's approach to and methods of performance improvement;

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

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

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

1.3.4 Credentials Review (see Part III: Credentials Procedures Manual)

1.3.5 Information Management

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

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

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

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

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

1.3.6 Emergency Preparedness

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

1.3.7 Strategic Planning

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

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

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

1.3.8 Bylaws Review

a. Conduct periodic review of the Medical Staff bylaw, rules, regulations, and policies; and

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

1.3.9 Nominating

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

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

1.3.10 Infection Prevention and Control Oversight

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

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

i. Review of cumulative microbiology recurrence and sensitivity reports;

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

iii. Collection of additional data as needed.

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

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

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

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

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

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

1.3.11 Pharmacy and Therapeutics Functions

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

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

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

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by The Joint Commission;

f. Perform practitioner analysis related to medication use;

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

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

   i. Prescribing/ordering of medications;

   ii. Preparing and dispensing of medications;

   iii. Administrating medications; and

   iv. Monitoring of the effects of medication.

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

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

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

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

1.3.12 Practitioner Health

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

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

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

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

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

1.3.13 Utilization Management Functions

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

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

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

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

e. Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff Quality Committee for their review and action;

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

g. Develop a utilization management plan for approval by the Board;

h. These functions shall be accomplished by the utilization management committee consisting of at least two (2) physician members of the Medical Staff.

Section 2. Medical Staff Committees

2.1 General Language Governing Committees

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

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

Medical Staff members may be appointed to hospital committees. The following hospital committees shall be chaired by an Active Member of the Medical Staff: Intensive Care, Pharmacy and Therapeutics, Surgical Services, and the Joint Quality Care Committee. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

2.2 Medical Executive Committee

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

2.3 Credentials Committee

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

2.4 Medical Quality Care

2.4.1 **Composition:** The composition of this committee is noted in the committee charter.

2.4.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.2 a-d above.

2.5 Department Review Committee

2.5.1 **Composition:** The Department Vice Chief shall chair this committee which shall consist of at least two (2) Members of the Department.

2.5.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.2 a-d above.

2.6 Bylaws Committee

2.6.1 **Composition:** The bylaws committee shall consist of at least four (4) Members of the Active staff, and one (1) representative from Administration, who shall be an ex-officio member.

2.6.2 **Responsibilities:** The committee shall be responsible for those functions described in section 1.3.8 above.

2.7 Practitioner Wellness and Oversight Committee

2.7.1 **Composition:** The Practitioner Wellness and Oversight Committee is an ad hoc committee and shall consist of the at least two (2) Members to serve on this committee.

2.7.2 **Responsibilities:** This committee shall be responsible for those functions described in section 1.3.12 above.

2.8 Nominating Committee

2.8.1 **Composition:** The Nominating Committee shall consist of six (6) Active Members consisting of at least one Member each from the departments of Medicine, Family Medicine, Surgery, and Obstetrics and Gynecology and one member from ancillary contracted services collectively (Radiology, Emergency Medicine, Anesthesia, and Pathology). The Nominating Committee shall be recommended by the Chief of Staff and appointed by the MEC.

2.8.2 **Responsibilities:** The committee shall provide a slate of nominees for the elected Medical Staff positions at least thirty (30) days prior to the election.

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

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

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

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

3.2 Immunity from Liability

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

3.3 Covered Activities

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

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

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

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

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

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

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

3.4 Releases

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

3.5 Conflict of Interest

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

Section 4. General Rules and Regulations

On recommendation of the Medical Executive Committee, the Medical Staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. They may be amended by a two-thirds majority of the members of the active voting staff as outlined in Article X. Such rules and regulations and any amendments shall be considered as part of these bylaws and shall become effective when approved by the Board of Trustees.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, the Ethical and Religious Directives for Catholic Health Care Services, adherence to the Code of Ethics as prescribed by his/her profession, and Case Management/utilization standards in effect in the Hospital.

4.1 Admission and Discharge of Patients

A. The Hospital shall accept patients for care and treatment. Only a member of the medical staff may admit them to the Hospital. All practitioners shall be governed by the official admitting policies of the Hospital and the Department concerned.
B. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the timeliness, completeness and accuracy of the medical record, for communicating special instructions to other members of the healthcare team, and for transmitting reports of the condition of the patient to the referring practitioner and to the patient and/or appropriate patient family member/surrogate. Whenever these responsibilities are formally transferred to another staff member, an order indicating the transfer must be entered onto the order sheet in the patient's medical record and a transfer note should be entered into the progress note detailing the acceptance of the transfer. Direct verbal communication should occur between the transferring and receiving physician to allow the receiving physician to ask pertinent questions regarding the assessment and plans. For informal or temporary transfer of care (e.g., weekends/vacation coverage) verbal communication should occur regarding each patient being covered. As the electronic medical record (EMR) provides the physician with the necessary objective information regarding each patient's care, the communication for the transfer should focus on the current assessment and plan for each patient. All formal transfers of responsibility shall be subject to the approval of the patient (or a parent or court appointed guardian as appropriate) and the accepting physician. (7/16/2007)
C. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
D. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.
E. Practitioners admitting emergency cases shall be prepared to justify to the appropriate review committees of the medical staff that the said emergency admission was a bona fide

emergency. The history and physical examination must clearly justify the patient's emergency admission. The findings must be recorded on the patient's chart as soon as possible after admission.

F. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend to him, with the concurrence of that practitioner. Where no such selection is made, a member of the staff on call in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairperson of each department shall provide a schedule for such assignments.

G. Covering Physicians
   1. It is the responsibility of each member of the medical staff to have a specific physician covering him anytime he is not available. Failure to provide this coverage may result in suspension.
   2. Covering physicians are defined as physicians in the same specialty or holding the same clinical privileges as the staff member. In the event that a covering physician is not available, the Chief of the Department/Division/Section shall have the authority to call any member of the active staff in such an event.
   3. Physicians should discuss potential coverage issues with covering physicians to ensure covering physicians understand scope of practice and pertinent clinical situations. Covering physician assumes responsibilities of the absent physician and are required to be a physician of the same specialty or holding the same clinical privileges as the staff member.

H. The admitting clerk will admit patients on the basis of the following order of priorities. Priority within each category will be determined by chronological sequence as recorded by the chief admitting clerk except where department priority rules apply:
   1. Emergency admissions – calling for immediate action where life, limb or bodily function is endangered.
   2. Scheduled surgical admissions
   3. Urgent admissions – pressing need requiring prompt attention
   4. Other elective admissions

I. Patient Transfers - Transfer priorities to a general care area shall be as follows:
   1. Emergency room to appropriate patient bed
   2. From intensive care unit to intermediate intensive care unit or general care area
   3. From cardiac care unit to intermediate coronary care unit or general care area
   4. From temporary placement to the appropriate clinical service area for that patient
   5. From obstetric patient care area (unit) to general care area, when medically indicated

J. The admitting practitioner shall be responsible for initiating such action as may be necessary to protect the patient from self-harm and to protect others whenever a patient might be a source of danger from any cause whatever.

K. For the protection of patients, the medical and hospital staffs and the Hospital, any patient known to be suicidal or homicidal shall be cared for and safeguarded in accordance with appropriate suicidal-homicidal precautions adopted by the medical staff.

L. Admissions to Intensive and Cardiac Care Units: Determination of the priority shall be the responsibility of the chairmen of the respective unit committees or the appropriately designated physician members of the committees in accordance with the current committee rules and regulations, criteria and policies. Admitting to and discharging from the units is the responsibility of the attending physician.

M. Upon request of the Utilization Review Committee, and in accordance with its rules and regulations, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient including an estimate of the number of additional

days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

N. Patients shall be discharged only on a written order of the attending practitioner or his designee. On day of discharge, patients may be discharged by a resident or Non-Physician Practitioner (NPP) after communication with the attending physician that the patient's discharge plan is complete. Should a patient leave the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

O. In the event of a hospital death, the deceased shall be pronounced dead by a licensed physician within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Policies with respect to release of dead bodies shall conform to local law. Policies with respect to release of dead bodies shall be posted in proper departments and approved by legal counsel.

P. Autopsies: It shall be the duty of all staff members to secure meaningful autopsies on deceased inpatients per criteria established by the Medical Staff whenever possible. An autopsy may be performed only with a written consent, signed in accordance with State law and approved and signed by a designated member of the administrative staff or, in the absence of the designated administrative staff member, approved and signed by the nursing supervisor on duty. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. All physicians attending the deceased shall be notified by the Chief of Pathology of the time of the autopsy. Provisional anatomic diagnoses shall be available within 24 hours. The complete autopsy report shall be made part of the patient record within sixty (60) days.

Q. All physicians shall cooperate fully in the area of Organ Procurement Organization (OPO) regarding reporting of imminent deaths, identification of potential organ, tissue and eye donors, requesting and obtaining appropriate consent to organ, tissue and eye donation, and performance of proper procurement and transportation techniques of donated organs, tissues, and eyes.

R. A Consent Agreement approved by Hospital administration shall be signed by the patient (or his representative) before admission to the Hospital.

4.2 Consultations

A. All physicians participating in ER call schedules, as defined by the departments, must respond to requests for assistance from the ER for purposes of consultation or primary treatment responsibilities (i.e. physician of record). Physician on call for the ER may also be asked to respond to in-house needs (urgent consultations, etc.) if necessary to provide timely rendering of care. Physicians on call for the ER must provide services irrespective of a patient's insurance or ability to pay. After appropriate clinical stabilization, physician on call for the ER may arrange for appropriate transfer of patient.

B. The attending practitioner is primarily responsible for requesting a consultation when indicated, and subject to the approval of the patient, a parent, or court-appointed representative, for calling in a qualified consultant.

C. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise as follows:
   1. Routine consultations must be performed within 24 hours of request

2. Patients under Observation status must have consultations initiated within 12 hours of physician notification
3. Physicians providing consultation services must respond to a request for an emergency consult if requested by a member of the medical staff and no other consulting staff is available.
4. Physician requesting emergency consultations must communicate directly with requested consultant.

D. Physician must respond to a chief of service request to provide consulting services in urgent or unusual situations. In such circumstances, the consulting physician may arrange for transfer of care after the patient is stabilized and may request that the action be reviewed by the Medical Executive Committee at a later date.

E. If an evaluation/consultation is performed by an Allied Health Practitioner under physician supervision, direct contact with the patient by the physician is required as identified in C-1.

F. Consultations do permit, but do not require or imply treatment or subsequent care of the patient. If the consultant is to assume the entire management of the case, the attending physician shall transfer the patient to him by a written order on the medical record. All transfers of responsibility shall be subject to the approval of the patient, a parent, or court-appointed representative and the accepting physician.

G. Consultations to the pain/palliative Care Service will be responded to by the hospital's Pain/Palliative Care Service nurse practitioner. If, after initial visit and verbal consultation with a covering pain physician, the patient's pain issues are resolved, the nurse practitioner will conclude the consultation. If the situation is not resolved by the next day, or, if the patient is determined to need a procedure, the patient will be seen the pain physician that day.

4.3 General Conduct of Care

A. Every patient admitted to the Hospital shall be informed by his physician, dentist, oral surgeon or podiatrist, with supportive documentation to be made a part of the patient's medical record, of the reason(s) for admission, the explanation of the procedure(s) or test(s) to be performed, the consequences or inherent risks involved, the alternative to treatment and alternative treatments. Where appropriate, the parent(s), legal guardian or patient's representative will be so informed.

B. Every patient shall be visited daily (except for day of discharge).

C. Every patient shall be informed by his physician, dentist, oral surgeon, or podiatrist with documentation in the medical record when appropriate, the outcome and results of any treatment or procedure when the outcome differs significantly from the anticipated outcome as described above

D. All orders shall be documented. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence. Only "licensed" personnel may be authorized to accept verbal medication orders. All verbal orders shall be dated, timed and signed by the appropriately authorized person to whom the order was dictated and with the name of the practitioner giving the order, and by the practitioner, or a partner or physician covering for the practitioner, who may sign the order following the statement agreement. The responsible practitioner shall authenticate such orders at the time of the next visit. Only "licensed" personnel, e.g. house staff, licensed registered nurses and pharmacists may be authorized to accept verbal medication orders.

E. The practitioner's orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.
F. Any practitioner receiving a critical value or test result is required to read back the results to ensure accurate verbal transfer of information. Critical values are those test results that may require rapid clinical attention to avert significant patient morbidity. Critical tests are identified when the physician/designee writes in the orders, "stat, call with results" or when physician/designee identifies this as a critical test.
G. All previous orders are suspended when patients go to surgery. For patients who have limitation of care orders (DNR, etc.), a full discussion occurs which identifies patient wishes, concerns and potential alternative orders. The results of the discussion is documented.
H. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Drug 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 regulations of the F.D.A. and the American Hospital Association.
I. All drugs and medications shall be administered according to the rules and regulations of the Pharmacy and Therapeutics Committee.
J. If a nurse or house physician has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the matter shall be called to the attention of that person's superior, who may in turn refer the matter to the Vice President of Nursing or Administration as appropriate. The Vice President of Nursing or Administration may bring the matter to the attention of the Chief of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chief of the department may himself request a consultation.
K. Restraints will only be used in accordance with general Hospital policy, if the attending physician deems restraints are necessary for the protection of patients or others.
L. Investigational or new drugs or devices shall only be used by a physician in accordance with an approved research protocol under the jurisdiction of the Institutional Review Board. Any physician involved in clinical research shall immediately report any adverse patient response to the Institutional Review Board, and where indicated in the research protocol or clinical trial agreement, to the Food and Drug Administration or the Department of Health and Human Services.
M. Medical students, residents or other classes of training individuals are not permitted to participate in the care of the patient unless a specific operating agreement with their training programs exist, and such agreement specifies the services to be provided by the resident and the expected level of supervision. All other trainees may be present in an observation status only and always with the informed consent of the patient.
N. Physicians, in general, should delegate the medical and surgical care of themselves, their immediate families and others with whom they have a significant emotional relationship to one or more of their colleagues in order to ensure that appropriate and objective care is provided. (Board approved 4/17/02)

4.4 General Rules Regarding Surgical Care

A. Except in severe emergencies, the preoperative diagnosis, appropriate history and physical and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the

practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

B. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or court-appointed representative, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is taken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.
C. Universal Protocol is to be followed in all settings where procedures, surgical or invasive are performed. Universal protocol consists of verifying the correct person, correct site, and correct procedure as part of a pre-operative/pre-procedure verification process. Marking of the operative/procedure site is required to be completed by the physician privileged to perform the procedure. A time-out must be performed prior to anesthesia and immediately before starting the procedure. Refer to CHMC Universal Protocol Policy for detailed procedures.
D. The anesthesiologist shall be responsible for complete anesthesia records to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
E. In any case requiring an assistant, the assistant shall be qualified and shall not be the referring physician. The choice of the physicians to perform any procedure, including assistants, is subject to the approval of the patient, a parent, or a court-appointed representative.
F. All specimens removed at the operation shall be sent to the Hospital pathologist in accordance with the Disposition of Surgical Specimens policy.

4.5 Emergency Services

A. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's medical records. The record shall include:
    1. Adequate patient identification;
    2. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
    3. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;
    4. Description of significant clinical, laboratory and roentgenologic findings;
    5. Diagnosis;
    6. Treatment given;
    7. Condition of the patient on discharge or transfer; and
    8. Final disposition, including instruction given to patient and/or his family, relative to necessary follow-up care.
B. Each patient's medical record shall be dated, timed and signed by the practitioner in attendance that is responsible for its clinical accuracy.

4.6 Medical Records

A. The attending practitioner shall be responsible for the preparation of medical record for each patient. All medical records All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by a member of the medical staff responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Its contents shall be pertinent and current. All medical records must be complete within seven (7) days after being made available to the physician. This completed record shall include identification data; appropriate histories and physicals, special reports such as consultations, clinical laboratory and radiology services and others; provisional diagnosis, medical or surgical treatments; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed. Note: All references in these Bylaws to written or recorded documentation may be done electronically through the EMR.

B. History and Physicals:
   1. The timeframe for completion of the history and physical examination and any update, if needed, as well as who may complete the history and physical is noted in the Bylaws in Part I, Section 2.6.8. The updated H&P must include:
      a. Address the patient's current status or any changes in the patient's status. If there are no changes in the patient's status, this should be specifically noted. The minimal required elements are:
         1. Reason of admission or procedure with description
         2. Past medical history
         3. Pertinent social, family and system review
         4. Relevant physical findings
         5. Medical decision making
         6. Allergies
         7. Medications
      b. Include an appropriate physical examination of the patient to update any components of the exam that may have changes since the prior H&P, or to address an area where more current data is needed.
      c. Confirm that the necessity for the admission, procedure or care is still present
      d. Be written or otherwise recorded on, or attached to, the previous H&P, or written in a progress note or consult note
      e. Be placed in the patient's medical record prior to the procedure or within 24 hours of admission.
   2. If an H&P is required for an outpatient invasive procedure, an appropriate H&P must be documented in accordance with (1-a) prior to initiation of the procedure.
   3. When a required history and physical examination is not recorded before an operation or any potentially high-risk diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.
   4. The department involved will define content and extent of history and physical and for which procedures a history and physical are required.
   5. For patients admitted through the Emergency Department, the ER admission note may serve as basis for clinical treatment until a formal H&P is recorded in the chart.

C. Progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on all patients and shall be

dated, timed and authenticated by a member of the medical staff. Any note written by an Allied Health Practitioner must be co-signed within 24 hours.

D. Operative and procedure reports shall include a detailed account of the findings and/or procedure as well as the details of the procedural technique. Operative and procedure reports shall be written and dictated immediately following the procedure for outpatients as well as inpatients and the report promptly signed by the physician and made a part of the patient's current medical record. Other procedures not performed in surgical or procedural suites shall be written and/or dictated immediately.
E. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.
F. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
G. The Medical Record Committee will define what verbal orders can be accepted.
H. Symbols and abbreviations may be used only when the medical staff has approved them. An official record of approved abbreviations should be kept on file in the record room.
I. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated, timed and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
J. A discharge summary shall be written or dictated within 72 hours for all bedded patients and all patients leaving AMA. The Medical Executive Committee of the Medical Staff shall identify these latter exceptions, and for these, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The responsible practitioner shall authenticate all summaries.
K. Written consent of the patient or legally responsible person is required for release of medical information to persons not otherwise authorized to receive this information.
L. Records may be removed from the Hospital'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 taken away without permission of the President of the Hospital. In case of readmission of the patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff. Release of information will be governed by Hospital administrative policy.
M. Free access to all medical records of all patients shall be afforded to all members of the medicals staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Medical Executive Committee of the Medical Staff shall approve all such projects not vetted trhough the Hospital IRB process before the records can be studied. Subject to the discretion of the President of the Hospital, 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. Other than the attending physician, no member of the medical staff, other than the Chief of Staff, Chief of Departments or Sections or persons

designated by them, or a member of a committee charged with the responsibility, should have authority to review a patient's medical record.

N. A medical record shall not be permanently filed until it is completed by the attending or covering medical staff member or is ordered filed by the Chairman of the Medical Record Committee.
O. A record may be filed incomplete by the Chairman of the Medical Record Committee if a medical staff member becomes incapacitated, deceased or has moved from the community.
P. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.
Q. The patient's medical record shall be complete at time of discharge, including progress notes, final diagnosis and discharge summary. Where this is not possible, the patient's chart will be available in a stated place in the medical record room after discharge.
R. Delinquencies: Patient's medical records must be completed within seven (7) days after being available to the physician for completion in accordance with Medical Record policies. The medical records department shall notify any physician who has incomplete records after this interval by phone call and fax that his privileges to admit patients shall be suspended from the date specified. Physicians will be permitted to see currently hospitalized patients and may perform surgeries previously boarded. Admitting privileges will be immediately reinstated upon completion of records. Staff members with consistent delinquencies will be handled on a case-by-case basis and may lead to suspension of clinical privileges/loss of medical staff membership.
S. Providers who fail to respond to Peer Review Committees / Professional Analysis Committee (PAC) requests for information after 3 validated notifications will receive a letter inviting them to the MEC to address the peer review concerns. Failure to appear before the MEC may result in revocation of privileges which is reportable to the NPDB (National Practitioner Databank).

Any suspension will be reviewed by the Chief of Staff and the President of the Hospital or his designee and presented to the Medical Executive Committee for review. The MEC may then decide to report the suspension of the privileges to the NPDB (National Practitioner Databank).

4.7 Medical Staff Dues

Members of the medical staff shall pay such dues and assessments as are determined by the Medical Executive Committee and approved by the Medical Staff. A specific portion of the dues approved by the Medical Executive Committee shall be placed in the library fund. The first dues notice is mailed prior to December 30. Annual dues of $500 must be paid by January 31. A $50 late fee will be assessed for each month dues are not paid. If a staff member has not paid their annual dues by March 31, their name will be submitted to the Medical Executive Committee and will be considered a voluntary resignation of staff membership and clinical privileges.

4.8 Miscellaneous

A. Solicitation of funds from members of the Medical Staff for any purpose by any member of the Medical Staff shall receive prior approval of the Medical Executive Committee and the President of the Hospital.
B. Grants from outside vendors will be accepted if designated for educational programs only.
C. News releases of the Medical Staff will conform to the applicable principles of medical ethics of component local and national professional societies and, if related to Hospital activity, will receive prior approval of the Chief of Staff and the President of the Hospital.

4.9 Graduate Medical Education Program Rules and Regulations

A. All residents participating in any Accreditation Council on Graduate Medical Education (ACGME) or AOA accredited residency program who performs clinical services at Ascension Providence Rochester Hospital will do so under the direction of a licensed independent practitioner who is a member of this medical staff and holds appropriate clinical privileges consistent with the services provided by the resident. The level of supervision varies as a function of the resident's documented competency and diminishes as the resident progresses through their training. The specifics of the supervision requirements are outlined in the affiliation contract and/or the policies and procedures of the sponsoring institution and are subject to review by this medical staff through its Medical Executive Committee.
B. Descriptions of the roles, responsibilities and patient care activities of the residents are described in the GMEC Policy and Procedure Manual and in the detail specifics of the individual Program Information Form (PIF). The policies define the mechanisms for progression of each resident's involvement and independence in specific care activities.
C. Clinical documentation provided by a resident (e.g., H&Ps, progress notes, discharge summaries, procedure notes, etc.) must be countersigned by the supervising attending, if the note is to fulfill the attending physician's obligation for clinical documentation as per the rules and regulations of this medical staff.
D. The attending should also provide documentation that critical components of the care were rendered by the attending if the physician intends to bill for that service.
E. If an attending chooses to provide their own documentation, then counter signature is not necessary.
F. Orders may be initiated by residents without co-signature. Exceptions to this are as follows:
    1. All chemotherapeutics orders must be countersigned by the attending prior to initiation.
    2. All orders for limitation of care must be countersigned by a physician prior to initiation.
    3. All documentation of brain death criteria must be countersigned prior to recognition by this institution.
    4. Residents may document verbal orders upon the request of the physician. Residents documenting verbal orders must follow the same policies and procedures for verbal orders, i.e., read-back procedures, as required by the institution.
G. A representative from a sponsoring institution will be asked to provide an annual update to the Medical Executive Committee and the governing body of this institution, or more frequently if so requested. Such reports should:
    1. Provide information about the safety and quality of patient care rendered by the participants in this training program.
    2. Describe the overall scope of the services and the supervising activities provided to the participants.

3. Provide information about and the results of reviews by applicable residency review committees, especially noting any citations/deficiencies and the actions taken to resolve noted deficiencies.

H. The Medical Executive Committee may request the presence of a Program Director at any meeting to provide further information regarding an activity, a program or a resident.

Board approved: December 11, 2017

Board Approved 09/09/2019

- Changed Name from Crittenton Hospital to Ascension Providence Rochester Hospital
- Added Telemedicine Part I; Section 1.3 Addition of a definition for telemedicine
- Part III: Section 5.1 Change from "telemedicine physicians" to "telemedicine practitioners" so as not to limit the option of priviledging a non-physician for telemedicine services
- Part III: Section 5:8 Addition of delegated credentialing verbiage. Added Sections 5:8 1 thru 5:8.

Board approved 12/14/2020 Part I Governanace, 2.4 Conditions and Duration of Appointment:

- A 60-day extenstion may be granted for completion of the reappointment proess if: (1) A national or state emergency has officaially been declared. "or" (2) Ascension Providence Rochester Hospital has activated its emergency management plan.

Board approved 7/19/2021 Medical Staff Bylaws – Five (5) additions to include:

- Medical Staff Bylaws Part III: Credentials Procedures Manual, Section 2: Qualifications for Membership and/or Privileges, 2.2.5 added language: or other board certification organization acceptable to the MEC
- Medical Staff Rules and Regulations, Section 4: General Rules and Regulations; Medical Records 4.6, B - H&P's, #1 "a." The minimal required elements are: Reason of admission or procedure with description, Past medical history, Pertinent social, family and system review, Relevant physical findings, Medical decision making, Allergies, and Medications
- Medical Staff Rules and Regulations, Organization and Functions Manual, Section 4: General Rules and Regulations; Medical Records 4.6, Add to "R" Delinquencies: The MEC may then decide to report the suspension of the privileges to the NPDB (National Practitioner Databank).
- Medical Staff Rules and Regulations, Organization and Functions Manual, Section 4: General Rules and Regulations; Medical Records 4.6, Add "S": S. Providers who fail to respond to Peer Review Committees / Professional Analysis Committee (PAC) requests for information after 3 validated notifications will receive a letter inviting them to the MEC to address the peer review concerns. Failure to appear before the MEC may result in revocation of privileges which is reportable to the NPDB (National Practitioner Databank).
- Medical Staff Bylaws, Part III: Credentials Procedures Manual, Reappointment. 4.2, Information Collection and Verification, 4.2.1 From appointee: Add "D": D. Each medical staff applicant and members has an ongoing duty to immediately report (within 30 business days) to Chief Medical Officer relevant facts and documents: regarding the institution of disciplinary proceedings or taking of action by any health facility (including HMOs), professional society or licensing authority of any state or nation; fine, limitation, suspension, revocation or resignation of clinical privileges at any health facility; censure, reprimand, suspension, restriction, probation or limitation of professional licensure by the licensing authority of any state or nation; or censure of any kind by any professional organization. Failure to inform the Chief Medical Officer shall result in an immediate administrative suspension pending further review the CMO and the MEC

Board approved 12/1/2022 Medical Staff Bylaws – Five (5) additions to include:

- Medical Staff Bylaws, Part I: Governance: Section 1: Medical Staff Purpose and Authority, 1.3 Definitions: Rename APPs and AHPs to Non-Physician Practitioner (NPPs) under Definitions and throughout the bylaws:
- Medical Staff Bylaws, Part III: Credentialing Procedures Manual: Section 3.3: Application Evaluation. Rename Category 1 and Category 2 to Type 1 and Type 2 under Application Evaluation and throughout the bylaws:
- Medical Staff Bylaws, Part II: Investigations, Corrective Action, Hearing and Appeal Plan: Section 2: Investigations. ADD 2.1.1 Whenever the MEC receives information that a Practitioner's activities or professional conduct may not adhere or comport with the standards or aims set forth in the Bylaws, or with any Hospital rule, regulations, policies, or professional standards, the MEC may consider whether corrective action is appropriate in accordance with the Medical Staff Accountability Policy.
- Medical Staff Bylaws, Part I: Governance: Section 3: Categories of the Medical Staff: ADD The Associate Without Clinical Privileges Category 3.3.1 Qualifications: The Associate Without Clinical Privileges Category is for those

physicians who do not wish to exercise any inpatient privileges. Applicants must have an existing arrangement for referral of their patients to a hospitalist group at APRH or an appropriately privileged physician with admitting privileges at APRH. 3.3.2 Prerogatives: The Associate Without Privileges category allows the following: a. Visit their patients socially in the hospital and follow progress of patient through discharge. b. Access to the inpatient medical record of your patient. c. Order outpatient ancillary tests/services and obtain results. d. May attend medical staff/department meetings of which they are a member. CME educational programs and other medical staff functions. e. Members of this category shall not have the ability to admit patients, write orders, make medical chart entries, or otherwise engage in any form of active medical management

- Medical Staff Bylaws, Part III: Credentialing Procedures Manual: Section 6: Clinical Competency Evaluation, 6.1 FPPE and 6.2 OPPE. Add language related to the FPPE1, FPPE2 and Low to No Volume Policy. 6.1 Focused Professional Practice Evaluation (FPPE) add two bullet to reads: FPPE1 – Initial evalustion and appointment and FPPE vent triggered evaluation. AND ADD: 6.4 Low/No Volume Practioners: For low/no volume practitioners who do not utilize APRH with sufficient frequency to allow for an adequate evaluation of current clinical competence, the practitioner will be responsible for providing alternative information for review that will allow an informed decision about the practitioner's current competence. This may include information from their primary hospital where they have significant volume relating to their privileges, similar data from a managed care plan, and/or an evaluation from a chief of service and/or peer references specific to the privileges being exercised at APRH. The appropriate Peer Review or Credentialing Committee will make a recommendation to the Medical Executive Committee (MEC) regarding whether the low volume/no volume information provided is adequate to establish current competence.

Board approved 5/1/2023 Medical Staff Bylaws Revision

- Medical Staff Bylaws, Part III: Credentials Manual: Section 3.3: Application Evaulation: Type 2: letter "e': Revise settlement amount from $100,000 to $150,000.

Board approved 5/1/2024 Medical Staff Bylaws Revision – Add language

- Medical Staff Bylaws, Part III: Credentialing Procedures Manual, Section 3, Initial Appointment Procedure: 3.2.8h: add (excluding misdemeanor arrests that did not result in convictions)