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Document Types	Policy

Tier 2: Henry Ford Jackson Medical Staff Bylaws

Applicability

Henry Ford Jackson Hospital (HFJH).

Scope

The HFJH Medical Staff Bylaws are intended for the Medical Staff Members (physicians and advanced practice professionals) and Allied Health Professionals credentialed and/or privileged at Henry Ford Jackson.

Background

Medical Staff Bylaws exist to guide HFJH in the journey of providing quality patient care. Bylaws are required by every regulatory agency (such as the CMS), and they outline how a medical staff organization is run. The Bylaws also help HFJH keep up with individual state regulations.

Definitions

None.

Policy

The HFJH Medical Staff Bylaws consist of the Core Bylaws, Credentials Procedure Manual, Medical Staff Rules and Regulations, Organization and Functions Manual, Fair Hearing and Review Plan, and the Appendix. These Bylaws are the rules and framework adopted by HFJH for the government of its members and the management of its affairs. They outline the administrative structure of the medical

staff, how high-level decisions are made in the organization, core due process rights of members, the mechanism for adoption and amendment of governing documents, and the outline the requirements providers must meet in order to be granted and maintain membership and/or privileges.

Related Documents

None.

References/ External Regulations

The Joint Commission (2022) IC 01.01.01

Appendices

Appendix

Core Bylaws

Credentials Procedure Manual

Fair Hearing and Review Plan

Medical Staff Rules and Regulations

Organization and Functions Manual

All Revision Dates

6/14/2023

Attachments

Appendix 2022 06.pdf

Core Bylaws 2023 05.pdf

Credentials Procedure Manual 2022 06.pdf

Fair Hearing and Review Plan 2012 01.pdf

Medical Staff Rules and Regulations 2023 05.pdf

Organization and Functions Manual 2022 06.pdf

Approval Signatures

Step Description	Approver	Date
SVP- CMO, CEO- HFJMG	Mark Smith: SVP - CMO, CEO - HFAMG [BT]	6/14/2023
Chair HFJH Medical Executive Committee (MEC)	Samir Parikh: Non HFHS Allegiance Physician [DS]	6/13/2023
System Policy Management Office	System Policy Management Offic	6/1/2023
Site Liaison Review	Monica Wieand: Coor-Accreditation & Quality	6/1/2023
document owner	Danielle Spooner: Supv-Medical Staff Office	5/31/2023

Standards

No standards are associated with this document

HENRY FORD HEALTH℠

Medical Staff Bylaws: Appendix

Henry Ford Jackson Hospital

Revised June 2022

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DEFINITIONS

1. **Administration**: The management team of Henry Ford Jackson Hospital.

2. **Advanced Practice Provider (APP):** The APP category shall consist of Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwives (CNM), Nurse Practitioners (NP), and Physician Assistants (PA) who exercise judgment within the areas of his/her scope of practice and professional competence and are licensed and permitted to provide services independently or may function in a medical support role to a physician. The limits of practice are established by the APP and her/his Participating Physician through a mutually agreed upon Practice Agreement, reviewed by the Clinical Service Chief and submitted to the Credentials Committee, MEC, and Board for approval.

   Allied Health Professional: An Allied Health Professional (AHP) is an individual other than a licensed physician of medicine or osteopathy, psychology, podiatry, or dentistry, or Nurse Practitioner, Physician Assistants, Certified Registered Nurse Anesthetist, or Certified Nurse Midwife who exercises judgment within the areas of his/her professional competence and the limits established by the governing body, the Medical Staff and statutes governing licensure and certification. AHP's are not eligible for Medical Staff membership.

   A. **Dependent Practitioners**: Dependent practitioners are those practitioners who are limited in their scope of practice, pursuant to relevant licensing regulations and Jackson Hospital and Medical Staff Documents to rendering direct or indirect medical or dental care under supervision or supplying specific services under direct physician order of a Medical Staff member possessing privileges to provide such care. Supervision of medical or dental care shall be defined in accordance with the definition of supervision as provided by relevant provisions of the Michigan Public Health Code and shall be defined by their clinical privileges.

   B. **Independent Practitioners**: Independent practitioners are those practitioners who, in accordance with their license and Jackson Hospital and Medical Staff Documents and when their services are initiated upon written order by the attending physician, are able to practice without supervision, within the scope of their license.

3. **Board of Trustees or Board:** The governing body of Henry Ford Jackson Hospital.

4. **Chief Executive Officer (CEO)**: The individual appointed by the Board to serve as chief administrative officer of Henry Ford Jackson Hospital.

5. **Chief of Staff**: The chief officer of the Medical Staff elected by members of the Medical Staff.

6. **Clinical Privileges or Privileges**: Based on a periodic evaluation of credentials and performance, clinical privileges or privileges means the permission granted to Medical Staff members by the Board to provide patient care independently

within the scope of their privileges and includes reasonable access to those hospital resources (including equipment, facilities and personnel) which are necessary to effectively exercise those privileges.

7. **Competency**: A determination of an individual's capability to perform up to defined expectations and clinical privileges requested. Measurement examples may include but are not limited to: formal training and education, participation in performance improvement activities and quality controls, measurement of skills, ongoing assessment and evaluation of the Clinical Service Chief, medical records and clinical pertinence review, number of patients treated, documented continuing education, presentations, publications, and peer review. For appointment/reappointment, a judgment of current competency is made by the Credentials Committee dependent on the information provided them and the recommendation of the Medical Executive Committee to the Board, which will take action as appropriate. Independent Health Care Professionals are incorporated into the current competency consistent with the concept of one level of quality care in Jackson Hospital.

8. **Emergency**: A condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. Health care practitioners are not required to be specifically privileged to provide "emergency" care. All personnel are expected and authorized to render care necessary to save the life or protect the welfare of a patient in an emergency situation, to the degree permitted by their licensure, training, and applicable laws.

9. **Exclusive Contract**: A contract between Jackson Hospital and a member or members providing for the exclusive delivery of certain services by the member or members.

10. **Ex Officio**: Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided in the Medical Staff Documents or in Clinical Service Rules and Regulations, means without voting rights.

11. **Henry Ford Health:** The collection of legal entities, of which Jackson Hospital is one member, all governed by the entity Henry Ford Health, which together establish a continuum of healthy care services in support of the charitable mission of Jackson Hospital.

12. **Good standing**: Means the staff member has met the attendance requirements during the previous Medical Staff year, is not in arrears in dues payment, and is not under a suspension of his/her appointment or admitting privileges at the time the issue of good standing is raised.

13. **Healthcare organization**: A generic term used to describe many types of organizations that provide health care services.

14. **Hospital or Jackson Hospital**: Henry Ford Jackson Hospital fka Henry Ford Allegiance Health, Allegiance Health, and W.A. Foote Memorial Hospital of Jackson, Michigan, (a unit of the Henry Ford Health System) including its outpatient surgery center, Jackson Outpatient Surgery Center (JOSC), Diabetes Center.

15. **Investigation**: A process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a Medical Staff member or individual holding clinical privileges.

16. **Joint Conference Committee**: A committee constituting a forum for the discussion of matters of the Hospital and Medical Staff policy, practice, and planning, and a forum for interaction among the Board, Administration, and the Medical Staff. The committee may consider matters on its own initiative or as suggested by individuals of the Medical Staff, the Administration or the Board of Trustees.

17. **Leader**: An individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, clinical, and support functions and processes. Leaders include, when applicable to the organization's structure, the owners, members of the governing body, the chief executive office and other senior managers, and the leaders of the Medical Staff.

18. **Medical Director**: A physician member of the Medical Staff in good standing contracted by Administration, after presentation to the Medical Executive Committee, for medical expertise in specified area(s).

19. **Medical Executive Committee (MEC)**: The executive committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these Medical Staff Documents.

20. **Medical Staff Documents**: These documents consist of the Core Bylaws, Credentials Procedure Manual, the Fair Hearing Plan/Appellate Review, Organization and Functions Manual, Rules and Regulations, and the Appendix.

21. **Medical Staff or Staff**: The formal organization of all licensed physicians, dentists, podiatrists, psychologists, and advanced practice providers who have been granted recognition as members of the Medical Staff in their respective capacities pursuant to the terms of the Medical Staff Documents.

22. **Medical Staff Membership**: Medical Staff membership is limited to certain professionals who must demonstrate the necessary evidence of licensure, relevant training/ experience, competence, and abilities for the category of membership requested. The qualifications for membership are found in the Medical Staff Documents. The Medical Staff membership is a formal organization of practitioners having the responsibility and authority, delegated by the Board, to maintain proper standards of patient care and to plan for the continued improvement of that care.

23. **Medical Staff Year**: The period from January 1st through December 31st.

24. **Member**: Any physician, dentist, podiatrist, psychologist, or advanced practice provider holding a current license to practice his or her profession who has been granted membership on the Medical Staff.

25. **Patient Encounter**: Contact with a Henry Ford Jackson Health patient under any of the following scenarios, noting in all cases the burden is on the member to establish requisite patient encounters:

    a. An admission of a patient to the Hospital on an inpatient basis, as the admitting physician;
    b. A consultation on a Hospital inpatient or Ambulatory Care patient, involving actual physical examination of the patient and preparation of appropriate formal notes; or
    c. The performance of medical, surgical or psychological procedures upon a Hospital patient on an inpatient or outpatient basis.

26. **Peer Review or Professional Review**: As used in these Bylaws and any of its appendices, the terms "Peer Review" and/or "Professional Review" have the meaning assigned to them under the Michigan Public Health Code relating to professional review activities and functions to review, monitor and reduce morbidity and mortality and improve the quality of care provided to patients.

27. **Physician**: An individual with an M.D. or a D.O. degree who is currently licensed to practice medicine in the state of Michigan.

28. **Physician Advisor**: A Medical Staff leader qualified by training, experience, and demonstrated ability in an area of expertise (utilization management, medical records, infection control, blood usage, ACLS, etc) selected by the Chief of Staff with approval of the Medical Executive Committee to report to the Quality Management Committee, the Medical Executive Committee or other appropriate committees at such times as determined by that Committee.

29. **Provisional Status, or Provisional.** During the first year of a member's Medical Staff membership in either the Active or Associate staff categories, s/he shall serve in a provisional status, during which time the subject matter expert, as assigned by the Credentials Committee, shall carefully monitor his/her quality of care, citizenship and compliance with the obligations of Medical Staff membership. Although this monitoring is generally an ongoing function as to all Medical Staff members during their affiliation with the Hospital, the intention with Provisional Status is that the new member will be more carefully observed and mentored as s/he transitions into the Medical Staff.

30. **Special Notice**: Written notification sent by certified or registered mail, return receipt requested, to the address of record. A special notice may be personally delivered in lieu of being sent by certified or registered mail.

31. **Vice President for Medical Affairs**: The member of Administration of Henry Ford Jackson Health charged with encouraging a cooperative and collaborative relationship between the Medical Staff and the Hospital.

CREDENTIALING POLICY

1. The Initial Application Process, as also noted in the Bylaws Credentials Procedure Manual, is handled by Henry Ford Health Credentials Verifications Office and is outlined in the Henry Ford Provider Affairs Tier 1 Credentialing/Recredentialing Policy.

2. Credentialing criteria, requirements, and verification sources are listed in the Henry Ford Provider Affairs Tier 1 Credentialing/Recredentialing Policy.

3. Additional credentialing criteria guidelines are listed in the following Henry Ford Provider Affairs Tier 1 policies:

   a. Board Certification Policy
   b. Criminal Background Policy
   c. Current Competency Policy
   d. Education-Training Verification Policy
   e. Government Sanctions Policy
   f. License to Practice Verification Policy
   g. Malpractice Coverage Policy
   h. Professional Reference Policy
   i. Work History Policy

ADOPTED by the Medical Staff on

June 16, 2022

Date

Rami Alzebdeh, MD
Chief of Staff

Imran Tarrar, MD
Secretary/Treasurer/Communications Officer

APPROVED by the Board of Trustees on

July 20, 2022
Date

Martha Fuerstenau
Chair

Aaron Boatin
Secretary

Emily Moorhead
President of the Hospital

Originally adopted: December 17, 2003
Revised: June 2004 October 2008
June 2022

HENRY FORD HEALTH℠

Medical Staff Bylaws:
Core Bylaws

Henry Ford Jackson Hospital

Revised March 2023

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PREAMBLE

These Bylaws which originate with the Medical Staff are adopted to provide for the organization of the Medical Staff of Henry Ford Jackson Hospital and to provide a framework for self-governance and accountability in order to permit the Medical Staff to discharge its responsibilities in matters involving quality of medical care and to govern the orderly resolution of those purposes.

These Bylaws provide the vehicle wherein issues relating to medical care and administrative functions of the Hospital can be resolved through the mutual efforts of the Medical Staff, Hospital Administration, and the Board of Trustees. These Bylaws, as adopted or amended, create an infrastructure for management of relationships between and the interdependence of the Medical Staff and the Hospital, and are subject to the corporate authority of the Board of Trustees in those matters where the Board has ultimate legal responsibility.

1.0 NAME

The name of this organization is Henry Ford Jackson Hospital.

2.0 PURPOSE OF THE BYLAWS

These Bylaws are the formal structure through which:

2.1 The benefits of membership on the Staff may be obtained. Members are able to act with a reasonable degree of freedom and confidence;
2.2 The obligations of Staff membership may be fulfilled;
2.3 The system of mutual rights and responsibilities among members of the Staff and the Hospital is maintained and improved;
2.4 The Staff is represented and participates in any Hospital deliberation affecting the discharge of Medical Staff responsibilities;
2.5 An established mechanism exists for the Staff to communicate with all levels of governance and management involved in policy decisions affecting patient care services;
2.6 Exercise of the Staff professional leadership in planning, assessing and improving the quality of care delivered in the organization is actively encouraged. This occurs at various levels within the organization.
Interactions:
2.6.1 Between individual staff members and patients;
2.6.2 With their Clinical Services;
2.6.3 Among the overall organization's planning process and policymaking.

3.0 MEDICAL STAFF MEMBERSHIP

3.1 Nature of Staff Membership

No physician, dentist, podiatrist, or Advanced Practice Providers including those in a medical administrative position by virtue of a contract with the Hospital or those who otherwise provide certain services pursuant to a contract with the Hospital for the exclusive delivery of those services, shall admit or provide medical or health-related services to patients in the Hospital unless s/he is a member of the Medical Staff and has been granted privileges, or has been granted temporary privileges, in accordance with the procedures set forth in these Medical Staff Documents. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Medical Staff Documents. Termination or withdrawal of Staff membership also shall be in accordance with these Medical Staff Documents.

3.2 Qualifications for Membership

Qualifications for membership are delineated in the Credentials Procedure Manual.

3.3 Nondiscrimination

Staff membership or particular clinical privileges shall not be denied on the basis of sex, race, creed, color, or national origin or on the basis of any other criteria prohibited by law.

3.4 Effect of Other Affiliations

No physician, dentist, podiatrist, or Advanced Practice Provider is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because s/he is licensed to practice in Michigan or in any other state, or because s/he is a member of any professional organization or board, or because s/he had or presently has, staff membership or privileges at another healthcare facility or in another practice setting.

3.5 Participation in Third Party Arrangements

Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with the Hospital.

3.6 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the member of the Medical Staff. The Board shall act on appointment and reappointment only after there has been a recommendation from the MEC. Appointment and reappointment to the Medical Staff shall be for no more than 24 calendar months.

3.7 Clinical Privileges

Requests for clinical privileges shall be processed only when the applicant meets the current minimum threshold criteria recommended by the Clinical Service, Credentials Committee, MEC, and approved by the Board. In the event there is a request for which there are no approved criteria, the Credentials Committee, with input from the Clinical Service, MEC and the Hospital Administration, will first determine if the privilege can be allowed and, if so, the Credentials Committee and appropriate subject matter expert(s) will develop privileging criteria for review and recommendation by the MEC and approval by the Board. (Refer to the Credentials Procedure Manual)

Except as otherwise provided in the Medical Staff Documents, a member providing clinical services within the Hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be Hospital specific, within the scope of any license, certificate or other legal credential-authorizing practice in this state and consistent with any restrictions therein, and shall be subject to the Medical Staff Documents.

3.8 Responsibilities of Each Member

The ongoing responsibilities of each member of the Medical Staff (except for honorary or retired staff) include:

3.8.1 Providing for high quality health care, which includes but is not limited to the following activities:

3.8.1.1 Providing patient care within the parameters of their professional competence, as reflected in the scope of their clinical privileges;
3.8.1.2 Providing patient care within the framework of the prevailing and appropriate standard of care;
3.8.1.3 Participating in a continuing education program relevant to quality improvement;
3.8.1.4 Participating in a utilization review program to review both inpatient and outpatient services;
3.8.1.5 Supporting an organization-wide structure for the ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes;
3.8.1.6 Participating in professional peer review functions as assigned by the Member's Clinical Service, and/or committees and/or individuals assigned professional review functions under the Medical Staff Documents.
3.8.2 Abiding by the Medical Staff Bylaws and Medical Staff Documents.
3.8.3 Abiding by Board-approved Hospital policies and the Corporate Compliance Plan that apply to the Medical Staff, which have been approved by the MEC and promulgated to all Medical Staff members.
3.8.4 Conforming to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteeing the security, privacy, and confidentiality of health information on all patients served.
3.8.5 Discharging assignments: Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments.
3.8.6 Establishing (1) adherence to the ethics of his/her profession, and (2) ability to work cooperatively with members of the Medical Staff, Hospital Administration and staff, and others so as not to adversely affect patient care or the delivery thereof, or to impair the orderly functioning of the Medical Staff and the Hospital.
3.8.7 Preparing and completing medical records for all the patients to whom the member provides care within the Hospital within the timeframes described in the Medical Staff Documents.
3.8.8 Participating in the on-call coverage, excepting APPs, of the emergency service and other coverage programs (including consultations for inpatients and other populations) as determined by the MEC.
3.8.9 Submitting to an independent medical examination of physical and/or mental health by a physician or physicians or other appropriate health care professional acceptable to the MEC, when the MEC has reason to question whether a member can safely function within his/her privileges because of his/her medical and/or mental status. Voluntarily submitting to such an examination at the MEC's request shall be a prerequisite to further consideration of an application for initial or reappointment to the Medical Staff, the exercise of previously granted privileges, or continuation of Medical Staff membership.
3.8.10 Paying Medical Staff dues and assessments as may be set forth in the Medical Staff Documents.
3.8.11 Notifying promptly the Medical Staff Affairs Office who will notify the Chief of Staff and Hospital Counsel of:
3.8.11.1 The voluntary or involuntary lapse, relinquishing, revocation of, suspension, or imposition of terms of probation or limitation upon his/her professional license, certification, or registration to prescribe or dispense controlled substances, by any state or federal agency; or
3.8.11.2 The voluntary or involuntary revocation or relinquishment of Staff membership or lapse, relinquishing, revocation of, suspension, or imposition of terms of probation or limitation upon any clinical privileges at any hospital or other healthcare organization; or
3.8.11.3 The commencement of a formal investigation, or the filing of charges by any healthcare organization or by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Michigan, or any other state; or

3.8.11.4 The commencement of a claim against the practitioner alleging professional liability, or

3.8.11.5 The voluntary or involuntary surrender or restriction of staff membership, third party payer participation, clinical privileges or license/certification in lieu of an investigation or corrective action at another healthcare organization or any licensing agency; or

3.8.11.6 The pendency or commencement of a formal investigation or quality review, or the restriction of or conditions of probation imposed upon his/her participation status or the participation status of any medical office/practice with which he/she is affiliated, in any third party payer or organized health plan, or involuntary exclusion, departicipation or debarment from Medicare, Medicaid, or any third party payer whether temporary or permanent;

3.8.11.7 The voluntary or involuntary non-renewal, termination, or change in coverage limits or type of professional liability insurance coverage, and/or change in the insurance company providing such coverage.

3.8.12 Maintaining in good standing a current professional licensure or certification, professional liability insurance and DEA registration (as applicable), and promptly providing the Medical Staff Affairs Office with current documentation evidencing compliance with these requirements. The Medical Staff Affairs Office of Henry Ford Jackson Hospital shall be listed as a certificate holder on professional liability insurance certificates.

3.8.13 All APP clinical activity within the Hospital must be in accordance with a Practice Agreement entered into with the APP and a licensed physician(s) currently on the HFJH Medical Staff.

3.8.14 Both parties shall immediately notify the Medical Staff Affairs Office, in writing, of any change in the APP applicable documents as noted above and/or employment status.

3.9 Rights of Members

3.9.1 Each practitioner on the Medical Staff has the right to an audience with the MEC. In the event such practitioner is unable to resolve a difficulty working with his/her respective Clinical Service/Service Chief, that practitioner may, upon presentation of a written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

3.9.2 Any practitioner on the Medical Staff has the right to initiate a recall election of a Medical Staff officer or Clinical Service Chief by following procedure outlined in the Core Bylaws.

3.9.3 Any Medical Staff member may call a special general Medical Staff meeting, upon presentation of a petition signed by twenty percent (20%) of the voting members of the Medical Staff, the MEC shall schedule the special general meeting for the specific purpose(s) addressed by the petitioners. No business other than that detailed in the petition may be transacted. (See Core Bylaws, Medical Staff Meetings.)

3.9.4 Any officer of the Medical Staff can request and be granted a meeting with any member of the Board, Hospital Administration, Joint Conference Committee, or the MEC to discuss any important issue at an agreed-upon date, place, and time.

3.9.5 Any member of the Medical Staff may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any member may submit a petition signed by ten percent (10%) of the voting Medical Staff members. When the MEC has received such petition, it will either (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy, and/or (2) schedule a meeting with the petitioners to discuss the issues.

3.9.6 Any Clinical Service member may request a Clinical Service meeting when a majority of the members eligible to vote in that Service believe that the Clinical Service has not acted in an appropriate manner.

The above Sections under Rights of Members do not pertain to issues involving professional review action, denial or requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging. Corrective Action, the Fair Hearing Plan/Appellate Review, and the Medical Staff Documents provide recourse in these matters.

3.9.7 Medical Staff members may have a right to a hearing/appeal pursuant to the Fair Hearing Plan/Appellate Review (see the Fair Hearing Plan/Appellate Review Manual).

3.10 Staff Dues

3.10.1 The Medical Staff, upon the recommendation of the MEC, shall determine annual Medical Staff dues.

3.10.2 Honorary, and Henry Ford Medical Group Providers, for which HFJH is *not* their primary location, are not required to pay dues.

3.10.3 Failure without good cause as determined by the MEC, to pay dues or assessments within 45 days of initial invoice, as required in the Medical Staff Documents, shall be grounds for automatic suspension of a member's clinical privileges, and if by within 90 days and after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated. Termination or suspension of privileges or membership under these conditions shall not entitle the member to any rights under the Fair Hearing Plan/Appellate Review.

4.0 CATEGORIES OF THE MEDICAL STAFF

4.1 The Active Category

4.1.1 Qualifications

The Active Staff shall consist of physicians, dentists, podiatrists, and Advanced Practice Providers who:

4.1.1.1 Have no less than 25 patient encounters (a patient encounter is defined in the Definitions) per two-year period. The MEC and the Board may expressly waive these requirements for a practitioner with at least ten (10) years of service in the active category or for a practitioner who provides other exceptional service within the Hospital to the satisfaction the MEC and Board.

4.1.1.2 Assume all functions and responsibilities of membership in accordance with the Medical Staff Documents.

4.1.1.3 Are located close enough to the Hospital to provide appropriate continuity of quality care as defined in the Clinical Service's Rules and Regulations or have entered into an alternative coverage arrangement that has been approved by the MEC.

4.1.1.4 Have completed satisfactorily their designated term in the Provisional status.

4.1.1.5 Are expected to comply with performance improvement activities of the Hospital and Medical Staff.

4.1.2 Prerogatives/Responsibilities

Appointees to this category:

4.1.2.1 May vote on all matters presented by the Medical Staff and by the appropriate Clinical Service of which s/he is a member.

4.1.2.2 May hold Staff or Clinical Service office and serve as a voting member on committees to which the member is appointed or elected by the Medical Staff or authorized representative thereof.

4.1.2.3 Shall attend meetings of the Medical Staff and Clinical Service of which s/he is a member if specifically requested by the Chief of Staff or Clinical Service Chief.
4.1.2.4 May attend any Hospital education programs.
4.1.2.5 Shall contribute to the organization and administrative affairs of the Medical Staff.
4.1.2.6 Shall actively participate in and collaborate with recognized functions of the Medical Staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the Provisional period and in discharging other Medical Staff functions as may be required.
4.1.2.7 Shall fulfill any meeting attendance requirements as established by the Medical Staff Documents.
4.1.2.8 Shall pay dues.

4.2 The Active Advanced Practice Provider (APP)

4.2.1 Qualifications

Advanced Practice Professionals (APP) are individuals other than licensed physicians of medicine or osteopathy, podiatry, or dentistry who are educationally and clinically prepared and maintain competency in a discipline which the Board of Trustees has determined by policy to allow to practice at HFJH.

The APP category shall consist of Certified Registered Nurse Anesthetist (CRNA, Certified Nurse Midwives (CNM), Nurse Practitioners (NP), and Physician Assistants (PA) who exercise judgment within the areas of his/her scope of practice and professional competence and are licensed and permitted to provide services independently or may function in a medical support role to a physician. The limits of practice are established by the APP and her/his Collaborating Physician through a mutually agreed upon Practice Agreement, reviewed by the Clinical Service Chief and submitted to the Credentials Committee, MEC, and Board for approval.

APPs must meet basic qualifications in order to provide specified patient care services as assigned in an appropriate Clinical Service under the overall direction of the Clinical Service Chief. The MEC shall establish qualifications required of members of the APP category provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformity with applicable State law. Professions eligible for APP membership shall be established by the MEC and approved by the Board of Trustees.

APPs may treat patients in conjunction with a member of the Physician Medical Staff but may not independently admit. Patients admitted to the service of an APP shall be the dual responsibility of the APP and admitting Physician member of the Medical Staff. Apps shall:

4.2.2.1 Have no less than 25 patient encounters (a patient encounter is defined in definitions) per a two-year period.
4.2.2.2 Assume all functions and responsibilities of membership in accordance with the Medical Staff Documents.
4.2.2.3 Have satisfactorily completed their designated term in the Provisional status.
4.2.2.4 Be expected to comply with performance improvement activities of the Hospital and Medical Staff.

4.2.2 Prerogatives/Responsibilities

Appointees to this category:
4.2.2.5 All clinical activity within the Hospital must be in accordance with a Practice Agreement entered into with the APP and a licensed physician(s) currently on the HFJH Medical Staff (independent/dependent).

4.2.2.6 Both parties shall immediately notify the Medical Staff Affairs Office, in writing, of any change in the APP applicable documents as noted above and/or employment status.
4.2.2.7 May vote on all matters presented by the Medical Staff and by the appropriate Clinic Service of which s/he is a member.
4.2.2.8 May serve as a voting member on committees to which the member is appointed.
4.2.2.9 Shall not hold Medical Staff or Clinical Service Office.
4.2.2.10 May chair a Medical Staff committee.
4.2.2.11 Shall attend meetings of the Medical Staff and Clinical Service of which s/he is a member if specifically requested by the Chief of Staff or Clinical Service Chief to do so.
4.2.2.12 Shall actively participate in and collaborate with recognized functions of the Medical Staff including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the Provisional period and in discharging other Medical Staff functions as maybe required.
4.2.2.13 Shall fulfill any meeting attendance requirements as established by the Medical Staff Documents.
4.2.2.14 Shall pay dues.

4.3 The Associate Category

4.3.1 Qualifications

The Associate Medical Staff category is reserved for providers who do not otherwise meet the eligibility requirements for the Active category. A provider assigned to this category is involved in fewer than 25 patient encounters (encounters are defined in Definitions) in the Hospital per two-year period except as expressly waived by the MEC and the Board after ten (10) years of service as a Medical Staff member or a provider who provides other exceptional service within the Hospital System to the satisfaction of the MEC and Board. Practitioners must satisfactorily complete their designated term in the Provisional status.

If s/he elects to apply through the normal credentialing process, the Vice President for Medical Affairs may become an Associate member of the Medical Staff.

4.3.2 Prerogatives/Responsibilities

Appointees to this category:

4.3.2.1 May vote and chair only in committees in which s/he is appointed as a member (excluding those with ex-officio status). May not vote in General Staff meetings.
4.3.2.2 Shall not be eligible to hold office in the Medical Staff organization.
4.3.2.3 Shall attend meetings of the Medical Staff and Clinical Service of which s/he is a member if specifically requested by the Chief of Staff or Clinical Service Chief.
4.3.2.4 May attend any Hospital education programs.
4.3.2.5 Shall contribute to the organizational and administrative affairs of the Medical Staff.
4.3.2.6 Shall actively participate in and collaborate with recognized functions of the Medical Staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the Provisional period and in discharging other Medical Staff functions as may be required. Note that Provisional staff members may not monitor Provisional staff.
4.3.2.7 Shall fulfill any meeting attendance requirements as established by the Medical Staff Documents.
4.3.2.8 Shall pay dues.

4.4 The Honorary Category

4.4.1 Qualifications

The Honorary Medical Staff shall consist of physicians, dentists, podiatrists, psychologists, and APPs who do not actively practice within the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, and/or their previous long-standing Active staff status at the Hospital, and who continue to exemplify high standards of professional conduct. They are recommended to this category by the MEC and approved by the Board.

4.4.2 Prerogatives/Responsibilities

Appointees to this category:

4.4.2.1 May serve and/or chair committees to which s/he is appointed a member.
4.4.2.2 May attend meetings of the Medical Staff and Clinical Service of which s/he is a member, including open committee meetings and educational programs.
4.4.2.3 May utilize the Medical Staff lounge and its resources.
4.4.2.4 Is not eligible to admit patients or to exercise clinical privileges within the Hospital.
4.4.2.5 Shall not vote, hold office or be required to attend meetings or serve on committees.
4.4.2.6 Does not pay dues.

4.5 The Telemedicine Category

4.5.1 Qualifications

The Telemedicine Staff shall consist of physicians and APPs who are responsible for a patient's care, treatment, and services via a telemedicine who:

4.5.1.1 Have completed satisfactorily their designated term in the Provisional status.
4.5.1.2 Assume all functions and responsibilities of membership in accordance with the Medical Staff Documents as appropriate for this Category of membership.

4.5.2 Prerogatives/Responsibilities

Appointees to this category:

4.5.2.1 Shall not vote, hold office, or be required to attend meetings or serve on committees.
4.5.2.2 Shall pay dues.

4.6 Locum Tenens Category

4.6.1 Qualifications

Members of the Locum Tenens Medical Staff are providers who provide recurring, short-term care and are appointed for the specific purpose of providing temporary coverage due to urgent patient care needs. Locum Tenens applications are vetted in the same manner as other applicants.

4.6.2 Prerogatives/Responsibilities

Appointees to this category:

4.6.2.1 May have admitting privileges.
4.6.2.2 Shall not vote, hold office or be required to attend meetings or serve on committees.
4.6.2.3 Shall pay dues.

4.7 Membership Only Category

4.7.1 Qualifications

Membership Only Medical Staff is comprised of those providers who wish to continue, or establish, a formal relationship with the hospital with no clinical privileges to admit or provide patient care in any manner. They may have access to medical records only by permission of the patient and the attending physician. Applicants are vetted in the same manner as other applicants and are reappointed every two (2) years.

4.7.2 Prerogatives/Responsibilities

Appointees to this category:

4.7.2.1 Do not have clinical privileges to provide patient care.
4.7.2.2 Shall not vote or hold office but may attend meetings or serve on committees
4.7.2.3 Shall pay dues.

5.0 OFFICERS AND REPRESENTATIVES OF THE MEDICAL STAFF

5.1 Identification

5.1.1 Officers

5.1.1.1 Chief of Staff
5.1.1.2 Chief of Staff-Elect
5.1.1.3 Secretary/Treasurer/Communications Officer

5.1.2 Other Representatives of the Medical Staff

5.1.2.1 Members-at-Large of the MEC
5.1.2.2 American Medical Association (AMA) - Organized Medical Staff Section Representative and Alternate
5.1.2.3 Medical Staff Nominees for the Board of Trustees
5.1.2.4 Physician Advisors (see Organization and Functions Manual)
5.1.2.5 Immediate Past Chief of Staff

5.2 Qualifications of Officers

Officers must be members in good standing of the active category, indicate a willingness and ability to serve (see Leadership Criteria in Appendix), have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of office, have demonstrated an ability to work well with others, have administrative and communication skills, and must remain members in good standing during their term in office. Failure to maintain such status shall create a vacancy in the position involved.

5.3 Election of Officers

5.3.1 The Nominating Committee

The Medical Staff elections shall take place at the September General Medical Staff meeting. The Nominating Committee shall be operative not later than one hundred and twenty (120) days prior to the annual meeting during an election year or at least forty-five (45) days prior to any special election. (See the Organization and Functions Manual for the composition of the Nominating Committee.) The Vice President for Medical Affairs shall be a nonvoting member. The Nominating Committee shall nominate one or more nominees for each office that will become vacant. In the case of elections at the annual Medical Staff meeting, the nominations of the Committee shall be approved by the MEC at least sixty (60) days prior to the annual meeting and, the nominations of the Committee as well as the nominating process shall be delivered or mailed to the voting members of the Medical Staff at least forty (40) days prior to the election.

5.3.2 Special Elections

In the case of a special election, the nominations of the Committee shall be approved by the MEC at least forty (40) days prior to the special election and shall be delivered or mailed to the voting members of the Medical Staff at least thirty (30) days prior to the special election.

5.3.3 By Petition

Further, nominations of any Medical Staff member who meets leadership criteria may be made for the Chief of Staff, Chief of Staff-Elect, Secretary/Treasurer/Communications Officer, member-at-large of the MEC by any active member of the Medical Staff, provided that the name of the candidate is submitted in writing to the Chairperson of the Nominating Committee, is endorsed by the signature of at least ten (10) other active members, and bears the candidate's written consent. These nominations shall be delivered to the Chairperson of the Nominating Committee as soon as reasonably practical, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the active members of the Medical Staff shall be advised by notice delivered or mailed at least ten (10) days prior to the date of election.

5.3.4 Conflict of Interest

All nominees for election or appointment to Medical Staff offices, representatives of the Medical Staff, or a member of the MEC shall comply with the Henry Ford Jackson Hospital Conflict of Interest Policy and shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the MEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

5.3.5 Elections

The Chief of Staff-Elect, Secretary/Treasurer/Communications Officer, AMA Organized Medical Staff Section Representative and Alternate, and MEC members-at-large shall be elected at the September General Medical Staff meeting. Invalid elections will be referred to the Medical Executive Committee, which will determine the outcome of the election, and decision shall be final. The Medical Staff will be notified of the final decision.

5.3.6 Term of Elected Office

Each Medical Staff officer shall serve a two-year term, commencing on the first day of the Medical Staff year (see Definitions in Appendix) following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff and the Chief of Staff-Elect shall automatically assume the office of Chief of Staff.

5.3.7 Recall

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff officer may be initiated by the MEC or shall be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote. Recall shall be considered at a special meeting of the Medical Staff called for that purpose. Recall shall require a two-thirds majority of the active Medical Staff members.

5.3.8 Vacancies in Elected Positions

Vacancies in office occur upon the death, disability, written resignation to the MEC, removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the MEC until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Chief of Staff-Elect shall serve out that remaining term. The MEC shall immediately activate the Nominating Committee and approve the nominees for the office of Chief of Staff-Elect. A special election to fill the position shall occur at the next regular general Medical Staff meeting. If there is not a vacancy in the office of Chief of Staff, but a vacancy in the office of Chief of Staff-Elect only, the latter office need not be filled by election, but the MEC shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

5.4 Duties of Officers

See Organization and Functions Manual.

5.5 Members-at-Large of the MEC

The two (2) members-at-large shall be nominated and elected in the same manner as the other officers of the Medical Staff and shall serve a two-year term, commencing on the first day of the Medical Staff year following his/her election. Each member shall serve until the end of his/her term or until a successor is elected. Members-at-large may not serve more than four (4) terms in succession. Duties and responsibilities of the two elected members-at-large shall include, but not be limited to:

5.5.1 Representing the entire Medical Staff in activities related to Hospital and Medical Staff interactions.
5.5.2 Attending all meetings of the MEC as voting members.
5.5.3 Assuming membership and/or the chairperson position of various committees and carry out other responsibilities as assigned by the Chief of Staff, especially in those areas relating to budgetary, economic, strategic planning and resource matters.
5.5.4 Members-at-large of other committees shall be elected by the Rules and Regulations of those respective committees.

5.6 American Medical Association (AMA) Organized Medical Staff Section (OMSS) Representative

The Vice Chief of Staff shall serve as the AMA-OMSS Representative and the Secretary/Treasurer shall serve as the Alternate. The duties of the AMA-OMSS Representative/Alternate shall include, but not be limited to:

5.6.1 Representing the Medical Staff in the OMSS at the AMA general assembly.
5.6.2 Reporting OMSS activities to the MEC.
5.6.3 Performing such other duties as may be assigned from time to time by the Chief of Staff or the MEC.

5.6.4 Alternate: The duties of the AMA-OMSS Alternate shall include but not be limited to assuming all duties and authority of the OMSS Representative in the absence of the Representative.

5.7 Physician Advisors and Other Appointed Advisors

See Organization and Functions Manual.

5.8 Nominations for Physician Members of the Board of Trustees

5.8.1 Approximately ninety (90) days prior to the annual meeting of the Board of Trustees (BOT), the MEC will provide to the BOT Governance Committee a list of potential Medical Staff members qualified under the leadership qualification criteria for governance positions to be nominees for BOT positions up for election. The leadership qualification criteria as approved by the Board are in the Appendix.

5.8.2 The term of Physician Board members, which shall be consistent in time period and length to the terms and term limits of all other Board members, shall be set forth in the Corporate Bylaws of Jackson Hospital. A copy of the Corporate Bylaws shall be accessible to the Medical Staff Affairs Office.

5.8.3 In the event a vacancy occurs during the term of a Physician Board member, the vacancy shall be filled in accordance with the provisions for addressing such vacancy in the Corporate Bylaws.

In the event a vacancy occurs during the term of a Physician Board member, the vacancy shall be filled in accordance with the provisions for addressing such vacancy in the Corporate Bylaws.

6.0 MEDICAL STAFF CLINICAL SERVICES

6.1 Organization of Clinical Services

6.1.1 Clinical Services

The current Clinical Services organized by the Medical Staff and formally recognized by the MEC are listed in the Organization and Functions Manual. Each service shall have a Service Chief with overall responsibility for the supervision and satisfactory discharge of assigned functions as listed in the Medical Staff Documents.

6.1.2 Recognizing a Clinical Service

New Clinical Services may be approved and existing Clinical Services may be eliminated by the Board, on the recommendation of the MEC. The MEC shall recommend the recognition or elimination of a Clinical Service based upon the probable impact upon the quality, effectiveness and efficiency of the delivery of care in the Hospital. In making its recommendation, the MEC shall solicit the input of the Medical Staff, by providing reasonable notice to the Medical Staff and providing interested parties a meaningful opportunity to respond to the MEC.

6.1.3 Meetings

Individual Clinical Services shall be required to hold regularly scheduled meetings, as determined by Medical Executive Committee in the Tier 2 Policy. Additionally, members are expected to attend a meeting if specifically requested by the Clinical Chief of that Service.

6.1.4 Assignment to Clinical Services

The MEC shall, after consideration of the recommendations of the Service Chief of the appropriate Service, recommend Service assignments for all members in accordance with their

qualifications. Each member shall be assigned membership to one primary Clinical Service but also may be granted membership and/or clinical privileges in other Clinical Services consistent with practice privileges granted. Clinical privileges are independent of assignment.

6.2 Functions of Clinical Services

Each Clinical Service is responsible for assessing and improving its activities. Such responsibilities encompass not only the internal functioning, but also the integration of each Service into the overall function of the organization. Fulfilling these responsibilities enables the integration of the Service into the operation of the Hospital as a whole, the coordination of its services with those of other Services, and the improvement of the services it provides.

The functions of each Clinical Service shall include:

6.2.1 Planning, assessing and improving the quality of care and services as designated to the Clinical Service by the MEC and/or the Quality Management Committee;
6.2.2 Developing objective criteria for use in evaluating patient care in the Service and conducting patient care reviews as requested by the Quality Management Committee in consultation with the MEC;
6.2.3 Recommending to the MEC and the Credentials Committee guidelines for the granting of clinical privileges and the performance of specified services within the Clinical Service;
6.2.4 Developing and implementing on an as-needed basis Service Policies and Procedures, Rules and Regulations that guide and support the provision of services in the Service and in collaboration with associated Services. Changes in these documents shall be made on an as-needed basis with the documents reviewed not less than every two years.
6.2.5 Conducting and participating in and making recommendations regarding the need for equipment, orientation, in-service training, continuing education programs pertinent to changes in the state of the art and to findings of review and evaluation activities of all persons in the Service.
6.2.6 Monitoring and adhering to:
6.2.6.1 Medical Staff Documents;
6.2.6.2 Requirements for alternate coverage and for consultations;
6.2.6.3 Sound principles of clinical practice and organizational performance;
6.2.6.4 Clinical Service programs for security, safety, hazardous materials, emergency preparedness, and life safety;
6.2.6.5 Coordinating patient care provided by the Clinical Service's members with other Services, other specialties, nursing, ancillary patient care services, and with administrative support services;
6.2.6.6 Establishing such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it, such as, for example, a proctoring protocol; and
6.2.6.7 Submitting timely, written reports of activities as may be requested by the MEC.

6.3 Clinical Service Officers

6.3.1 Qualifications

Each Clinical Service shall have a Chief and may have a Vice-Chief who shall be members of the active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Clinical Service.

6.3.2 Selection

A Clinical Chief and, if applicable, Vice-Chief shall be elected by a majority vote every two (2) years by those members of the Clinical Service who are eligible to vote for general officers of the Medical Staff. In the event a majority vote is not obtained, a second vote will be conducted. In

the event a majority vote is not reached at the conclusion of second vote, the Medical Executive Committee will determine the final decision. The election is subject to ratification by the MEC.

6.3.3 Term of Office

Each Chief and, if applicable, Vice-Chief shall serve a two (2) year term that coincides with the Medical Staff year or until their successors are chosen, unless the Chief or Vice Chief resigns, is removed from office, or loses Medical Staff membership or clinical privileges in that Clinical Service. Upon a vacancy in the office of Clinical Service Chief, the Vice-Chief, if any, shall become the Clinical Service Chief until a successor is elected by the Clinical Service. These officers shall be eligible to succeed themselves.

6.3.4 Removal

After election and ratification, removal of either Chief from office can occur for cause by a two-thirds vote of the Clinical Service members eligible to vote on Service matters. In this case, the Clinical Service members shall vote on a replacement for the remainder of the term. For cause may include:

6.3.4.1 The Chief ceases to be a member in good standing in the Medical Staff.
6.3.4.2 The Chief fails in the majority opinion of the Service to demonstrate that s/he is effectively carrying out the responsibilities of the position.

7.0 COMMITTEES

7.1 Designation and Substitution

There shall be a MEC, a Credentials Committee, a Quality Management Committee, a Bylaws Committee, an Institutional Review Board, Nominating Committee, Operating Room Committee and a Pharmacy and Therapeutics Committee. Such other standing and special committees as established by the MEC are described in the Organization and Functions Manual. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation (such as Physician Advisors). Unless otherwise specified, the Medical Staff representatives and Chairs (and vice chairs if applicable) of committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval of the MEC. Ad hoc committees may be created by the MEC to perform specified tasks. Medical Staff members of committees shall be appointed by the Chairperson of the committee, the Chief of Staff, the appropriate Clinical Service Chief and/or the MEC as described in the Organization and Functions Manual. All Medical Staff committees and Medical Staff representatives shall be responsible to the MEC.

7.2 Medical Executive Committee (MEC)

7.2.1 Composition

The MEC shall consist of Medical Staff Officers, Clinical Service Chiefs (from the Services of Anesthesiology, Cardiology, Emergency Medicine, Family Medicine, Imaging Services, Internal Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry and Surgery), the Medical Director of the (Adult) Hospitalist Program, Director of Advanced Practice Providers and two (2) members-at-large. The Chief of Staff shall be a voting member and the Chairperson and shall preside at meetings. In the event that a Clinical Service Chief is unable to attend a meeting, the Vice Chief, or designee, of that Service may attend as a voting member. Appropriate administrative members of the Hospital will be invited to attend MEC meetings on an ex-officio basis without vote.

7.2.2 Purpose

The Medical Executive Committee has responsibilities, delegated by the Medical Staff, within the governance function. This Committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The leadership of the Hospital includes the Medical Staff leaders.

7.2.3 Duties

The duties of this Committee shall include but not be limited to:

7.2.3.1 Acting on behalf of the Medical Staff to represent its interests and to assure performance of its responsibilities, subject to such limitations as may be imposed by these Bylaws;

7.2.3.2 Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

7.2.3.3 Receiving and acting upon reports and recommendations from Medical Staff Clinical Services, committees, and assigned activity groups;

7.2.3.4 Recommending policies and actions to the Board on matters relevant to the Medical Staff and its functions;

7.2.3.5 Formulating policies regarding the structure of the Medical Staff, the mechanisms to review credentials and delineate individual clinical privileges, the recommendations of individual staff memberships and privileges, the organization of quality assessment and improvement activities and mechanisms of the Medical Staff, the managing of matters of individual physician health that is separate from the Medical Staff disciplinary function, termination of Medical Staff membership and performance of fair hearing procedures, needed changes to Medical Staff Documents, and other matters relevant to the operation of an organized Medical Staff;

7.2.3.6 Evaluating the medical care rendered to patients within the Hospital;

7.2.3.7 Participating in the development of all Medical Staff and Hospital policy, practice, and planning;

7.2.3.8 Conducting and overseeing peer and professional review activities of the Medical Staff, including the review of the qualifications, credentials, performance and professional competence, and character of applicants and Staff members, and making recommendations to the Board on an "as needed" basis but at least quarterly regarding Staff appointments and reappointments, assignments to Clinical Services, clinical privileges, and corrective action;

7.2.3.9 Taking reasonable steps to promote ethical conduct, address ethical issues, and promote competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

7.2.3.10 Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

7.2.3.11 Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

7.2.3.12 Reporting to the Medical Staff in an effective, timely manner throughout the year;

7.2.3.13 Assisting in the obtaining and maintenance of accreditation;

7.2.3.14 Developing and maintenance of methods for Medical Staff participation in the protection and care of patients and others in the event of internal or external disaster;

7.2.3.15 Appointing such special or ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff;

7.2.3.16 Reviewing and making recommendations to the Board regarding quality of care and service issues related to exclusive arrangements for physician and/or professional services in the Hospital, and related to the creation or termination of Clinical Services within the Medical Staff, prior to any decision being made, in the following situations:

7.2.3.16.1 The decision to execute an exclusive contract in a previously open Clinical Service or service; or
7.2.3.16.2 The decision to renew or modify an exclusive contract in a particular Clinical Service or service; or
7.2.3.16.3 The decision to terminate an exclusive contract in a particular Clinical Service or service; or
7.2.3.16.4 A request for recognition of a Clinical Service, or a proposal to eliminate an existing Clinical Service within the Medical Staff.
7.2.3.17 Establishing a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient;
7.2.3.18 Reviewing ethical issues involving Medical Staff members, including related ethical matters brought to the attention of other Hospital committees. These issues may be remanded to the Credentials Committee, or handled by other appropriate Medical Staff processes as defined in the Medical Staff Documents;
7.2.3.19 Participating in Hospital strategic and business planning, including helping to identify community health needs and developing Hospital goals and implementing programs to meet those needs;
7.2.3.20 Overseeing that portion of the Corporate Compliance Plan that pertains to the Medical Staff and its members; and
7.2.3.21 Approving all expenditures of Medical Staff funds. Expenditures greater than $5000 must also be approved by the Medical Staff. If an expenditure of greater than this amount is needed on an urgent basis, the Executive Committee may authorize this, but the Medical Staff must be informed in a timely manner.
7.2.3.22 Third-Party Arrangements: Prior to the Hospital committing the Medical Staff to any additional obligations to provide medical service, such as participating in third-party arrangements, Administration shall discuss the arrangement with the MEC for its recommendation. The MEC is responsible for communicating the proposal to the Medical Staff for its input.
7.2.3.23 Dues or Assessments: The MEC shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. The MEC shall have the authority to recommend an application or reappointment fee subject to the approval of the Medical Staff.

7.2.4 Action Taken by Medical Staff Officers on Behalf of MEC

The Chief of Staff, Chief of Staff-Elect, and Secretary/Treasurer/Communications Officer may meet and act on an emergency basis on behalf of the MEC when a meeting of the full Committee is not feasible and the circumstances require immediate action in the judgment of the Medical Staff Officers. In so acting, the Medical Staff Officers shall not exceed the specific authority and powers of the MEC set forth in the Medical Staff Documents. Any action taken by the Medical Staff Officers on behalf of the MEC will be reviewed by the MEC within seven (7) days and may be modified or reversed by the full Committee, except to the extent that action has already been taken in reliance thereon.

7.2.5 Delegated Functions

See Organization and Functions Manual.

7.2.6 Reporting of Delegated Functions

See Organization and Functions Manual.

7.2.7 Meetings

This Committee shall meet monthly. Minutes of its proceedings and actions shall be maintained. The Chief of Staff on his/her own authority can call an executive session or a special meeting of the Executive Committee or these meetings may be called upon the written request of twenty

percent (20%) of the voting members of the Medical Staff or fifty percent (50%) of the voting members of the MEC.

7.2.8 Quorum
A quorum for the MEC shall require the presence of at least 50% of the voting members.

8.0 MEDICAL STAFF MEETINGS

8.1 Meetings

8.1.1 Regular Meetings
The General Medical Staff shall meet quarterly in the months of March, June, September and December. The September meeting shall be the annual meeting when elections will take place. The Chief of Staff, other officers, Clinical Service Chiefs, Committee Chairs, and the MEC shall present reports on actions taken and on other matters of interest and importance to the members. Two (2) weeks notice shall be given for all regular and rescheduled general Staff meetings via appropriate media and posted conspicuously.

8.1.2 Attendance Requirements
Each member of the Active staff status category shall be required to attend at least 50% of regularly scheduled General Medical Staff meetings (i.e. two meetings per year) duly convened pursuant to these Bylaws. Failure to attend the meetings as outlined above shall result in the following corrective action:

8.1.2.1 The first and second missed meeting of each calendar year shall constitute no disciplinary action.

8.1.2.2 The third missed meeting of each calendar year shall constitute a fine of $100.

8.1.2.3 The fourth missed meeting of each calendar year shall constitute a fine of $500.

8.1.2.4 Excused Absences: An excused absence may be granted by the Medical Executive Committee for reasons of disability, medical emergency or other exigency not to include vacations.

8.1.2.5 Waivers: Should a member request a waiver to the requirement, s/he must submit a written request to the Chief of Staff, which will be evaluated by the Medical Executive Committee.

8.1.2.6 Fines: All fines are due and payable within thirty (30) days of the receipt of notice from the Medical Staff Affairs Office. Fines not paid within thirty (30) days will constitute grounds for suspension of the practitioner's privileges.

8.1.2.7 Refund of Fine Paid: A member will receive a refund of any fines paid if s/he attends all regularly scheduled General Medical Staff meetings the following year.

8.1.2.8 The Medical Executive Committee may impose additional consequence, at its own discretion, should it determine it is necessary.

8.1.3 Agenda
The order of business at a general meeting of the Medical Staff shall be determined by the Chief of Staff. The agenda shall include, insofar as feasible:

8.1.3.1 Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting
8.1.3.2 Administrative reports from the Chief of Staff, Clinical Services, Committees, the CEO, and the Vice President for Medical Affairs
8.1.3.3 Election of officers and representatives when required by these Bylaws
8.1.3.4 Reports on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Medical Staff and on the fulfillment of other required Medical Staff functions
8.1.3.5 Old business
8.1.3.6 New business

8.1.4 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC, or shall be called upon the written request of twenty percent (20%) of the members of the active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The MEC shall schedule the meeting within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

8.1.5 Quorum for General Staff Meetings (Regular and Special)

For the conduct of business at any regular or special General Staff Meeting, a quorum is established by all eligible voting members of the Medical Staff present at the meeting.

8.1.6 Voting

The requirements for all matters requiring a vote of the Medical Staff (e.g., elections, amendments to Medical Staff Documents) shall be done by written or electronic ballot vote sent to the Medical Staff at least seven (7) business days prior to the General Medical Staff (GMS) meetings, and for voting to be concluded on the day following the GMS meeting. Voting members shall have the option of either one of the methods, but may only vote once, with the first vote cast by either method being the official vote of that Member. The procedure for e-Voting shall be approved by the MEC, and minimally must provide a confidential and secure process for voting by electronic means that includes the ability to track Member voting by Provider ID number or other reliable means.

8.1.6.1 <u>Procedure for voting:</u>

8.1.6.1.1 At least seven (7) days prior to the GMS meeting at which the option to vote is to occur, the Medical Staff Affairs Office shall electronically distribute copies of the proposal subject to vote to all Medical Staff Members.

8.1.6.1.2 At the GMS meeting, the Chief of Staff (or designee) shall present the voting proposals and provide those present an opportunity to ask questions about the proposals. If in the sole judgement of the Chief of Staff the questions asked or comments made at the GMS meeting reflects significant problems or concerns about the proposal as presented, the Chief of Staff may refer the proposal back to the MEC for further review rather than proceeding with the voting process.

8.1.6.1.3 Unless the Chief of Staff determines the proposal should not proceed to vote as described above, Voting Members may cast their vote by written ballot at the GMS meeting. Alternatively, Voting Members may opt to cast their vote electronically via the e-Voting methodology approved by the MEC.

8.1.6.1.4 The time period for casting of electronic votes shall expire on the next calendar day following the GMS meeting.

8.1.6.1.5 For any election to be valid, at least 30% of the Members eligible to vote, must cast their vote for a candidate or note their abstention from the election. A nominee shall be elected upon receiving a majority of the valid votes cast. If 30% of the Members eligible to vote do not cast their vote by the day following the General Medical Staff meeting, voting will continue via electronic or paper ballot for a period of fourteen (14) calendar days, at which time the voting will cease and the election will be considered closed and complete, and the results will be communicated to the MEC. If after the fourteen (14) day extension the 30% threshold has been obtained, the election will be deemed valid. If the 30% threshold has not been obtained, the Medical Executive Committee will determine the outcome of the election pursuant to §5.3.5, and the MEC decision shall be final. The Medical Staff will be notified of the final decision.

8.1.6.1.6 The Medical Staff Secretary or other designee of the Chief of Staff shall compare the written ballots and e-Votes to ensure that no duplicative votes are made by Members who attended the General Staff meeting. If a Member is found to have cast a duplicative vote, the vote first cast shall stand as the Member's vote.

8.1.6.1.7 The Chief of Staff shall certify the voting results and provide a report to the MEC no later than the next regularly scheduled MEC meeting. The MEC shall communicate the results of the vote to the Medical Staff.

8.1.6.1.8 If the proposal is not approved by vote, or the Chief of Staff has exercised his/her secretion in not proceeding to vote as described above, the MEC shall review the proposal and determine whether to accept the results or to modify the proposal and resubmit to the Medical Staff for approval. If the MEC determines to resubmit the proposal for approval, the MEC may determine in its discretion to resubmit for approval at the next regularly scheduled GMS meeting, or at a Special Meeting, or to resubmit immediately via written ballot and a 14 day e-Voting option. In making this determination, the MEC should consider the relative complexity of the modified proposal compared to the original proposal and whether presentation at a GMS meeting is necessary.

8.2 Committee and Clinical Services Meetings

8.2.1 Regular Meetings

Except as otherwise specified in these Bylaws, the Chiefs of Committees, and Clinical Services may establish the time for the holding of meetings. The Chiefs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

8.2.2 Special Meetings

A special meeting of any Medical Staff Committee or Clinical Service may be called by the Chief thereof, the MEC, or the Chief of Staff, or shall be called by written request by the majority of the current members eligible to vote in that Committee or Service.

8.3 Quorum

8.3.1 Quorum for Clinical Service and Committee Meetings

Unless otherwise specified in the Medical Staff Documents, a quorum shall be declared by the number of eligible voting Medical Staff members present (but not less than two [2] members) after sufficient prior notice to all members. Specified committees requiring at least a 50% quorum include the MEC, Bylaws Committee, Credentials Committee, and the Institutional Review Board. A quorum shall be declared at Quality Management Committee meetings when four (4) or more voting members are present.

8.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting (by presence or by written ballot), or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference.

8.5 Minutes

Except as otherwise specified herein, if a special mandated meeting is called by the Chairperson of the Committee or Chief of Service, minutes of that meeting shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

8.6 Attendance Requirements

8.6.1 Regular Attendance

Except as stated elsewhere in these Bylaws, Medical Staff members are:

8.6.1.1 Expected to attend all General Staff meetings and all Committee meetings of which Medical Staff member has been assigned

8.6.1.2 Encouraged to attend any other Medical Staff meetings pertinent to the Medical Staff member. Failure to attend Committee meetings of which a Medical Staff member has been appointed may result in removal from the Committee.

8.6.1.3 Expected to attend meetings specifically requested by the Chief of Staff, Vice Chief, or Clinical Service Chief

8.6.2 Special Attendance

At the discretion of the Chairperson or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular Clinical Service or Committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. A member who fails without good cause to appear and satisfy the requirements requesting his or her presence at a special meeting listed in the Medical Staff Documents shall without good cause be automatically suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that Section.

8.7 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

8.8 Executive Session

Executive session is a meeting of a Medical Staff Committee, which only voting Medical Staff Committee members may attend, unless others are expressly requested by the Committee to attend. Executive session may be called by the presiding officer in his/her sole discretion at the request of any Medical Staff Committee member, and shall be called by the presiding officer

pursuant to a duly adopted motion. It shall be used to foster positive communications and to discuss sensitive issues concerning the Medical Staff. Executive sessions cannot be used to address peer review issues.

9.0 PROFESSIONAL REVIEW AND CORRECTIVE ACTION

9.1 Requests for Professional Review

9.1.1 Criteria for Initiation

Any person may provide information to a Medical Staff officer about the conduct, performance or competence of any practitioner. However, a request for an investigation or action against a member may be initiated by the Chief of Staff or designee, a Service Chief or designee, the MEC on a majority vote, or the CEO when reliable information indicates a member may have exhibited acts, demeanor or conduct reasonably likely to be:

9.1.1.1 Detrimental to patient safety or to the delivery of patient care within the Hospital; or
9.1.1.2 In violation of the Medical Staff Documents, or the Clinical Service Rules and Regulations; or
9.1.1.3 Below applicable professional standards; or
9.1.1.4 Considered aberrant behavior that compromises the quality of patient care provided by the Medical Staff member or disrupts the ability of others to provide quality patient care.

9.1.2 Initiation

A request for an investigation must be in writing, submitted to the MEC, and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate record of the reasons. A copy of the request for an investigation shall be sent to the affected individual(s). The Chief of Staff shall continue to keep the CEO or designee fully informed of all actions taken in conjunction therewith.

9.1.3 Investigation

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. Typically, in matters involving clinical competence, the MEC may delegate the investigation to the Quality Management Committee. The MEC may in its discretion conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff Service, another standing or ad hoc committee of the Medical Staff, and/or Hospital Administration representatives. If outside expertise is required, the Chief of Staff may request the retention of such expert(s) to participate in the investigation as part of the peer review process. The investigation shall be conducted in a prompt manner.

The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the manner may, but is not obligated to, conduct interviews with persons involved; such investigation, however, shall not constitute a "hearing" as that term is used in the Fair Hearing Plan/Appellate Review, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

The individual or body to whom the MEC has delegated the investigation shall prepare and submit a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action.

9.1.4 MEC Action

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

9.1.4.1 Determining that the concerns underlying the request were unsubstantiated and recommending that no corrective action be taken and that a confidential memorandum summarizing the disposition of the complaint shall be retained in the member's Quality Management file.
9.1.4.2 Deferring action for a reasonable time for further investigation or other clarification when circumstances warrant;
9.1.4.3 Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Clinical Service Chiefs from issuing informal written or oral warnings outside the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's Credentials or member's Quality Management file;
9.1.4.4 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-admission, mandatory consultation, or monitoring;
9.1.4.5 Recommending reduction, modification, suspension, or revocation of clinical privileges;
9.1.4.6 Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
9.1.4.7 Recommending suspension, revocation or probation of Medical Staff membership; and
9.1.4.8 Taking other actions deemed appropriate under the circumstances.

The recommendation of the MEC shall promptly be sent to the member and Board. The Board shall consider the MEC recommendation and take final action, unless the member requests a hearing in compliance with the Fair Hearing/Appellate Review Plan, in which case the final decision shall be determined as set forth in the Fair Hearing/Appellate Review Plan.
The recommendation of the MEC shall include, if applicable, the proposed wording for the National Practitioner Data Bank Adverse Action Report and/or any other report required by law if the recommendation were to be adopted by the Board.

9.1.5 Initiation by the Board

If the MEC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board may direct the MEC to initiate investigation or disciplinary action, but only after consultation with the MEC. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the MEC fails to take action in response to that Board direction, the Board may initiate corrective action after written notice to the MEC, but this corrective action must comply with the Fair Hearing Plan/Appellate Review in the Medical Staff Documents.

9.2 Summary Restriction or Suspension

9.2.1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken in order to:

9.2.1.1 Protect the life or well-being of patient(s);
9.2.1.2 Reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patients, Hospital staff, or other person.

Under these circumstances, the Chief of Staff, the CEO, the MEC, or the Clinical Service Chief or designee in which the member holds privileges may summarily restrict or suspend the Medical Staff membership and/or clinical privileges of such member. 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 Board, the MEC and Administration. In addition, the affected Medical Staff member shall be provided with a written notice of the action which notice fully complies with the requirements of 9.2.2 below. The summary 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. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the Clinical Service Chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member. Henry Ford Jackson Hospital shall report summary suspensions as required by state and federal law.

9.2.2 Written Notice of Summary Suspension

Within one (1) working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This notice shall include a summary of facts providing the basis for the summary suspension. This notice pursuant to this Section shall not substitute for, but is in addition to, the notice required under the Fair Hearing Plan/Appellate Review. The notice under the Fair Hearing Plan/Appellate Review may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

9.2.3 MEC Action

Within seven (7) calendar days after such summary restriction or suspension has been imposed, a meeting of the MEC (or a subcommittee appointed by the Chief of Staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning of the Fair Hearing Plan/Appellate Review Plan, nor shall any procedural rules under the Plan apply. The MEC may recommend that the summary restriction or suspension be modified, continued or terminated, but in any event it shall furnish the member with notice of its decision as soon as possible, but no longer than two (2) working days of the meeting.

9.2.4 Procedural Rights

Unless the MEC recommends termination of the summary restriction or suspension, the member shall be entitled to the procedural rights afforded by the Fair Hearing/Appellate Review Plan. In addition, the affected provider shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the provider may present this challenge to the MEC at the meeting held pursuant to Section 9.2.3 above. If the MEC's recommendation is to continue summary suspension in its original form or with modifications, the suspension shall remain in effect until final action by the Board.

9.3 Automatic Suspension or Limitation

In the following instances, the member's privileges and/or membership shall be automatically suspended or limited as described, without the rights set forth in the Fair Hearing Plan/Appellate Review Plan.

9.3.1 Licensure/Certification/Registration (To Practice Medicine and/or Healing Arts, or to Prescribe Controlled Substances)

9.3.1.1 Revocation, Suspension, or Lapse: Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended, or lapses[1] for any reason whatsoever, Medical Staff membership and/or clinical privileges shall be automatically suspended as of the date such action becomes effective.

9.3.1.2 Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner (in other words, the member may continue to practice only to the extent allowed by the unrestricted aspects of his/her license or credential, if any), as of the date such action becomes effective and throughout its term.

9.3.1.3 Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation, effective as of the date the probation was imposed.

9.3.1.4 Termination of Suspension/Restriction and Reinstatement. The automatic suspension or restriction imposed upon a member pursuant to this Section may terminated and membership and/or privileges reinstated under the following terms and conditions:

9.3.1.4.1 Revocation, Restriction, or Probation. When and if the member's license/certification/registration is reinstated following a revocation or restrictions or terms of probation removed by the licensing/certifying agency, the member may make a written request to the MEC that the automatic suspension or restrictions be removed. Upon request, the MEC shall consider the matter at its next regularly scheduled meeting, and shall make a recommendation to the Board. If the MEC recommendation is potentially adverse to the member, then the member shall have a right to a Fair Hearing pursuant to the Fair Hearing and Appellate Review Plan, and the matter shall be resolved in accordance with the Plan. If the MEC recommendation is not potentially adverse to the member, then the recommendation shall be referred to the Board for final action. If the Board's proposed final action is potentially adverse to the member, than the member shall have the right to an appellate review pursuant to the Fair Hearing and Appellate Review Plan, and the matter shall be resolved in accordance with the Plan.

9.3.1.4.2 Lapse of Licensure/Certification/Registration. When a member's license/certification/registration has lapsed and is subsequently reinstated without restriction or modification, then upon the member's request and presentation of appropriate documentation of such reinstatement, the Chief of Staff may summarily reinstate the member's membership and/or clinical privileges. However, if in the sole discretion of the Chief of Staff there are extenuating circumstances that warrant further review, the Chief of Staff may decline to reinstate the member's membership/privileges, pending review by the MEC. If the MEC concludes that a restriction or terms of probation should be imposed upon the member's membership and/or privileges, it shall make a recommendation to the Board and the member shall be afforded the right to a Fair Hearing under the Fair Hearing and Appellate Review Plan.

9.3.2 Medicare/Medicaid/Federal Health Program Sanctioned Provider Exclusion List

The staff membership and clinical privileges of a member whose name appears on the list of excluded providers maintained by Medicare, Medicaid, or other applicable federal health programs shall be automatically terminated without rights under the Fair Hearing Plan/Appellate Review, effective upon the date the member's name so appears.

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[1] For purposes of these Bylaws, a "lapse" refers to a lapse in good standing status as a result of the member's failure to timely renew or other inaction by the member, or the failure of the licensing/certifying agency to timely renew the license or certification due to factors beyond the control of the member.

9.3.3 Fourteen-Day Rule

In the following instances, the member's privileges and/or membership may be suspended or limited as described for up to 14 days which action shall be final without a right to hearing or further review:

9.3.3.1 Failure to Satisfy Special Appearance Requirement: A member who fails without good cause to appear and satisfy the requirements requesting his or her presence at a special meeting listed in the Medical Staff Documents shall without good cause be automatically suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that Section.

9.3.3.2 Medical Records: Members of the Medical Staff are required to complete medical records within the timeframes prescribed in the Medical Staff Rules and Regulations. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or his/her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases and providing professional services within Jackson Hospital on patients. Bona fide vacation or illness may constitute an excuse subject to approval by the MEC. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations and when good faith effort to provide alternative coverage failed and the Chief of Staff or his/her designee has been notified. The formal suspension shall continue until lifted by the Chief of Staff or his/her designees in accordance with the Tier 1 Medical Records Completion Policy.

9.3.4 Failure To Pay Dues/Assessments

Failure without good cause as determined by MEC, to pay dues or assessments by February 1, as required in these Bylaws, shall be grounds for automatic suspension of a member's clinical privileges, and if by March 31 after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated.

9.3.5 Failure to Maintain Professional Liability Insurance

Failure to maintain professional liability insurance, if required, shall result in an automatic suspension of a member's clinical privileges, and if within 90 days after written notice of the automatic suspension the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

9.3.6 MEC Deliberation

As soon as practicable after action is taken or warranted as described above in Section 9.3.1, 9.3.2, 9.3.3, 9.3.4, or 9.3.5, the MEC shall convene to review and consider the facts, and may recommend any further corrective action, including summary restriction or suspension, as it may deem appropriate in accordance with the Medical Staff Documents.

9.3.7 Reporting to State

Any adverse actions taken against privileges or membership shall be reported to the appropriate state and/or federal agencies as required by law.

10.0 GENERAL PROVISIONS

10.1 Construction of Terms and Headings

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. The Bylaws apply with equal force to both sexes wherever either term is used.

10.2 Notices

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee, if known or applicable
Name of Department or Committee
(c/o Medical Staff Coordinator, Chief of Staff)
Hospital name
Street address
_____, Michigan _____

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the Hospital.

11.0 Review, Revision, Adoption, and Amendment of Medical Staff Documents

11.1 Procedure for Core Bylaws, Credentials Manual, Organization and Functions Manual, Rules and Regulations, and Fair Hearing Plan/Appellate Review

Upon the request of (1) the MEC, the Chief of Staff and/or Bylaws Committee after approval by the MEC, or (2) upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of the Core Bylaws, Credentials Manual, Organization and Functions Manual, Rules and Regulations, and Fair Hearing Plan/Appellate Review Manual.

11.2 Action On Core Bylaws, Credentials Manual, Organization and Functions Manual, Rules and Regulations, And Fair Hearing Plan/Appellate Review Changes

Following the MEC's approval of the form and substance of a proposed amendment generated by the MEC per §11.1(1) above, or the form (not substance) of a proposed amendment generated by the Medical Staff per §11.1(2) above, each member of the Medical Staff eligible to vote will receive the proposed amendment(s) with the electronic voting ballot, distributed at least seven (7) business days prior to the meeting at which the amendments will be voted upon. Such action will be taken at a regular, special, or electronic meeting of the Medical Staff, provided one (1) written notice of the proposed change was sent to members at least seven (7) business days prior to the meeting. Should the Medical Staff recommend approval of proposed revisions as presented, without substantive revision, the recommendation for approval shall be forwarded to the Board for consideration.

Members may notify the Chief of Staff of concerns prior to the Medical Staff meeting at which a vote will be conducted; the Chief of Staff will notify the Medical Staff of such concerns and/or recommendations.

Adoption of, or changes in, the Medical Staff Documents shall require an affirmative vote by the eligible voting members, in order for the amendment to be approved. Electronic voting ballots will be sent to the Medical Staff at least seven (7) business days prior to the GMS meeting and will conclude on the day following the meeting.

Invalid elections (i.e. insufficient number of votes cast) will be referred to the Medical Executive Committee, which will determine the outcome of the Medical Staff's decision prior to forwarding a recommendation to the Board. The Medical Staff will be notified of the Medical Executive Committee's recommendation. Any proposed amendment so approved by the Medical Staff shall be forwarded to the Board for consideration. Amendments so adopted shall be effective when approved by the Board.

The Medical Staff Documents shall be reviewed (and may be revised if necessary) every two (2) years. Applicants and members of the Medical Staff shall be governed by such Medical Staff Documents as are properly initiated and adopted. If there is a conflict between the Bylaws and other Medical Staff Documents, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Documents.

11.4 Approval

Bylaw changes approved by the Medical Staff shall become effective following approval by the Board. If approval is denied or unreasonably delayed, the Board shall specify the reasons for the denial/delay in writing to the Chief of Staff. The Medical Staff shall amend the Bylaws or any other Medical Staff Document in order to bring the Medical Staff and/or Hospital into compliance with state or federal law. In the case of a documented need for an urgent amendment to the Rules and Regulations as a result of legal or compliance concerns, the MEC may provisionally adopt and the Board may provisionally approve such an amendment without prior notice to Medical Staff. However, the Medical Staff shall be urgently notified of such action by the MEC, and the Medical Staff shall be provided an opportunity for retrospective review and comment on the provisional amendment. If the Medical Staff does not object to the provisional amendment by the number of votes required to otherwise reject an amendment to the Rules and Regulations, the provisional amendment shall stand as a final amendment. If the provisional amendment is rejected by the Medical Staff, the process for resolving conflicts between the MEC and the Medical Staff shall be implemented.

11.5 Exclusivity

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Documents.

11.6 Effect of the Bylaws

Upon adoption and approval as provided in this Section, the revised Bylaws will be posted on the Henry Ford Health intranet. These Bylaws shall govern the activities of the Medical Staff, both individually and collectively.

11.7 Successor in Interest

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff and the Hospital, and any successor in interest of the Hospital, except where Medical Staffs are being combined. In the event that the Staffs are being combined, the Medical Staffs shall work together to develop new Bylaws, which will govern the combined Medical Staffs, subject to the approval of the Board or its successor in interest.

Until such time as the new Bylaws are approved, the existing Bylaws of each institution will remain in effect.

11.8 Affiliations

Affiliations between the Hospital and other Hospitals, health care systems or other entities shall not, in and of themselves, affect these Bylaws.

ADOPTED by the Medical Staff on

March 16, 2023
Date

Samir Parikh, MD
Chief of Staff

Nicholas Dyc, MD
Secretary/Treasurer/Communications Officer

APPROVED by the Board of Trustees on

May 17, 2023
Date

Martha Fuerstenau
Chairman

Aaron Boatin
Secretary

Emily Moorhead
President of the Hospital

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June 2022
March 2023

Medical Staff Bylaws:
Credentials Procedure Manual

Henry Ford Jackson Hospital

Revised June 2022

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1.0 CREDENTIALS COMMITTEE

1.1 Composition

The members of this Committee of the Medical Staff shall consist of the Chief of Staff, Chief of Staff-Elect, the three (3) past Chiefs and an at-large member recommended by the Chief of Staff and appointed by the MEC, and the Chief Nursing Officer or designee. The Chair of the Credentials Committee shall be the current Chief of Staff-Elect. When an application or matter regarding a physician is considered, the Chief of that Service may be invited to participate in the discussion and is expected to come to the meeting upon request. Vacancies created by the departure of any of the former Chiefs of Staff shall be filled, whenever possible, by a previous Chief of Staff. If this is not possible, the Chief of Staff shall appoint an experienced, active Medical Staff member. Non-voting members shall include the Vice President for Medical Affairs, and a representative from Hospital Administration.

1.2 Duties

The duties of this Committee shall include:

1.2.1 Reviewing and evaluating the qualifications of each individual applying for initial appointment or reappointment as Medical Staff members or initial granting, renewal or modification of clinical privileges for Staff members or Allied Health Professionals, and, in connection therewith, obtaining and considering the input of the appropriate Clinical Service Chief if indicated;
1.2.2 Reviewing and recommending action on all applications and reapplications for membership and status on the Medical Staff;
1.2.3 Submitting required reports to the MEC on the qualifications of each individual applying for membership or particular clinical privileges for Medical Staff members or Allied Health Professionals, including recommendations with respect to appointment, membership category, Clinical Service affiliation, clinical privileges and special conditions;
1.2.4 Investigating, reviewing and reporting on matters referred by the Chief of Staff or the MEC concerning the qualifications, conduct, professional character or competence of any applicant or Medical Staff member;
1.2.5 Maintaining records/minutes and reporting as scheduled to the MEC on its activities and the status of pending applications and
1.2.6 Performing such other functions as requested by the MEC.

1.3 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair, but not less than quarterly.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the Credentials 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.

2.0 QUALIFICATIONS FOR MEMBERSHIP TO THE MEDICAL STAFF

2.1 No Entitlement to Membership

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

2.2 Qualifications

All applicants for appointment and reappointment to the Medical Staff must meet the following qualifications before an application will be processed (except for the honorary and retired staff in which case criteria shall apply as deemed individually applicable by the MEC).

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine; in the field that encompasses the privileges held or sought;

2.2.1.1 APP applicants must demonstrate that s/he has successfully completed an accredited training program, as listed on the delineation of privilege forms.

2.2.2 Have obtained or are in the process of obtaining certification from an American Board of Medical Specialties or American Osteopathic Association-approved Board or their equivalent which must be obtained within six years from date of completion of training and education to be eligible for appointment or reappointment.

2.2.2.1 APPs must have obtained certification by a recognized body, as per the delineation of privilege forms to be eligible for appointment or reappointment.

2.2.3 Maintain board certification as required by the appropriate specialty Board, in the specialty which is the primary focus of the provider's practice.

2.2.3.1 If an Applicant does not meet Board Certification requirement and there are extraordinary reasons to support the application, the Clinical Service Chief must send a written request to the Credentials Committee requesting a waiver prior to that committee's review of the applicant's initial appointment file. Following review by the Credentials Committee, a recommendation will be forwarded to the Medical Executive Committee, who will make the final decision regarding approval or denial of the waiver. Reappointment is contingent upon Board Certification as outlined in the Medical Staff documents.

2.2.4 Oral and maxillofacial surgeons or other dental specialists 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 training program and be board certified or board admissible to the appropriate American Dental Specialty Board.

2.2.5 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 board admissible by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine.

2.2.6 Do not meet the criteria listed in 1-5 above, but have Medical Staff membership prior to January 1, 1998, will be grandfathered in at the time of the adoption of the present Credentials Procedure Manual (1/04).

2.2.7 Have a current unrestricted license, if applicable, as required for the practice of his/her profession with the state of Michigan.

2.2.8 Possess a current, valid, unrestricted drug enforcement administration (DEA) number if necessary for hospital practice.

2.2.9 Demonstrate recent clinical performance and competence in the area in which clinical privileges are sought, for purposes of ascertaining current clinical competence.

2.2.10 Provide evidence of skills to provide a type of service that the Board of Trustees has determined to be appropriate for the performance within the Hospital and for which a need exists.

2.2.11 Shall not appear on Medicaid/Medicare sanctioned provider exclusion lists.

2.2.12 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 the specific privileges requested by and granted to the applicant.

2.2.13 Have appropriate personal qualifications, to include a record of applicant's observance of ethical standards including:

2.2.13.1 Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities.
2.2.13.2 A record of working professionally and in a collaborative and cooperative manner with others within an institutional setting.
2.2.14 Have appropriate written and verbal communication skills.
2.2.15 Any member of the Medical Staff who may have occasion to admit an inpatient must demonstrate the capability to provide continuous care by having a plan to reside and/or have established or plan to establish an office within a reasonable distance of Jackson Hospital (unless the applicant is joining a group practice in which members of the group live within that distance). The applicant must provide evidence of acceptable patient coverage to the MEC.
2.2.16 Medical Staff Financial Obligations: All financial obligations of the Medical Staff shall be approved in accordance with the Bylaws. All dues and assessments are due and payable at the first of each calendar year. Statements will be mailed by December 1st. Dues not paid by February 1 as required in the Medical Staff Documents, shall be grounds for automatic suspension of a member's clinical privileges, and if by March 31 after written warnings of the delinquency the member does not pay the required dues or assessments, the member's membership shall be automatically terminated. Termination or suspension of privileges or membership under these conditions shall not entitle the member to any rights under the Fair Hearing Plan/Appellate Review.

2.3 Liability Insurance

Maintain professional liability insurance from an insurer recommended by the MEC and approved by the Board. The following kinds of insurers shall be deemed approved by the Board:

2.3.1 An insurer which writes primary insurance as part of Hospital-sponsored insurance program; or
2.3.2 An insurer licensed by the state of Michigan; or
2.3.3 An insurer authorized by the Michigan Insurance Bureau to do business in Michigan as an eligible authorized surplus line ("surplus line") carrier, which has a current A.M. Best Rating of "A" (excellent).
2.3.4 For approval of any other type of insurer, financial statements and other documentation requested by the MEC and the Board shall be submitted by the Medical Staff member. The MEC shall send its recommendation to the Board. The decision of the Board is final and is not reviewable under the Fair Hearing Plan/Appellate Review.
2.3.5 Effective January 2004, new applicants joining the Medical Staff and current Medical Staff members must maintain coverage of at least $200,000 per claim/incident and $600,000 annual aggregate. In the event the insurance coverage obtained by a Medical Staff member is "claims-made" coverage, the Medical Staff member shall be required to maintain tail coverage or its equivalent relative to services performed within the Hospital in the event Medical Staff membership is terminated or the member changes professional liability insurance carriers. The Medical Staff Affairs Office of Jackson Hospital shall be listed as a certificate holder on professional liability insurance certificates.

3.0 APPLICATION REQUEST PROCEDURE

All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to the Medical Staff Affairs Office. Upon receipt of a request for an application, the Medical Staff Affairs Office will provide the potential applicant with an application, a privilege request form(s) including criteria for privileges, a detailed list of requirements for completion of the application, and a copy of the Medical Staff Documents.

4.0 INITIAL APPOINTMENT/REAPPOINTMENT PROCEDURE

(Also see Section 5.0 for additional information on reappointment procedure.)

4.1 Burden of Producing Information

In connection with all applications for appointment and/or reappointment, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the MEC, which may select the examining physician.

4.2 Appointment Authority

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Medical Staff Documents, but only after there has been a recommendation from the MEC to the Board of Trustees, or as set forth under Corrective Action.

4.3 Duration of Appointment and Reappointment

Except as otherwise provided in the Medical Staff Documents, initial appointments and reappointments shall be for a period of twenty-four (24) months. The first twelve (12) months of a Member's initial appointment shall be in a Provisional status, as that term is defined in the Appendix to the Medical Staff Documents and described in Article 6 of this Credentials Procedure Manual.

4.4 Application for Initial Appointment and Reappointment

4.4.1 Application Form

The Henry Ford Health Provider Affairs Office shall develop an application form. The form shall require detailed information which may include, but not be limited to, information concerning:

4.4.2.1 The applicant's qualifications, i.e., professional training and experience, current licensure, current DEA registration, life support training certification (if applicable), and continuing medical education information appropriate to the clinical privileges requested by the applicant;
4.4.2.2 Peer references familiar with the applicant's professional conduct, competence and ethical character;
4.4.2.3 Requests for membership categories, Clinical Service(s), and clinical privileges
4.4.2.4 Past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, probation, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters at any organization;
4.4.2.5 Current physical and mental health status which may affect the applicant's ability to safely perform the privileges requested with or without accommodation;
4.4.2.6 Final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending; and
4.4.2.7 Professional liability coverage and claims history obtained and evaluated for the past five (5) years.

Applications shall be submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable) and signed by the applicant. A photo ID shall be submitted with the application.

4.4.3 Effect of Application

In addition, by submitting an application for appointment to the Medical Staff each applicant:

4.4.3.1 Signifies willingness to appear for interviews;
4.4.3.2 Authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
4.4.3.3 Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
4.4.3.4 Releases from any liability, to the fullest extent provided by law, all persons for their acts performed in good faith in connection with investigating and evaluating the applicant;
4.4.3.5 Releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
4.4.3.6 Consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law;
4.4.3.7 Agrees that any lawsuit brought by the applicant against any individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located;
4.4.3.8 If a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
4.4.3.9 Pledges to provide for continuous quality care for patients;
4.4.3.10 Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners; and
4.4.3.11 Pledges to be bound by the Medical Staff Documents and policies.

4.4.4 Verification of Information

The applicant shall electronically submit a completed, signed, and dated application and supporting documents to the Central Verification Office. and payment of medical staff dues, if applicable.

The appropriate members of the Medical Staff and Administration shall be notified of the application. The Central Verification Office and Medical Staff Affairs Office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. In addition, the Central Verification Office shall query the National Practitioner Data Bank regarding the applicant or member and any other data bank source required by law or regulation.

The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any requested information. When collection and verification of all information is accomplished, the application shall be considered complete. All such information shall be transmitted to the Credentials Committee. A recommendation from the appropriate Clinical Service Chief may be requested. Applicants are contacted weekly by the Central Verifications Office (CVO) to submit a completed application. After multiple attempts to

obtain a completed application, the CVO will reach out to the Medical Staff Affairs Office to ask if the initial application portal may be closed. The Medical Staff Affairs Office will connect with local leaders to determine a course of action regarding the initial applicant's voluntary withdrawal, due to non-responsiveness. When an applicant does return the application, but it is incomplete, the CVO will contact the applicant once every three (3) business days to obtain the missing items. If there is no progress after multiple attempts to obtain the missing information, the CVO will reach out to the Medical Staff Affairs Office to ask if the initial application portal may be closed.

If within six (6) months of the aforementioned voluntary withdrawal of the application, the applicant decides to reactivate the application process, s/he will be sent his/her original application for updating and re-signing, along with a Consent to Release form for signature and submission to the Medical Staff Affairs Office. All missing information, which caused the initial voluntary withdrawal, must also be submitted prior to the Medical Staff Affairs Office recommencing the processing of the file.

If more than six (6) months have passed since the applicant voluntarily withdrew his/her application, and s/he decides to reactivate the process, a new application shall be completed and submitted to the Central Verification Office. In addition, the missing information, which initially caused the voluntary withdrawal of the application, shall be submitted.

Should the application have two (2) consecutive deactivations, the applicant will not be eligible to reapply to the Medical Staff for a period of twenty-four (24) months from the effective date of the last deactivation at which time a new application shall be completed and submitted to the Central Verification Office. In addition, the missing information, which initially caused the voluntary withdrawal of the application, shall be submitted.

4.4.5 Clinical Service Action

Under the direction of the Credentials Committee, the Chief(s) and appropriate subject matter experts, as deemed necessary by the Credentials Committee, may review the application and supporting documentation according to established Medical Staff criteria regarding clinical privileges, professional conduct and competence, and may conduct a personal interview with the applicant. If requested by the Credentials Committee or Medical Executive Committee, the Chief and/or subject matter expert shall forward a written evaluation to the Credentials Committee. The Chief and/or subject matter expert may also suggest that the Credentials Committee defer action.

4.4.6 Credentials Committee Action

The Credentials Committee shall review the application and evaluate the supporting documentation, the Service Chief's/subject matter expert's evaluation, if provided, and other relevant information. The Credentials Committee may elect to defer action to interview the applicant and seek additional information. The Credentials Committee shall transmit to the MEC a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, Service affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

4.4.7 MEC Action

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or soon thereafter, the MEC shall consider the report and any other relevant information. The MEC may defer action to request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The MEC shall forward to the Board, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, Service affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The reasons for each adverse recommendation shall be stated.

4.4.8 Effect of MEC Action

4.4.8.1 **Deferred Action**: The MEC shall notify the applicant in writing of this action and the general rationale behind it.

4.4.8.2 **Favorable Recommendation**: When the recommendation of the MEC is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

4.4.8.3 **Adverse Recommendation**: When a final recommendation of the MEC is adverse to the applicant, the Board and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in the Fair Hearing Plan/Appellate Review.

4.4.9 Board Action on the Application

The Board may accept the recommendation of the MEC or may refer the matter back to the MEC for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

4.4.9.1 **Favorable MEC Recommendation**: The MEC recommendations are forwarded to the Board for final action.

4.4.9.1.1 If the Board concurs in that recommendation, the decision of the Board shall be deemed final action.

4.4.9.1.2 If the tentative final action of the Board is unfavorable, the CEO shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in the Fair Hearing Plan/Appellate Review. If the applicant waives procedural rights, the decision of the Board shall be deemed final action.

4.4.9.2 **Adverse MEC Recommendation**: In the event the recommendation of the MEC, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in the Fair Hearing/Appeal Plan shall apply.

4.4.9.2.1 If the applicant waives procedural rights, the recommendations of the MEC shall be forwarded to the Board for final action.

4.4.9.2.2 If the applicant requests a hearing following the adverse MEC recommendation or an adverse Board tentative final action, the Board shall take final action only after the applicant has exhausted all procedural rights as established by the Fair Hearing Plan/Appellate Review. After exhaustion of the procedures set forth in this Plan, the Board shall make a final decision. The Board's decision shall be in writing and shall specify the reasons for the action taken.

4.4.10 Notice of Final Decision

4.4.10.1 Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and the Credentials Committees, the Chief of each Service concerned, the applicant, and Administration.

4.4.10.2 A decision and notice to appoint or reappoint shall include, if applicable:

4.4.10.2.1 The Staff category to which the applicant is appointed;

4.4.10.2.2 The Service to which that person is assigned;

4.4.10.2.3 The clinical privileges granted; and

4.4.10.2.4 Any special conditions attached to the appointment.

4.4.11 Reapplication after Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of twenty-four (24) months from the date of the final decision. Any such reapplication shall be processed as an initial application, and the

applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.5 Timely Processing of Applications

Applications for appointments shall be considered in a timely manner by all persons and committees required by the Medical Staff Documents to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

4.5.1 Evaluation, review, and verification of application and all supporting documents by the Medical Staff Affairs Office;
4.5.2 Evaluation by Chief of the Service(s) and/or the Credentials Committee's designated subject matter expert: 15 days after receipt of all necessary documentation from the Medical Staff Affairs Office;
4.5.3 Review and recommendation by Credentials Committee: 30 days after receipt of all necessary documentation from the Service(s);
4.5.4 Review and recommendation by MEC: 30 days after receipt of all necessary documentation from the Credentials Committee; and
4.5.5 Final action: review by the Medical Staff Affairs Office after conclusion of hearings.

5.0 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

5.1 Application

5.1.1 At least 150 days prior to the expiration date of the current staff appointment (except for temporary appointments), a link to the electronic reappointment application shall be emailed to the member requesting response within 30 days. If an application for reappointment is not received by the end of the month (30 days), the reappointment application will not be accepted, and the completion of a new application will be required for staff membership and/or privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.0 above, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Section 4.0 above.
5.1.2 A Medical Staff member who seeks a change in Medical Staff status (if applicable) or modification of clinical privileges may submit such a request at any time upon a form developed by the MEC except that such application may not be filed within 90 days of the time a similar request has been denied.

5.2 Effect of Application

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.0 above.

5.3 Standards and Procedure for Review

When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Section 4.0 above. Also see Credentialing Policy in the Appendix.

5.4 Limited Reappointment

If it appears that an application for reappointment will not be fully processed by the expiration date of the member's appointment, for reasons other than due to the applicant's failure to return documents or otherwise timely cooperate in the reappointment process, the MEC and the Board shall approve a time- and member-specific reappointment of the member's status and clinical privileges. Any reappointment pursuant to this Section does not create a vested right in the applicant for continued appointment through the entire next term. The applicant shall continue to be subject to the reapplication review process as outlined in Parts 4 and 5 above. The length of the subsequent reappointment shall be adjusted to keep the Medical Staff member in the original 24-month reappointment period.

5.5 Failure to Submit Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic termination of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current Staff appointment. If the practitioner fails to submit a completed application for reappointment 90 days prior to the expiration of his/her current Medical Staff appointment, the individual shall be sent a certified, return receipt letter declaring that within 5 business days from the receipt of the letter, the practitioner must respond with a completed application or be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in the Fair Hearing Plan/Appellate Review shall not apply.

6.0 PROVISIONAL STATUS

6.1 Provisional Period

All initial appointments with clinical privileges granted to a Medical Staff member, are provisional for a period of one year, during which time all individuals with provisional privileges shall be subject to review of their performance. Provisional staff shall participate in a hospital/medical staff orientation process at the beginning of their provisional period.

6.2 Action Required

Based upon a report concerning the applicant's performance at the end of the provisional period the Credentials Committee makes a recommendation to the MEC concerning continuing or terminating the provisional period.

6.3 Extension

If occasionally, initial appointees require proctoring and are unable to obtain the number of cases required of him/her with respect to a particular clinical privilege because his/her caseload was inadequate to demonstrate the ability to exercise that privilege, s/he will be required to submit to the Credentials Committee a statement to this effect. Included in this statement shall be a description of his/her caseload as well as a signature by the Clinical Service Chief or subject matter expert. Upon review of the documentation with input from the Service Chief and/or subject matter expert, the Credentials Committee may extend the practitioner's provisional period for an additional defined period.

6.4 Termination by Practitioner

If the practitioner no longer wishes the privilege or privileges at issue, then his/her request for the deletion of these privileges will not create an adverse action triggering the Fair Hearing Plan/Appellate Review.

6.5 Adverse Conclusions

Whenever a provisional period (including any period of extension) expires with an adverse recommendation for the practitioner based on reasons of professional conduct or quality of care issues, or whenever extension is denied, the CEO will provide him/her with notice of the adverse result and of his/her entitlement to procedural rights provided in the Fair Hearing Plan/Appellate Review.

7.0 CLINICAL PRIVILEGES

7.1 Delineation of Privileges in General

7.1.1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for additional clinical privileges may be made, but such requests must be supported by documentation of training, current competence, and/or recent experience supportive of the request, as described in the respective Medical Staff Documents.

7.1.2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence as specified by the Hospital in its Board-approved criteria for clinical privileges and judgment, clinical performance, current health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, such as a program director or Chief's response as to the ability to perform requested privileges.

7.1.3 Privileges for Which No Criteria Have Been Established

7.1.3.1 In the event a request for privileges is submitted for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) days, during which the MEC will, upon recommendation from the Credentials Committee and appropriate subject matter experts, formulate the necessary criteria and recommend these to the Board of Trustees. Once objective criteria have been established, the original request will be processed as described herein.

7.1.3.2 For the development of criteria, the applicant in conjunction with the Medical Staff Affairs Office as well as an expert or outside expert 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.

7.1.3.3 Criteria to be established for the privilege(s) in question include education, training, board status, or certification (if applicable), and experience. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital-related issues such as equipment and management will be referred to the appropriate Hospital department director.

7.1.3.4 If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Chair of the Credentials Committee 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.

7.1.4 Following Procedures

Medical Staff privileges may be granted, continued, modified or terminated by the Board only upon recommendation of the Medical Staff through the MEC only for reasons directly related to quality of patient care and other provisions of the Medical Staff Documents, and only following the procedures outlined in those Documents.

7.2 Conditions for Privileges of Podiatrists

7.2.1 Surgery

Surgical procedures performed by podiatrists shall be under the oversight of the Chief of the Clinical Service of Surgery or the Chief's designee.

7.2.2 Medical Appraisal

All patients co-admitted for care in the Hospital by a podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a podiatrist based upon medical or surgical factors outside the scope of licensure of the podiatrist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Service(s).

7.3 Conditions for Privileges of Maxillofacial Surgeons and Dentists

7.3.1 Admissions

7.3.1.1 Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the Post Graduate Program in Oral and Maxillofacial Surgery and have been determined by the Medical Staff to be competent to do so, may admit and perform a history and physical examination and determine the ability of his/her patient to undergo the surgical procedures the oral and maxillofacial surgeon proposes to perform. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

7.3.1.2 Dentists or other dental specialists who are members of the Medical Staff may only co-admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry), and assumes responsibility for the care of the patient's medical problems present at the time of co-admission or that may arise during hospitalization which are outside of the dentist's lawful scope of practice.

7.3.2 Surgery

Surgical procedures performed by oral and maxillofacial surgeons and dentists shall be under the overall supervision of the Chief of the Clinical Service of Surgery or the Chief's designee.

7.3.3 Dispute Resolution

Where a dispute exists regarding proposed treatment between a physician member and oral and maxillofacial surgeon or dentist, based upon medical or surgical factors outside of the scope of licensure of the oral and maxillofacial surgeon or dentist, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Service(s).

7.4 Privileges of Psychologists

Psychologists may not admit patients. Psychologists, however, may perform services within the scope of their specifically delineated clinical privileges for patients admitted by other staff members at the request of such practitioner.

7.5 Privileges of Telemedicine Practitioners

Those practitioners who diagnose or treat patients via telemedicine received within the Hospital are subject to the credentialing and privileging processes of the Medical Staff Documents. If the telemedicine practitioner is consulting only, then the practitioner does not need to be privileged and these requirements do not apply. The MEC recommends to the Board the clinical services to be provided by telemedicine. The Board shall determine the appropriate services to be provided.

7.6 Temporary Clinical Privileges

7.6.1 Temporary Privileges

The denial, termination, suspension or restriction of any category of temporary privileges does not entitle the practitioner to any of the procedural rights under the Fair Hearing Plan/Appellate Review unless it adversely impacts the practitioner's application for Medical Staff membership.

7.6.2 Care of a Specific Patient

Temporary clinical privileges may be granted where good cause exists to a board-certified or board-eligible physician, dentist, podiatrist, psychologist, nurse practitioner, physician assistant, certified registered nurse anesthetist, or certified nurse midwife for the care of a specific patient for a limited time frame as determined by the Chief of Staff or designee) provided that the procedure described in Section 7.6.6 below has been completed.

7.6.3 Locum Tenens

Temporary clinical privileges may be granted to a board-certified or board eligible physician or APP serving as a locum tenens, provided that the procedure described in Section 7.6.6 below has been completed. Such physician may attend patients for a period not to exceed 90 days, unless the MEC recommends a longer period for good cause. The locum tenens privileges shall not be used to circumvent or expedite the credentialing process.

7.6.4 Pending Application for Medical Staff Membership

Temporary privileges in this category can only be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time and after approval by the Board or its designee upon recommendation by the Chief of Staff or his/her designee. Temporary privileges are not to be routinely used for applications not completed in a timely manner. In addition, temporary privileges shall not be used to circumvent or expedite the credentialing process. Temporary clinical privileges may be granted to a person during pendency of that person's application for Medical Staff membership and privileges, provided that the procedure described in Section 7.6.5 below has been completed. This period shall not exceed 120 days.

7.6.5 Application and Review

7.6.5.1 Upon receipt of a completed application and supporting documentation from an authorized practitioner to practice in Michigan, the Board or its designee, upon recommendation by the Chief of Staff or his/her designee, may grant temporary privileges to an applicant who appears to have qualifications, ability and judgment, but only on a case by case basis when there is an important patient care need that

mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Temporary privileges shall not be used to circumvent or expedite the credentialing process. Basic data for temporary privileges must include:

7.6.5.1.1 The Hospital's authorized representative's query of the National Practitioner Data Bank regarding the applicant for temporary privileges.

7.6.5.1.2 The Hospital's authorized representative's verification of the practitioner's current licensure, professional liability insurance, and DEA registration as applicable.

7.6.5.1.3 The Clinical Service Chief may contact a person who has recently worked with the applicant, has directly observed the applicant's professional performance over a reasonable time and provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care. The Clinical Service Chief may, at his/her discretion, interview the applicant.

7.6.5.1.4 The submission of a photo ID.

7.6.5.2 The applicant is otherwise eligible for the expedited credentialing process as evidenced by:

7.6.5.2.1 No current or previously successful challenge to licensure or registration;

7.6.5.2.2 Not having been subject to involuntary limitation, reduction, denial or loss of clinical privileges by any healthcare organization; and

7.6.5.2.3 Not having been subject to involuntary termination of Medical Staff membership at another healthcare organization.

7.6.5.2.4 Having a satisfactory determination by the Chief of Staff that there has been neither an unusual pattern of, nor an excessive number of, professional liability actions resulting in a final judgment against the applicant.

7.6.5.3 The applicant's file, which includes the evaluation of the Clinical Service Chief, is forwarded to the Credentials Committee Chair and Chief of Staff or designee who recommends the granting of temporary privileges. The Hospital President or its designee shall grant temporary privileges.

7.6.5.4 In the event of a disagreement between the Hospital President or its designee, the Credentials Committee Chair, and/or the Chief of Staff or his/her designee regarding the granting of temporary clinical privileges, temporary privileges shall not be granted until the matter is sent to the MEC for its recommendation. The recommendation shall then be forwarded to the Board for final approval.

7.6.5.5 If the applicant requests temporary privileges in more than one Service, interviews shall be conducted, and written concurrence shall first be obtained from the appropriate Service Chiefs and forwarded to the Chief of Staff or designee.

7.6.6 <u>General Conditions</u>

7.6.6.1 If granted temporary privileges, the applicant shall act under the supervision of the Clinical Service Chief to which the applicant has been assigned, and shall ensure that the Chief, or the Chief's designee, is kept closely informed as to the applicant's activities within the Hospital.

7.6.6.2 Temporary privileges shall automatically terminate at the end of the designated period unless affirmatively renewed because of extenuating circumstances determined by the Clinical Service Chief and the Chief of Staff. The applicable procedure as set forth above shall be followed. As necessary, the appropriate Chief or designee shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member. Procedural rights under the Fair Hearing Plan/Appellate Review are not available to those holding temporary privileges.

7.6.6.3 Requirements for proctoring and monitoring including, but not limited to, those in this Section shall be imposed according to such terms as may be appropriate under the circumstances on any member granted temporary privileges by the Chief of Staff after consultation with the Service Chief or the Chief's designee.

7.6.6.4 All persons requesting or receiving temporary privileges shall be bound by the Medical Staff Documents.

7.6.7 Outside Consultants

Upon request of the Credentials Committee or Quality Management Committee or MEC to ascertain outside consultants for the purpose of reviewing a specific case(s) or situation(s), evaluating the quality of care under the Committee's assigned professional review function, an appropriately licensed practitioner may, without applying for membership on the Medical Staff, be granted temporary privileges for a duration to be recommended by the Credentials Committee and approved by the Chief of Staff and the Hospital President.

7.6.8 Outside Proctors

Upon request of the Credentials Committee or Quality Management Committee or MEC to ascertain outside proctors for the purpose of observing and monitoring a member of the Medical Staff, an appropriately licensed practitioner may, without applying for membership on the Medical Staff, be granted temporary privileges for a duration to be recommended by the Credentials Committee and approved by the Chief of Staff and the CMO.

7.7 Privileges in Emergency Situations

In the case of an emergency, any member of the Medical Staff, to the degree permitted by the scope of the applicant's license and regardless of Service, Staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the Service Chief concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the qualified members of the Medical Staff with respect to further care of the patient. A practitioner utilizing the emergency privileges shall promptly document in the medical record the circumstances of the emergency.

7.8 Emergency Operations Plan

If the institution's Emergency Operations Plan has been activated, the Disaster Command Officer (AOC) may, on a case by case basis consistent with professional licensing and other relevant state statutes, grant emergency disaster privileges to provide patient care to selected licensed independent practitioners who present at least two (2) of the following required documents (see also EM.02.02.13.05):

7.8.1 Picture identification from a health care organization that clearly identifies professional designation;
7.8.2 Current license to practice with photo identification issued by a state, federal or regulatory agency;
7.8.3 Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group;
7.8.4 Identification indicating the practitioner has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;
7.8.5 Primary source verification of license to practice medicine, nursing, etc.; or
7.8.6 Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

Each practitioner granted disaster privileges will be required to practice under the supervision of a designated member of the Medical Staff whose privileges at a minimum include the disaster

privileges granted to the practitioner. All practitioners will be required to display hospital issued identification while serving in an emergency response capacity.

Primary source verification of licensure will occur as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival.
- Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.
- Evidence of the hospital's attempt to perform primary source verification as soon as possible.

The institution will make a decision within 72 hours regarding the continuation of disaster privileges initially granted. Once the immediate situation has passed and such determination has been made consistent with the institution's Emergency Operations Plan, the practitioner's disaster privileges will terminate immediately. As soon as the disaster is under control, the supervising physician will provide a retrospective review of the practitioners assigned to him/her during the disaster. (see EM.02.02.13.04).

Any individual identified in the institution's Emergency Operations 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 the Fair Hearing Plan/Appellate Review.

7.9 Modification of Clinical Privileges or Service Assignment

On its own, upon recommendation of the Credentials Committee, or pursuant to a request (according to Medical Staff Documents), the MEC may recommend a change in the clinical privileges or Service assignment(s) of a member. The MEC may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Medical Staff Documents.

If a Medical Staff member requesting a modification of clinical privileges or Service assignments fails to furnish the information within the timeframe designated by the Credentials Committee, the application shall automatically lapse, and the applicant shall not be entitled to a hearing as set forth in the Fair Hearing Plan/Appellate Review

7.10 Reporting Requirements

The CEO or his/her designee shall be responsible for compliance with the Health Care Quality Improvement Act of 1986 and its successor statutes and other applicable state and federal law.

7.11 Special Conditions for Intensive Care Medicine Privileges

7.11.1 The area of interest is the care of patients having Intensive Care Patient status.

7.11.2 The applicant must be a member of the Medical Staff in good standing.

7.11.3 Qualifications for Intensive Care Medicine Privileges: Physicians eligible for Intensive Care Medicine clinical privileges must qualify under the following criteria:

7.11.3.1 Board certified in subspecialty of critical care medicine, or if the Physician completed training prior to availability of a subspecialty certification in critical are medicine, be otherwise board certified in medicine, anesthesiology, pediatrics, emergency medicine

or surgery and has (and continues) to provide at least six weeks of fulltime critical care service each year, or

7.11.3.2 Board certified physicians who are additionally certified in the subspecialty of Neurocritical Care Medicine, awarded by the United Council for Neurologic Subspecialties (UCNS) or through the Society of Neurological Surgeon's CAST fellowship with subsequent passage of the associated ABNS exam, or if the board certified physician completed his/her CAST fellowship prior to the availability of the associated ABNS exam, he/she has (and continues) to provide at least six weeks of fulltime critical care service each year.

7.11.4 The intensivist shall be available for consultation and/or intervention in a timely manner consistent with the following Leapfrog ICU guidelines:

7.11.4.1 The intensivist shall be present during daytime hours (8 a.m. – 5 p.m., Sunday thru Saturday) and,

7.11.4.2 Shall manage clinical care to Intensive Care Patients, either exclusively as the attending physician, or as a co-managing physician in a consult and manage status together with admitting/attending physician.

7.11.5 The intensivist shall contact the unit within five (5) minutes of being paged by the patient care team.

7.11.6 All patients admitted to Intensive Care Patient status must be admitted by a physician having Intensive Care Medicine privileges, or if not admitted by a physician having such privileges, be accompanied with an order to consult and co-manage to a physician having such privileges.

7.11.7 Appropriate consultants may be made at the discretion of the attending physician or Intensivist.

7.11.8 The designation of the Captain of the Ship will be determined upon patient admission to an ICU status.

7.11.9 Patients currently assigned an intensive care Accommodation Code are "Intensive Care Patients" under this Section 7.11

7.12 Moonlighting Physicians

Moonlighting Physicians are those physicians currently enrolled in a residency or fellowship program and who provide supplemental physician staffing for specified hospital services. Moonlighting physicians are eligible to provide services at the hospital on a part-time, temporary basis, not to exceed 24 months. Recredentialing is required if twenty-four (24) months is exceeded. Even though a Moonlighting Physician is not providing services at the Hospital as a part of his/her residency training program, he/she must still be in good standing in a full-time formal training program

Moonlighting Physicians shall have no membership rights or responsibilities, including no rights under the Fair Hearing Plan/Appellate Review. No dues are required to be paid.

Moonlighting physicians shall be required to submit a credentialing application, must possess qualifications as listed in sections 2.2.7 through 2.2.14, and professional liability insurance as described in section 2.3 is required.

Moonlighting physicians shall be bound by the Bylaws, rules and regulations, and policies of the Medical Staff.

7.13 Histories and Physicals

All practitioners having privileges to admit patients to the Hospital shall perform, or arrange for another qualified practitioner to perform a physical examination and medical history no more than 30 days before or 24 hours after a patient is admitted to the Hospital, in accordance with such requirements or procedures as are set forth in more detail in the Medical Staff Rules and Regulations or policies.

9.0 LEAVE OF ABSENCE AND NOTIFICATION OF RESIGNATION

9.1 Leave Status

A leave of absence is defined here as any absence from the Hospital over 45 consecutive days but less than one year, with the exception of maternity/paternity leave. A leave of absence of over one year shall result in an automatic termination unless contemplated leaves of longer than one year are acted upon by the Board of Trustees upon recommendation of the MEC. A Medical Staff member may obtain a leave of absence from the Medical Staff upon submitting a written request to the Chief of Staff, Credentials Committee, and Service Chief(s) stating the reason for the leave, the approximate period of leave desired, and coverage arrangements. The leave of absence will be acted upon by the Board of Trustees upon the recommendation of the MEC. During the period of the leave, the member shall not exercise clinical privileges and membership rights and responsibilities shall be inactive unless extenuating circumstances are approved by the MEC.

The obligation to pay dues, if any, and complete medical staff applications, shall continue, unless waived by the MEC.

9.2 Termination of Leave

At least 45 days prior to the termination of the leave of absence, if the leave is greater than three (3) months, or at any earlier time, the Medical Staff member shall request reinstatement of privileges by submitting a written notice to that effect to the Credentials Committee which will be acted upon by the Board of Trustees upon recommendation of the MEC. The Medical Staff member shall submit a summary of relevant activities during the leave.

9.3 Failure To Request Reinstatement

Failure, without good cause, to request reinstatement (after notification by certified mail) 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 under these conditions, shall not be entitled to the procedural rights provided in the Fair Hearing/Appeal Plan. 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.

9.4 Medical Leave of Absence

Whether or not the member has the ability to request a leave, the MEC shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. If the request does involve a pending or active disciplinary matter, the decision to grant the leave of absence shall be determined by the MEC. The request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming his/her practice and safely exercising the clinical privileges requested.

9.5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the MEC. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions in this Manual, but may be granted subject to monitoring and/or proctoring as determined by the MEC.

9.6 Notification of Resignation

The Medical Staff Affairs Office must receive written notification of resignation from the Medical Staff or Allied Health Professional Staff a minimum of two months prior to the effective date of said resignation.

10.0 MEDICAL STAFF CREDENTIALS/QUALITY MANAGEMENT FILES

10.1 Peer Review Files

Any and all information gathered for or by an individual or committee assigned professional or peer review function shall be confidential and not subject to disclosure except as provided by law.

10.2 Retention of Peer Review Information

The *only* information allowable for credentialing and privileging will be maintained in one of two files:

10.2.1 Credentials File

Peer review information that has or is being used as a basis for a credentialing or peer review action, including adverse corrective action, shall be maintained in the Credentials file.

10.2.2 Quality Management File

Information such as trends, statistics, and peer review not used in credentialing shall be found in the Quality Management file. This information must remain confidential and cannot be sent to another individual or health care organization without the knowledge of the physician concerned, except as may be required by law.

10.3 Confidentiality

The following applies to records of the Medical Staff and its Clinical Services and Committees responsible for the evaluation and improvement of patient care:

10.3.1 Medical Staff, Clinical Services, and Committees

The records of the Medical Staff and its Clinical Services and Committees responsible for the evaluation and improvement of the quality of patient care rendered within the Hospital shall be maintained as confidential.

10.3.2 Access

Access to such records shall be limited to the CEO or designee, to Hospital Counsel, Medical Staff Counsel, and to duly appointed officers and Committees of the Medical Staff, Governing Board, and the Quality Management Department, for the sole purpose of discharging their responsibilities and subject to the requirement that confidentiality be maintained. The Medical Staff Affairs Office shall have such access only as is necessary to perform their duties and functions subject to the requirement that confidentiality be maintained.

10.3.3 Copies Made

If copies of a peer review nature are produced, these copies shall remain in the possession of the above named individuals only for the time necessary to carry out their duties pertaining to this material. All copies are then destroyed by the Quality Management Department so that the Credentials file and the Quality Management files remain as the only two locations for peer review documents and related information. If a document of a peer review nature is originally sent to a Service Chief, Officer of the Medical Staff, or an Administrator, s/he may keep this document only to carry out their duties related to such and then promptly have all related material, including the original document, placed in the Quality Management peer review file.

10.3.4 Disclosure

Disclosure of such information to third parties, i.e., licensing or regulatory agencies, other health care providers or facilities, shall be allowed only in conformity with Medical Staff policies officially adopted by the Medical Staff or as may be required by law. Where no officially adopted policy exists, disclosure may occur only with the express approval of the member involved and the MEC, except as required by law.

Information which is disclosed to the Board of the Hospital or its appointed representatives, in order that the Board may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential. Disclosure of such information shall only be made where expressly required or permitted by law, pursuant to officially adopted policies of the Medical Staff.

10.3.5 Medical Staff Member Access

A Medical Staff member will receive a quarterly report from the QM Department outlining his/her practice profile. In addition, a Medical Staff member shall be granted access to his/her own Credentials/Quality Management files, subject to the following provisions:

10.3.5.1 Timely notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee;

10.3.5.2 The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Chief of Staff. Such summary shall disclose the substance, but not the source, of the information summarized;

10.3.5.3 The review by the member shall take place in the Medical Staff Affairs Office, during normal working hours, with a Medical Staff officer or designee present.

10.3.6 Prehearing Procedure

In the event a notice of action or proposed action is filed against a member, access to that member's Credentials/Quality Management file shall be governed by the Prehearing Procedure.

10.4 Member's Opportunity To Request Correction/Addition to Information in Files

10.4.1 After review of the files as provided under this Section, the member may address to the Chief of Staff a written request for comments/addition of information in the credentials/ Quality Management files. Such request shall include a statement of the basis for the action requested.

10.4.2 The Chief of Staff shall review such a request within a reasonable time and shall recommend to the MEC, after such review, whether or not to make the

comments/addition requested. The MEC, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

10.4.3 The member shall be notified promptly, in writing, of the decision of the MEC and a copy of this request and the MEC's written decision shall be inserted in the member's file.

10.4.4 In any case, a member shall have the right to add to his/her own files, upon written notice to the MEC, a statement responding to any information contained in the files.

11.0 PRACTITIONER PROVIDING CONTRACTUAL SERVICES

11.1 Exclusivity Policy

Whenever Hospital policy specifies that certain Hospital services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the Hospital and qualified practitioners, then other staff appointees 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 services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the System. Limitations of privileges pursuant to this Section will not be considered an adverse action and, therefore, the Fair Hearing Plan will not apply.

11.2 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 at least 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.

11.3 Effect of Disciplinary or Corrective Action Recommended by the MEC

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

11.4 Effect of Contract or Employment Expiration or Termination

See Fair Hearing Plan/Appellate Review.

12.0 REVIEW, REVISION, ADOPTION AND AMENDMENT OF CREDENTIALS PROCEDURE MANUAL

Refer to Section 11.0 of the Core Bylaws.

ADOPTED by the Medical Staff on

June 16, 2022
Date

Rami Alzebdeh, MD
Chief of Staff

Imran Tarrar, MD
Secretary/Treasurer/Communications Officer

APPROVED by the Board of Trustees on

July 20, 2022

Date

Martha Furstenau
Chair

Aaron Boatin
Secretary

Emily Moorhead
President of the Hospital

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HENRY FORD HEALTH℠

Medical Staff Bylaws: Fair Hearing and Review Plan for the Medical Staff of Henry Ford Jackson Hospital

Approved January 2012

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1. GENERAL

1.1 Purpose. The purpose of this Fair Hearing and Review Plan ("the Plan") is to establish a cohesive and fair process for the initiation and review of actions and formal recommendations affecting the Membership, Privileges or other status (such as officer status) of Members of the Medical Staff.

1.2 General Application. The procedures set forth in this Plan are intended to be utilized with regard to certain types of disciplinary and administrative actions taken or about to be taken with Members and Initial Applicants who make a timely request for same.

2 DEFINITIONS

2.1 The following definitions shall apply to this Plan, in addition to those set forth in the Medical Staff Bylaws which are incorporated by reference:

Affected Practitioner means a Member or Initial Applicant as to whom a Medical Staff or Board recommendation was made or action taken.

BOT or *Board* means the Henry Ford Jackson Hospital Health Board of Trustees

COS means the Medical Staff's Chief of Staff

Initial Applicant means a physician, dentist, or podiatrist making application for initial appointment to the Medical Staff.

MEC means the Medical Staff Medical Executive Committee

President means for all purposes, herein, the President, or designee, but shall always include the Chief Medical Officer (CMO) as a designee, absent a contrary written notice by the President or the CMO.

Special notice means written notice by certified or registered mail, return receipt requested or delivered in person by a representative of the Hospital, or such other means agreed upon in writing by the Affected Practitioner and the Chief of Staff.

V-COS means the Medical Staff's Vice-Chief of Staff

3 HEARINGS

3.1 Procedure / Rules Applying to Board of Trustees Basic and Special Hearings

3.1.1 Informal Review and Non-Application of Formal (Basic and Special) Hearing Procedures. The basic and special hearing procedures specified in Sections 3.1.2 through 5 of this Plan do not apply to any of the following recommendations or actions:

(a) Removal from any committee for failure to fulfill the responsibilities of membership;

(b) Issuance of a written warning letter or letter of admonition;

(c) Continuation of provisional status when Membership has been no more than two years;

(d) Summary suspension when rescinded within fourteen (14) days;

(e) Withholding of Privileges on account of late filing of a recredentialing application;

(f) Non-reappointment for failure to file a recredentialing application;

(g) A reduction of Privileges which applies equally and generally to all of a class of Members of like or similar training, experience, and Membership duration;

(h) Imposition of a consultation requirement of fourteen (14) days or less without the pendency of hearing or appeal proceedings, or for the duration of hearing and appeal proceedings regarding Membership or Privileges, or during provisional status monitoring, whichever is longer;

(i) Involuntary resignation of Membership as a result of a failure to timely request reinstatement while on leave of absence;

(j) Termination of Membership or Privileges pursuant to the terms of a written contract;

(k) Mandatory leave of absence of an Official (i.e., Medical Staff or Division/Department officer) or removal from a Medical Staff Official position by the Medical Staff or Board of Trustees (BOT or Board) ;

(l) Removal from a medico-administrative capacity by virtue of action by the Administration, Medical Executive Committee (MEC), or BOT or by contract operation or expiration;

(m) Denial of an initial application to the Medical Staff by reason of material inaccuracies in the application, by reason of failure to submit a complete and accurate initial application (including all required attachments) or conduct for any reason unrelated to competence or professional conduct of the Initial Applicant;

(n) Denial of transfer to a Medical Staff category which has fewer prerogatives and responsibilities than that to which an Affected Practitioner is appointed;

(o) Revocation or withdrawal of the Membership and Privileges of a member of the provisionally appointed staff by reason of insufficient activity upon which to base an evaluation of his/her ability;

(p) Expiration or revocation of temporary Privileges; or

(q) Withholding of Privileges on account of violation of medical records completion requirements.

When the formal (basic or special) hearing procedures delineated in this Plan do not apply to a recommendation or action, any Affected Practitioner who believes (s)he is aggrieved by any such action or recommendation of the MEC or BOT may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reasons therefore. The statement shall be read or furnished to whichever body made the recommendation or took the action, and made a part of the Affected Practitioner's credentials file. The statement may also request an opportunity to appear before the MEC or BOT to informally discuss his/her position on the action, which request may be granted in the discretion of the MEC or BOT. After review, the BOT may also, in its sole discretion, direct a basic or special hearing be held (even though one is not required), to review and make recommendations concerning

the underlying matter at issue. A denial of a request by either the MEC or the BOT is not an adverse action entitling a Practitioner to any type of hearing under this Plan.

3.1.2 Adverse Recommendation of Action

3.1.2.1 Notice of Recommendation of Action. When a recommendation is made or action taken by the MEC or the BOT which, according to this Plan, entitles an Affected Practitioner to a basic hearing (3.2) or special hearing (3.3) that action does not become final until the Affected Practitioner has waived or exhausted his/her opportunity for hearing under this Plan and a final decision of the Board is thereafter made. Accordingly, prior to a final decision of the BOT on that recommendation or action, the Affected Practitioner shall be promptly given Special Notice by the COS (MEC) or President (BOT). The Special Notice shall contain:

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

(b) A statement that the Affected Practitioner has the right to request in writing a hearing on the recommendation within thirty (30) days of his/her receipt of the notice;

(c) A statement of the kind of hearing (basic or special) to which the Affected Practitioner is entitled; and

(d) A copy of this Plan, unless it has already been provided to the Affected Practitioner.

3.1.2.2 Request for Original Hearing. The Affected Practitioner shall have thirty (30) days following receipt of the Special Notice pursuant to Section 3.1.2.1 to file a written request for a hearing. The request shall be made in writing and delivered in person or by certified mail to the Chief of Staff (COS) or President as applicable.

3.1.2.3 Waiver by Failure to Request a Hearing. An Affected Practitioner who fails to request a formal hearing within the time and in the manner specified in Section 3.1.2.2 waives any right to such hearing and to any possible appellate review. When such waiver is in connection with:

(a) A proposed or actual adverse action by the BOT, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the BOT;

(b) An adverse recommendation or action by the MEC, it shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the BOT. In this event, the BOT shall consider the MEC's recommendation at its next regular meeting following waiver. In its deliberations, the BOT shall review and consider the recommendation and supporting documentation of the MEC and may consider any other relevant information received from any source. The Board's action on the matter shall constitute the final decision of the BOT.

(c) The President shall promptly send the Affected Practitioner notice of each official action taken pursuant to this Section 4.1.2.3 and shall notify the COS of each such action.

3.1.3 The Parties, Legal Representatives and Other Involved Parties

3.1.3.1 The Parties

(a) Basic Hearings. If the Affected Practitioner who requests a hearing desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Section 3.2 of this Plan, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Practitioner to be so represented, the MEC or the BOT may also be represented by an attorney at the hearing.

(b) Special Hearings. If the Affected Practitioner desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Section 3.3 of this Plan, the request for such hearing or appellate review must so state. The Affected Practitioner shall have an unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Practitioner chooses to be so represented, the MEC or the BOT may also be represented by an attorney at the hearing.

(c) Consultation. Notwithstanding the foregoing, however, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the presiding officer.

3.1.3.2 The Hearing Committee, Appellate Review Body, or President. A hearing committee, appellate review body, or President may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s). Hospital counsel may serve as counsel to Hospital, the hearing committee and the Advocate (See Section 4.2.5.2) in the same proceeding.

3.1.4 Waiver. If at any time after receipt of Special Notice of an adverse recommendation, action or result, an Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Plan, the Affected Practitioner shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Medical Staff Bylaws then in effect or under this Plan with respect to the matter involved.

3.1.5 Independent Consultants. At any stage of hearing proceedings, a hearing committee or the BOT may retain an independent consultant, who may or may not be a Member of the Medical Staff. The consultant may be provided with medical records, films, slides, reports, or such other materials (s)he and the requesting body may deem appropriate for his/her review. The consultant shall present a written or oral report to the requesting body which shall be made available to the parties. A consultant so elected should not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence which may be considered.

3.1.6 Supplemental Hearing Rules. The presiding officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Plan. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Plan. The supplemental rules may set forth order of presenting evidence and oral statements as well as time limits for presentations for the in-person aspects of the hearing. In this respect, the hearing rules may require that certain testimony be taken in deposition format and submitted to the hearing committee in the form of transcript, videotape, and/or abstracts of relevant testimony. When feasible, the presiding officer may in his/her discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the

parties (or their representatives) to meet and propose rules subject to his/her approval. When such rules are promulgated by the presiding officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered and, when deemed meritorious, amendments shall be made in the rules to address the objections.

3.1.7 Number of Reviews. Notwithstanding any other provision of the Bylaws or of this Plan, no Affected Practitioner shall ever be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action. Further, the MEC and the BOT need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Affected Practitioner, absent a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

3.1.8 Release. By requesting a hearing or appellate review under this Plan, an Affected Practitioner agrees to be bound by the provisions of the Bylaws, this Plan, and the rules established for hearing, in all matters relating thereto.

3.1.9 Time Limit Modification. Any procedural rule or time limit specified in this Plan may be modified or waived by agreement between the presiding officer of the hearing committee, and the Affected Practitioner, or the duly authorized designate of any of them. The BOT or the presiding officer at a hearing may, in its/his discretion, grant an extension of any time limits when required for fundamental fairness to any party. A request by an Affected Practitioner who for a hearing for an extension of any time limits, which is granted, waives any right to insist on the time limits specified herein being complied with.

3.1.10 Medical Executive Committee Review. If at any time during the Board's consideration and review of a recommendation or action with respect to an Affected Practitioner, the BOT deems it necessary or advisable, the BOT may refer the matter to the MEC. Within fifteen (15) days of its receipt of a matter referred to it by the BOT pursuant to the provisions of this Plan, the MEC shall convene and consider this matter and submit its written recommendations to the BOT for final action.

3.1.11 Good Faith Alternative Special Notice

3.1.11.1 Good Faith. In addition to those duties imposed in the Bylaws, it shall be the duty of each Affected Practitioner who requests a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Plan without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the BOT that an Affected Practitioner is not acting or has not acted in good faith with regard to the hearing process of this Plan, the hearing committee, hearing officer or BOT may limit or deem waived the Affected Practitioner's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.

3.1.11.2 Alternative Mailing. If, in attempting to give Special Notice, despite reasonable efforts, either postal authorities are unable to deliver or obtain signature on a return receipt for registered or certified mail, or a representative of the Hospital is unable to make personal delivery, at the designated place of mail delivery for the Affected Practitioner, such Special Notice may alternatively be given by regular mail that is mailed at least five days before any deadline to the last home address and last office address provided by the Affected Practitioner to Administration.

3.1.11.3 Time Limits Constructive Receipt. For the purpose of time limits of this Plan, if the alternative mailing procedure of Section 3.1.11.2 is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authorities or personal delivery by Hospital personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Practitioner, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption may be overcome only by a clear and convincing showing to the presiding officer that the failure to make delivery or sign a receipt, was due to error, neglect, or unreasonable delay, of the postal authorities or Hospital representatives, and not the Affected Practitioner.

3.1.11.4 Designated Place of Mail Delivery. The designated place of mail delivery shall be the office address last provided by an Affected Practitioner to Administration and any person who signs a receipt for mail there shall be deemed as authorized by the Affected Practitioner to do so. In the event of his/her absence, each Affected Practitioner shall either: (a) authorize his/her office Members to receive and sign receipts for mail on his/her behalf, or alternatively, (b) if his/her office shall be closed for more than two successive business days or (s)he does not wish his/her office staff to be authorized to receive and sign a receipt for mail on his/her behalf, (s)he must in a writing sent by certified mail to the President, designate the name and address of an alternate designated place of delivery (e.g., a law or accounting firm) and provide a statement that any person who receives and signs for mail there is authorized to do so on his/her behalf.

3.1.11.5 Purpose - Good Faith. The purpose of the foregoing provisions of Sections 3.1.11.2, 3.1.11.3 and 3.1.11.4 are to assure reasonable efforts to give required notices and proceed forward with requested hearings are not thwarted or delayed by refusal to accept delivery, refusal to sign receipts, office closure, absence from the community, or the bad faith on the part of an Affected Practitioner.

3.1.12 Consolidation. If two or more hearings and/or appeals with respect to the same Member are proceeding simultaneously, (e.g., summary suspension and non-reappointment), the BOT, at the request of the Affected Practitioner, the COS, the President, or the MEC, may order the two proceedings consolidated into a single hearing or appeal. In this respect, the BOT shall have the authority to suspend or modify time limits and take whatever action most reasonable and fair to all concerned to accommodate the consolidation.

3.2 Basic Hearing

3.2.1 Application of Basic Hearing Procedures. The basic hearing procedures as set forth in Section 3.2 of this Plan shall apply only to the following recommendations or actions:

(a) Imposition of consultation requirement of more than fifteen (15) days;

(b) Automatic suspension of Membership or Privileges due to suspension or loss of licensure; the temporary or permanent exclusion from Medicare, Medicaid or other federal or state health care program; or conviction of any felony or any crime arising out of professional practice or involving fraud, theft, embezzlement or other financial misconduct, the abuse or neglect of patients, the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(c) Denial of a request by an Active or Associate category Member to increase Privileges which are not ordinarily possessed by Practitioners of like training, experience, board certification status, Medical Staff category and Membership duration;

(d) Denial of a requested change in Medical Staff category;

(e) Issuance of a letter of reprimand without any reduction or limitation on the exercise of Privileges;

(g) Involuntary resignation of Privileges or Membership, or non-reappointment, on account of violation of medical records completion requirements;

(h) Suspension, termination of Privileges, termination of Membership or non-reappointment for failure to comply with a written agreement between the Member and the MEC or Board used in lieu of corrective action or alternative action which provides for such suspension, termination of Membership, and/or non-reappointment in the event of non-compliance (However, a hearing based on this action shall be limited to the issue of whether compliance with the agreement has been established by the Member).

(i) Suspension, termination of Privileges, termination of Membership or non-reappointment for recurrent failure to work cooperatively with others after disruptive Practitioner or alternative action procedures have been undertaken and professional conduct or competence in the care of patients is not involved.

(j) Non-reappointment by reason of failure to comply with Board Certification requirements. (However, a hearing based on this action shall be limited to the issue of whether Board Certification requirement compliance has been documented by the Member);

(k) Denial, non-reappointment, suspension, or involuntary reduction of Privileges for more than fifteen (15) days for reasons unrelated to the professional competence or professional conduct of the Member;

(l) Imposition of a requirement of additional education for a Member which immediately limits prerogatives (e.g., removed the Practitioner from the on call list) but does not materially limit exercise of Privileges;

(m) Imposition of a probationary or a special retrospective review process without limiting privileges;

(n) Suspension of clinical privileges for disciplinary purposes when of a duration of no more than fourteen (14) days;

(0) Such other recommendations or actions as the MEC or Board may direct, in its discretion, after consultation with the other.

3.2.2 Notice of Time and Place for Hearing. Upon receipt of a timely request for hearing, the President shall deliver such request to the COS or the BOT, depending on the body whose recommendation or action prompted the request for hearing. The COS or the BOT, as appropriate, shall promptly schedule and arrange for a basic hearing. At least thirty (30) days prior to the hearing date, the COS shall notify the Affected Practitioner of the date, time and place of the commencement of the hearing by Special Notice. Such notice shall include a list of witnesses (if any) expected to testify at the hearing on behalf of the Hospital. Unless waived in writing by the Affected Practitioner the hearing date should not be more than forty-five (45) days from the date of receipt of the request for hearing. A hearing for an Affected Practitioner who is under suspension then in effect shall ordinarily be held as soon as the arrangements and preparations for it may be reasonably made and requirements for same met. The notice may also furnish hearing rules, including time limits, prepared by the COS or BOT Chairman, that take into account the anticipated

nature and scope of the hearing, as well as the interests of BOT parties and the hearing committee.

3.2.3 Statement of Reasons. If the reason(s) for the action or recommendation have not already been provided in writing to the Affected Practitioner seeking a hearing, the reasons shall be mailed or delivered to the Affected Practitioner at least three (3) days before the scheduled date for the hearing. The statement of reason(s) may be amended at any time, provided the Affected Practitioner is given a reasonably sufficient opportunity to prepare to meet any added reasons.

3.2.4 Appointments of Hearing Committee

3.2.4.1 By Medical Staff. A hearing occasioned by recommendation of the MEC shall be conducted by:

(a) A quorum of the MEC; or

(b) A subcommittee of no less than three Practitioners, at least one of whom must be a member of the MEC appointed by the COS to conduct the hearing.

The COS, who shall not be a member of the committee, shall appoint all members of the committee, including a member of the committee to serve as its Chair.

3.2.4.2 By Board of Trustees. A hearing occasioned by proposed or actual adverse action of the BOT shall be conducted by a hearing committee appointed by the BOT. This committee shall be composed of not less than three persons, at least one of whom shall be a Member. The Chairman of the BOT, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chair.

3.2.4.3 Service on Hearing Committee. A Medical Staff or BOT member shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter at issue or because of knowledge of facts involved. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

3.2.5 Appearance and Representation

3.2.5.1 Appearance of Member. The Affected Practitioner requesting the hearing must be present for the hearing; his/her failure to appear at the date and time set forth in the notice shall constitute a waiver of the right to a hearing.

3.2.5.2 Representation. At any Basic Hearing:

(a) An Affected Practitioner shall represent him/herself.

(b) If the hearing committee is the MEC or a subcommittee thereof, the COS may, in his/her discretion, appoint him/herself or another Member to present the position adverse to the Affected Practitioner.

(c) If the hearing committee is a committee appointed by the BOT, the Chairman of the BOT may, in his/her discretion, appoint a Member or other person to present the position adverse to the Affected Practitioner. This person shall be called the "Advocate".

(d) Neither Affected Practitioner nor Advocate may participate in deliberations of the hearing committee.

3.2.6 Hearing Conduct and Evidence

3.2.6.1 Hearing Conduct. The chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the considerations of evidence. The presiding officer may also promulgate hearing rules including reasonable time limits, pursuant to Section 6.4 of this Plan, which may modify any rules provided by the COS or BOT Chairman under Section 3.1.6. The hearing shall be conducted in such a manner that the BOT, the Affected Practitioner and the Advocate (if any) has an opportunity to have his/her position fairly heard and considered. Members of the hearing committee may ask questions of the Affected Practitioner and the Advocate (if any).

3.2.6.2 Evidence. The Affected Practitioner and the Advocate (if any) may submit to the hearing committee for consideration:

(a) Written statements, letters and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Hospital regarding the Affected Practitioner;

(b) Oral statements by the Affected Practitioner and the Advocate (if any);

(c) Neither the Affected Practitioner nor the Advocate (if any) shall have a right to present witnesses, or cross-examine in person. Only when deemed essential to a meaningful hearing, the presiding officer may, in his/her discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules;

Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

3.2.7 Burden of Proof. The Affected Practitioner shall have the burden of proof and must demonstrate that the action or recommendation is:

(a) Arbitrary;
(b) Capricious; and/or
(c) Based on inaccurate or insufficient information through no fault of the Affected Practitioner.

3.2.8 Recording of Hearing. The hearing shall be recorded by transcript prepared by a court reporter.

3.2.9 Recommendation

3.2.9.1 Notice. Within thirty (30) days after completion of the hearing, the hearing committee shall meet, deliberate, and then issue its report in writing to the President. The report shall be submitted by the COS to the MEC or BOT, as appropriate, and to the Affected Practitioner (by Special Notice).

3.2.9.2 Action on Recommendation

(a) If the hearing committee was a subcommittee of the MEC, its report shall be submitted to the MEC for consideration. Thereafter, the MEC shall make its final recommendation, subject to approval by the BOT.

(b) If the hearing committee was the MEC, its report shall become the final recommendation of the MEC, subject to BOT action.

(c) If the hearing committee was a committee appointed on behalf of the BOT, its report shall become its final recommendation, subject to BOT action. If timely requested, final BOT action may be subject to reconsideration on appeal.

3.2.10 Notice of Affected Practitioner. Within seven (7) days after the BOT action or approval, the COS shall send written notice to the Affected Practitioner regarding its decision, and the basis thereof.

3.2.11 Appeal. If, following a basic hearing pursuant to this Section, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be the sole grounds for appeal, (s)he may, within fifteen (15) days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefore to the COS. If such an appeal is filed, the hearing committee or a representative thereof may submit a written response in opposition within fifteen (15) days after the appeal is received. The appeal shall be considered by the BOT which shall, within forty-five (45) days after receipt of the appeal, take one of the following actions:

(a) Refer the matter back to the hearing committee for further review or supplemental findings; if this is done, the hearing committee shall respond in writing to the BOT request within fifteen (15) days of request, and the BOT shall then take the actions in (b), (c) or (d) below within thirty (30) days after receipt of the response; or

(b) Adopt or modify the recommendation of the hearing committee and take final action accordingly;

(c) Reverse the recommendation of the hearing committee, with or without the requirement that further hearings be conducted by the hearing committee; or

(d) Reverse the recommendation of the hearing committee and require a special hearing be held in accordance with the provisions of Section 3.3 of this Plan.

The President shall advise in writing the Affected Practitioner, by Special Notice of the outcome of the appeal.

3.3 Special Hearing

3.3.1 Application of Special Hearing Procedures. The special hearing procedures as set forth in Section 5 of this Plan shall apply to the following recommendations or actions:

(a) Non-reappointment, for reasons relating to professional competence or professional conduct, not including administrative-type issues such as: failure to timely submit a recredentialing application; document financial responsibility; failure to timely request reinstatement following an expiration of leave of absence; termination of a written contract with the Member and/or his/her employer; recurrent non-compliance with medical records requirements; failure to comply with a written agreement between the MEC or Board and the Member which provides for non-reappointment for failure to comply; and recurrent failure to work cooperatively

with others after disruptive Practitioner or alternative action procedures have been undertaken;

(b) Denial, involuntary reduction or suspension of Privileges of an Active or Associate category Member which are ordinarily possessed by a Member of like or similar training or Medical Staff duration, for fifteen (15) days or more for reasons related to professional competence or professional conduct in the care of patients, except for failure to comply with a written agreement between the MEC or Board and the Member which provides for denial, involuntary reduction or suspension of Privileges for failure to comply;

(c) Revocation or suspension of Membership or Privileges for more than 15 days for reasons relating to professional competence or conduct, not including administrative-type issues such as: failure to timely submit a recredentialing application; failure to document financial responsibility; timely request reinstatement following expiration of a leave of absence; resignation due to insufficient activity as a Member on Provisional Status; expiration or termination of a written contract with the Member and/or his/her employer; failure to comply with a written agreement between the MEC or Board and the Member which provides for revocation or suspension for failure to comply; and recurrent failure to work cooperatively with others after disruptive Practitioner or alternative action procedures have been undertaken; failure to meet Board Certification requirements; or any other ground which is not based on professional conduct or competence in the care of patients;

(d) Denial of an initial application for appointment to the Medical Staff for reasons related to the professional competence or professional conduct of the initial Applicant, not including: the application being incomplete; the application containing material inaccuracies or omissions; absence or termination of a written contract with the Member and/or his/her employer where required for Privileges; or any reason unrelated to the professional competence or professional conduct in the care of patients of the Initial Applicant; and

(e) Such other recommendations or actions as the MEC or Board may direct, in its discretion, after consultation with the other.

3.3.2 Notice of Time and Place for Hearing.

3.3.2.1 Scheduling of Hearing. Upon the receipt of a timely and proper request for a special hearing, the COS shall promptly schedule and arrange for the hearing. The hearing date shall ordinarily be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing, unless such time requirements are waived in writing by the Affected Practitioner.

3.3.2.2 Shortened Time Limit for Hearing. A hearing for a Member who is under suspension then in effect may be held in less than thirty (30) days after the request is made, provided such Member's request for the hearing includes a specific request that the hearing be held in less than thirty (30) days; in the event such a special request for a shorter period is made by a Member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to Section 3.3.2.3 below.

3.3.2.3 Lengthened Time Limit for Hearing. If pursuant to Section 3.3.4 the Affected Practitioner objects to the composition of an ad hoc hearing committee, or a determination is made that a hearing officer who is not a Member shall conduct the hearing, the sixty (60) day maximum limitation shall be deemed waived by the Affected

Practitioner. In such event, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and the requirements for same met. The President shall give written notice of the new scheduled date, time, and place of the hearing to the Affected Practitioner, hearing committee or officer, and the COS or BOT, once the questioning and objection processes are complete and the hearing committee or officer has been finally selected.

3.3.3 Hearing Notice, Response and Witness Lists

3.3.3.1 Hearing Notice. The COS shall issue a notice of hearing by Special Notice to the Affected Practitioner and by any suitable means of notice to others involved in the hearing process. The notice of hearing shall specify:

(a) Time and Location - The scheduled date, scheduled time and location of the hearing, as well as a statement of reasons and list of witnesses (as provided in 3.3.2.2 and 3.3.2.3).

(b) Statement of Reasons - As applicable, a statement of the alleged acts or omissions of a Member, a list by number of the specific or representative patient charts in question and/or other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

(c) List of Witnesses - A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses to testify in support of the recommendation or action at the time of the hearing.

3.3.3.2 Response and List of Witnesses of Affected Practitioner. Within fourteen (14) days after receipt of the notice of hearing, the Affected Practitioner shall furnish to the COS his/her written response to the Statement of Reasons and a list of the individuals (and their addresses) who may or will be called as witnesses in support of the Affected Practitioner's position at the time of the hearing.

3.3.3.3 Amendments. The statement of reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period in which to prepare to meet the substance of the testimony of additional witnesses. For the purpose of this provision, a time period of one week or more, shall be presumed to be a "reasonable period". The permissibility of a shorter period of notice shall be subject to the discretion of the presiding officer for the hearing.

3.3.3.4 Inspection of Records

(a) The Affected Practitioner shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The Affected Practitioner shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Affected Practitioner to prepare a defense, including such evidence which formed the basis of the MEC or BOT determination whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Hospital or Medical Staff.

(b) The MEC/Advocate shall have the right to inspect and copy at its expense any documents or other evidence relevant to the charges which the Affected Practitioner possesses or controls as soon as practicable after receiving the request.

(c) The failure by either party to provide access to this information at least ten (10) days before the hearing shall constitute good cause for a delay or continuance of the hearing.

3.3.4 Appointments of Hearing Committee.

3.3.4.1 By Medical Staff. A special hearing occasioned by recommendation of the MEC pursuant to Section 3.1 shall be conducted by an ad hoc committee composed of no less than three and no more than five Practitioners, appointed by the COS in consultation with the COS. The CMO and the COS, who shall not be hearing committee members, shall appoint the presiding officer of the hearing committee who may, but need not be a Practitioner; an attorney may be appointed as a hearing officer but if this is done, while the attorney may participate in committee deliberations and assist in the preparation of the hearing committee report, (s)he shall not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the procedures of Section 3.3.1.

3.3.4.2 By Board of Trustees. A hearing occasioned by adverse action of the BOT pursuant to Section 3.1 shall be conducted by a hearing committee of three or more persons appointed by the Chairman of the BOT, at least one of which must be a Practitioner, who may but is not required to be a Member and at least one of which must be a BOT member. One of the appointees to the hearing committee shall be designated as presiding officer. The appointments are subject to the procedures of Section 3.3.1.

3.3.4.3 Service on Hearing Committee. A Member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter and issue, because of knowledge of the facts involved, or because of participation in an earlier disciplinary hearing involving the Affected Practitioner. However, if after objection timely submitted, the COS, in his/her good faith discretion, determines that there is reasonable evidence to support the conclusion that a proposed member of an ad hoc hearing committee is either in direct economic competition with the Affected Practitioner, or could not decide the matter with good faith objectivity, the proposed member of the ad hoc hearing committee shall be removed and, except as provided in Section 3.3.4.3, replaced before the hearing.

3.3.4.4 Notice of Appointment to Hearing Committee. Within seven (7) days after the Affected Practitioner is given notice of those who are proposed to serve on the hearing committee, the Affected Practitioner shall be entitled to submit reasonable written questions (except in extraordinary circumstances only of the "short answer" type) of not more than 10 in number limited to the issues of direct economic competition or bias to all or any one or more of the proposed hearing committee members through the President. The President shall, in his/her good faith discretion, determine whether questions are unreasonable or irrelevant to the issues of direct economic competition or bias, and shall strike such questions which are unreasonable or irrelevant. The questions, except those which are deemed by the President to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then each submit his/her response(s) within thirty (30) days to the President. The President shall in turn forward the answers on a prompt basis to the Affected Practitioner and the COS or BOT Chairman, depending upon the body which took the adverse action or made the recommendation which is the subject of the hearing.

3.3.4.5 Objections to Proposed Hearing Committee Members. Within seven (7) days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in Section 4.3.4.4 was elected by the Affected Practitioner, seven (7) days after his/her receipt of the responses to the written questions, the Affected Practitioner shall be entitled to submit his/her written objections, if any, to those proposed members of the

hearing committee which (s)he believes are in direct economic competition with him/her or are so biased against him/her as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the President who shall determine in his/her good faith discretion as to whether or not the objections are meritorious.

(a) If none of the objections are deemed to be meritorious by the President, (s)he shall so advise the Affected Practitioner who requested the hearing, in writing, and the hearing committee shall be constituted in the manner proposed.

(b) If the President determines that any objections to any or all of the hearing committee membership have substance, (s)he shall confer with the COS or the Chairman of the BOT, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.

(i) If the COS or Chairman of the BOT believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the hearing committee, the process set forth in Section 3.3.4.4 and this Section 3.3.4.5 regarding written questions and objections, shall be repeated as necessary until an appropriate hearing committee can be constituted.

(ii) If, however, the COS or Chairman of the BOT believes that there is no person available at the Hospital or in the community, who meets the committee membership requirements for participation on a hearing committee, the requirements of Sections 3.3.1 and 3.3.2 shall not apply.

3.3.4.6 Waiver of Rights. In the event the Affected Practitioner who requested the hearing fails to, within seven (7) days to timely submit written questions or raise objections to proposed members of the hearing committee, (s)he shall be deemed to have waived his/her right to submit such questions and/or make objections to the composition of the hearing committee.

3.3.5 Personal Presence. The personal presence of the Affected Practitioner who requested the hearing shall be required. An Affected Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights or review in the same manner and with the same consequence as provided in Sections 3.1.2.3 and 3.1.4.

3.3.6 Presiding Officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of law, procedure, and the considerations of evidence.

3.3.7 Representation. The Affected Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Member in good standing or by a member of his/her local professional society. The MEC or BOT, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation or action who shall be referred to as "Advocate". The Advocate may present evidence but, even if a MEC or BOT member, shall not participate in deliberations nor vote on the matter at issue. Representation of either party by an attorney at law shall be governed by the provisions of Section 3.1.3.

3.3.8 Rights of Parties. During a hearing, each of the parties shall have the right to:

(a) Call and examine witnesses and cross-examine witnesses called by the other party;
(b) Introduce exhibits;
(c) Question witnesses on matters relevant to the issues; and
(d) Rebut any evidence within the scope of supplemental hearing rules, including time limits, established pursuant to Section 3.1.6.

If the Affected Practitioner does not testify, (s)he may be called and examined as if under cross-examination.

3.3.9 Conduct of Hearing

3.3.9.1 The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. BOT the MEC and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

3.3.9.2 Notwithstanding any provision of this Plan to the contrary, the taking of evidence and/or testimony from the Parties shall in the normal course of business be concluded in a period not to exceed nine (9) hours (e.g., three, 3-hour hearing sessions), and shall not extend beyond this period of time absent a written ruling by the Hearing Officer that extenuating circumstances require that such an extension of time be made. In so ruling, the Hearing Officer shall describe the extenuating circumstances warranting the extension, and shall place specific time limits on the extension granted (e.g., one additional 3-hour hearing session). Additional extensions of time beyond that initially granted shall require subsequent written rulings by the Hearing Officer as described above. If there is a perceived need to present more than can reasonably be presented within the allotted time, the matter shall be submitted to the Hearing Officer prior to the issuance of hearing rules under Section 3.1.6 so that alternative procedures (e.g., depositions and abstracts) can be authorized and timely used.

3.3.9.3 If the Hearing Officer grants extensions of time for the taking of evidence and/or testimony as described above, the MEC may in its sole discretion approve an hourly stipend to be paid to Fair Hearing Panel members to compensate them for their service in excess of the nine (9) hour expectation described above. If so approved, the amount of the hourly stipend is also within the sole discretion of the MEC, should be based upon appropriate factors (e.g., the amount of additional time anticipated to be required, the burden such additional time places on the Fair Hearing Panel members [e.g., whether the time is during normal business hours or evenings], etc.), and shall be paid on a 50/50 basis by the Medical Staff and the Hospital. If the member at issue objects to such payment on grounds that it might improperly influence the judgment of Panel members, then the sole remedy for the member at issue is to contribute whatever amount he/she deems appropriate (but not to exceed 50% of the total stipend) towards the payment of such stipend, with such contribution being formally acknowledged to the Panel members.

3.3.9.4 Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, at the close of or if specifically requested and authorized by the presiding officer, within seven (7) days of the hearing, be entitled to submit a memoranda concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required, to order that oral evidence be only taken on oath or affirmation.

3.3.10 Matters Considered. In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information which can be considered in connection with applications for appointments or reappointments to the Staff and a request for Privileges. In this respect, to facilitate the hearing efficiency, subject medical charts, investigative reports, pertinent correspondence, committee minutes, and the statement of reasons, may be furnished by the President in his/her discretion, to the hearing committee provided the Affected Practitioner is advised same have been furnished to the hearing committee and may challenge its relevancy at the hearing. The hearing committee shall be entitled to conduct independent review, research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Practitioner and the Advocate are aware of such, and have an opportunity to rebut any information so gathered.

3.3.11 Burden of Proof. The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Affected Practitioner shall thereafter have the burden of proof and must demonstrate that the action or recommendation is arbitrary, capricious, and/or based upon inaccurate or insufficient information through no fault of the Affected Practitioner.

3.3.12 Record of Hearing. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any person or group that may later be called upon to review the record and render a recommendation or decision in the matter. If the President and the Affected Practitioner cannot agree on method, the presiding officer shall select the method to be used for making the record such as a court reporter, electronic recording unit or detailed transcription. The Affected Practitioner, who requested the hearing, shall be entitled to obtain a copy of the record upon payment of the reasonable charges associated with the preparation of same. If the Affected Practitioner who requested the hearing elects an alternate method of recording, (s)he shall bear the primary cost thereof.

3.3.13 Postponement. Requests for postponements of a hearing shall be granted by the presiding officer only upon a showing of good cause.

3.3.14 Recesses and Adjournment. The hearing committee or officer may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

3.3.15 Deliberations and Recommendation of the Hearing Committee or Hearing Officer

3.3.15.1 Deliberations. Upon conclusion of the presentation of evidence, the hearing shall be closed. Within 30 days thereafter, the hearing committee, outside the presence of any other person, shall conduct deliberations and consider the admitted evidence and prepare a written report.

3.3.15.2 Contents of Report. The hearing committee shall prepare a report which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the President

3.3.16 Disposition of Hearing Committee Reports. Upon receipt, the COS shall forward the hearing committee report and recommendation, along with all supporting documentation, to the BOT for further action. The COS shall also send a copy of the report and recommendation by Special Notice to the Affected Practitioner. A copy of the report of the hearing shall be delivered by the COS to any body other than the BOT that made the adverse recommendation for informational purposes.

3.3.17 Notice and Effect of Results

3.3.17.1 Effect of and Action Upon Favorable Hearing Committee Report. If the hearing committee's report pursuant to 3.3.15 is favorable to the Affected Practitioner, the COS shall promptly forward it, together with all supporting documentation, to the BOT for its final action.

(a) The BOT may, before taking final action thereon, refer the matter back to the hearing committee or the MEC for further consideration or information. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the BOT must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the BOT shall take final action.

(b) If the BOT action on the matter is favorable to the Affected Practitioner it shall become the final decision of the BOT, and the matter shall be closed.

(c) If the Board's action would result in any of the recommendations or actions listed in Sections 3.2.1 or 3.3.1 the Special Notice shall inform the Affected Practitioner of a right to request an appellate review by the BOT as provided in Section 4.1 of this Plan, as if the hearing committee's report had been adverse. In such circumstances, the BOT's tentative position, adverse to the Affected Practitioner, shall be represented by a person, selected by the Chairman of the BOT for appellate review. All references in Sections 3.3.15 through 4.10, of this Plan to the "hearing committee" would instead refer to the BOT, as the context requires.

3.3.17.2 Effect of Adverse Hearing Committee Report. If the report and recommendation of hearing committee pursuant to 3.3.15 is adverse to the Affected Practitioner in any of the respects listed in 3.2.1 or 3.3.1, Special Notice shall be given of the report and recommendation and his/her right to request appellate review by the BOT as provided in Section 4 of this Plan.

4 APPEALS

4.1 Request for Appellate Review. An Affected Practitioner shall have ten (10) days following receipt of a notice pursuant to Sections 3.3.17.1(c) or 3.3.17.2, to file a written request for an appellate review. Such request shall be delivered to the President either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the adverse action or result.

4.2 Waiver by Failure to Request Appellate Review. An Affected Practitioner who fails to request an appellate review within the time and in the manner specified in Section 4.1 waives any right to such review. Such waiver shall have the same force and effect as that provided in Sections 3.1.2.3 and 3.1.4 of this Plan.

4.3 Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the President shall deliver such request to the BOT. The BOT shall schedule and arrange for an appellate review which shall be not more than 45 days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made. The President shall send the Affected Practitioner notice of the time, place and date of the review. The time for the appellate review may be extended by the BOT for good cause.

4.4 Appellate Review Body. The BOT shall be the appellate review body; one BOT member shall be designated as chairperson of the appellate review proceedings.

4.5 Nature of Appellate Review Proceedings. The appellate review proceedings of the BOT shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The BOT shall also consider the written statements as may be presented and accepted under this Section.

4.6 Written Statements. The Affected Practitioner shall submit a written statement detailing those findings of fact, conclusions and procedural matters with which (s)he disagrees, and the reason for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the BOT through the President at least five days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the MEC, or if BOT action is being appealed, the person selected by the BOT to take the position adverse to the Affected Practitioner. If submitted, the President shall provide a copy thereof to the Affected Practitioner at least two (2) days prior to the scheduled date of the appellate review.

4.7 Presiding Officer. The chairperson of the appellate review proceedings shall be presiding officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

4.8 Oral Statement. The BOT in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the BOT.

4.9 Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in his/her record shall be introduced at the appellate review only under unusual circumstances. The BOT in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

4.10 Recesses and Adjournment. The BOT may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the proceedings shall be closed. The BOT shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared adjourned.

4.11 Action Taken by Board of Trustees on Appeal. The BOT may affirm, modify or reverse the adverse result or action taken by the hearing committee or officer pursuant to Section 3.3.2, in its discretion, may refer the matter back to the hearing committee or officer for further review and recommendation to be returned to it within 45 days and in accordance with its instructions. Within 15 days after receipt of such recommendation after referral, the BOT shall make its final decision.

4.12 Final Board of Trustees Action After Appellate Review. Unless the matter is referred back to a hearing committee or officer pursuant to Section 4.11, within 15 days after the conclusion of the appellate review, including referrals back to the hearing committee or officer, the BOT shall render its decision in the matter in writing and shall send notice thereof to the Affected Practitioner by Special Notice, to the President and to the MEC.

4.13 Health Care Quality Improvement Act of 1986. Those actions or recommendations which entitle an Affected Practitioner to a special hearing pursuant to Section 3.3, are those matters the Hospital and Staff reasonably believe represent "professional review action" and "professional review activity" which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Plan that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of §412 of the Act.

5 AMENDMENT AND APPLICATION

5.1 Amendment**.** This Plan may be amended or repealed, in whole or in part, by a resolution of the Medical Staff recommended to and adopted by the BOT subject always to the bylaws of the respective bodies.

5.2 Application. Any matter subject to review or hearing pursuant to the Medical Staff Bylaws after adoption of this Plan shall be governed by its terms; any prior review and hearing procedures shall be deemed superseded by the terms of this Plan.

RECOMMENDED by the Medical Staff on

December 13, 2013
Date

Nitin Ambani, MD
Chief of Staff

APPROVED by the Board of Trustees on

January 25, 2012
Date

Larry Schultz
Chairman, Board of Trustee

Georgia Fojtasek,
Chief Executive Officer

Approved: January 25, 2012

HENRY FORD HEALTH℠

Medical Staff Bylaws:
Medical Staff Rules and Regulations

Henry Ford Jackson Hospital

Revised March 2023

TABLES OF CONTENTS

1.0 GENERAL RULES OF THE MEDICAL STAFF

1.1 Admission, Alternate Coverage, Transfer, Discharge, and Death of Patients

1.1.1 Admission Criteria

1.1.1.1 **Categories of Patients Who May Be Admitted**: Henry Ford Jackson Hospital may accept all categories of patients except those requiring highly specialized care, equipment, or evaluation not available in the Hospital.

1.1.1.2 **Professionals Who May Admit and Care for Patients**: Only a Staff member with admitting privileges may admit a patient to the Hospital. A physician Staff member shall be responsible for the general medical care and treatment of every patient admitted to the Hospital (see Medical Staff Documents).

1.1.1.3 **Patients with Psychiatric Disorders**: Patients with a primary diagnosis of mental illness or substance abuse shall be admitted to the appropriate unit unless they have serious medical conditions requiring the care and facilities of a medical or surgical unit of the Hospital.

1.1.1.4 **Admission Note**: An admission note shall be made by the attending Staff member or his/her designee on all patients admitted into the Hospital. This note shall include a concise summary of the patient's chief complaint, condition, any changes or additions to the history and physical examination already performed, a provisional diagnosis, and a plan for evaluation or therapy. In any event, the record shall clearly provide evidence justifying the need for this patient's admission.

1.1.1.5 **Admission of Potentially Suicidal or Dangerous Patients**: The attending Staff member shall, throughout a patient's admission, be held responsible for providing such information as s/he knows which may be necessary to ensure the protection of the patient from self-harm and to ensure the protection of others whenever his/her patients might be a source of danger from any cause whatsoever. For the protection of patients, visitors, and staff, when a patient is, or is suspected to be, dangerous to himself/herself or others, the attending Staff member shall request a consultation by a representative of the Service of Psychiatry who will promptly see the patient and make a record of the consultation. If the consultation confirms that it is probable the patient is dangerous to himself/herself or others, the attending Medical Staff member and the psychiatrist responsible for the consultation shall jointly decide the course of the patient's further behavioral management. Such behavioral management may include transfer to the Behavioral Health Unit, if there is a bed available and the patient's medical condition may be suitably managed in a psychiatric hospitalization setting.

1.1.1.6 **Additional Responsibilities of Admitting Staff Member(s)**: In addition to the responsibilities already outlined in this Section, the attending physician is required to document the need for hospitalization. When these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The completion of the medical record is the ultimate responsibility of the attending physician.

1.1.2 Provisional Diagnosis

Except in emergencies, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated on the admission record. In case of emergency, the provisional diagnosis shall be entered on the admission record as soon as possible after admission.

1.1.3 Admission of Emergency Patients

Transfer of Medical Staff Member Responsibilities of Patients Being Treated in the Emergency Room: The emergency physician shall be responsible for the patient's care until a Medical Staff member has accepted the patient.

1.1.4 Alternate Physician Coverage

1.1.4.1 Each member of the Medical Staff with admitting privileges shall arrange to have one (1) member of the Active or qualified Associate Staff provide full-time coverage for his/her

Hospital--related practice in the event of an emergency, urgent situations, illnesses, vacations or other absences. The Medical Staff member providing said coverage must be a member of the same Clinical Service and/or possess requisite or greater clinical privileges as the Staff member who initially requested and received coverage from him/her. Each agreement to provide coverage shall be in writing, signed by the member agreeing to provide such coverage, and be on file in the Medical Staff Affairs Office. Such arrangements shall be renewed at the time of reappointment by the member who requested and received coverage.

1.1.4.2 **Failure To Name or Inability To Make Contact with Alternate Physician Coverage When a Medical Staff Member Is Going To Be Unavailable**: In the event another Medical Staff member is not named as an alternate, or contact cannot be made with the alternate, any Medical Staff Officer or the Chief of the respective Clinical Service shall have the authority to call any member of the Active Staff in order to provide care and treatment to the patient(s) in question.

1.1.5 Emergency Situation Response

Members of the Medical Staff are encouraged to live within the service area of the Hospital. Physicians on call must be present at the Emergency Room within thirty (30) minutes of the initial contact from the Emergency Service under normal conditions and when warranted by the clinical circumstances, and must be in telephone contact with the Emergency Service within fifteen (15) minutes when this mode of communication is sufficient for proper care. Members whose practice specialty falls within specialty areas having a more specific response time requirement as expressed in Medical Staff and/or Clinical Service Documents must be able to demonstrate the ability to comply with such requirements. Members whose primary residence and/or primary office site precludes their ability to comply with those requirements must arrange for other active or associate members who are of the same Clinical Service and/or possess the requisite or greater clinical privileges to provide coverage for their patients. Such arrangements must be in writing, signed by the member agreeing to provide such coverage, approved by the Clinical Service Chief and be on file in the Medical Staff Affairs Office. Such arrangements shall be renewed at the time of reappointment of the member who has obtained the coverage.

1.1.6 Patient Transfers

1.1.6.1 **Transfers of Inpatients to Other Hospitals**: No inpatient shall be transferred to another hospital unless that patient has been seen by the Medical Staff member ordering the transfer within the preceding twenty-four (24) hours and the Medical Staff member indicates the reason for the transfer in the patient's medical record.

1.1.6.2 **Types of Situations Requiring Transfer to Other Hospitals**: Patients with specific injuries or illnesses in need of specialized services not offered by the Hospital shall be transferred to a hospital providing the needed specialized services or in the event an appropriate physician is unavailable.

1.1.6.3 **Transfer of Inpatients from One Hospital Unit to Another**: Except in emergencies, no inpatient shall be transferred from one unit to another within the Hospital without the approval of the patient's attending Medical Staff member. In the event an approval cannot be obtained and the need for transfer is imperative, approval for such transfer shall be obtained from the Chief of Staff, Chief of Staff-Elect, or Clinical Service Chief.

1.1.7 Patient Discharge

1.1.7.1 **Written/Verbal Discharge Orders by Attending Staff Member or by Attending Staff Member's Appropriately-Privileged Nurse Practitioner or Physician Assistant Required**: Subject to those exceptions outlined below, patients shall be discharged only upon written/verbal order of the attending physician or by the attending physician's nurse practitioner or physician assistant. Discharge summaries may be written and discharge planning developed by the attending physician's nurse practitioner or physician assistant with appropriate oversight by the attending physician.

1.1.7.2 **Discharge Orders Not Required in Specific Circumstances**: No written discharge orders are required in the following circumstances:

1.1.7.2.1 When a patient is removed pursuant to a disaster plan,

1.1.7.2.2 When a patient leaves the Hospital against medical advice.

1.1.8 Patient Departure Against Medical Advice

1.1.8.1 **Notification and Reporting**: Should a patient threaten to leave or leave the Hospital against the advice of a physician, a notation of the event shall be made in the patient's medical record and immediately reported to the Nurse Manager and shall be submitted to the Hospital's Vice President, Patient Care Continuum. The patient's attending Medical Staff member shall also be notified as soon as practicable of the patient's anticipated or actual departure from the Hospital without observing required procedures.

1.1.8.2 **Release Form**: Inpatients leaving the Hospital against the advice of a physician shall be requested to sign the proper release form to be placed in the patient's medical record. A patient's failure or refusal to sign the proper release form shall be recorded on the release form, which becomes part of the patient's medical record. A discharge note shall then be prepared by the attending Staff member within twenty-four (24) hours.

1.1.8.3 **Limitations on Patient's Rights to Discharge against Medical Advice**: A competent patient generally has the right to leave the Hospital against the advice of his/her attending Staff member. However, the Hospital has the right in cases of competence or concerns of immediate danger to him/herself or others not to allow a patient departure. In such cases, the Nurse Manager and/or the Administrator-on-call shall be immediately notified.

1.1.9 Time of Patient Discharge

It is desirable for the attending Staff member to discharge his/her patients prior to 2:00 p.m. on the day of discharge. Whenever possible, the Medical Staff member should write a tentative discharge order the day before discharge. Under certain conditions, which require the patient to remain in the Hospital an additional half day, the Staff member may write an order for a late discharge. The patient may be discharged by 11:00 p.m. if a late discharge is ordered.

1.1.10 Patient Death

1.1.10.1 **Pronouncement of Death**: In the event of a patient's death, the deceased shall be pronounced dead by a Medical Examiner, a Medical Staff member, or their designees within six to eight (6-8) hours. 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 or his/her designee. Release of dead bodies shall be in accordance with applicable law. Hospital policies may prescribe additional requirements where there is a fetal death, stillbirth, or death shortly after birth.

1.1.10.2 **Obtaining Autopsies**: All Medical Staff members are encouraged to secure autopsies whenever indicated on non-Medical Examiner cases. Unless otherwise required by the County Medical Examiner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. A pathologist, designated by the Pathology Service of the Hospital, shall perform all autopsies. The Pathology Service shall notify attending Staff members as to the time of autopsy. Unless special circumstances justify variance, provisional anatomic diagnoses shall be recorded on the medical record within

seventy-two (72) hours and a final diagnosis shall be made a part of the decedent's medical record within thirty (30) days.

1.2 Patient Management, Consultation, and Utilization

1.2.1 Daily Patient Assessment

A hospitalized patient shall be visited and assessed daily (i.e., preferably on the day of admission and at least once every 24 hours thereafter) by his/her attending Medical Staff member or his/her designee. If an APP requests that their Collaborating Physician see a patient on a particular day, the physician is required to do so. However, these are minimum requirements and patient acuity may require that assessments be performed sooner and more frequently thereafter as clinically appropriate. Evidence of these daily assessments shall be recorded in the patient's medical record.

1.2.2 Special Request for Patient Visit

Any Medical Staff member requested by a Nursing Supervisor or Administrator to come to the Hospital to attend his/her patient, whether that patient be an inpatient or outpatient, shall comply with that request as soon as possible having due regard only to the immediate needs of other patients under his/her care.

If attendance by the attending Medical Staff member is impossible within a reasonable time having due regard to the condition of the patient as described by the person communicating the request, then the attending Medical Staff member shall instruct the nursing staff to call his/her alternate, who shall then come to the Hospital as soon as possible to attend the patient in question. If the attending Medical Staff member and his/her alternate are both unable to come to attend the patient in a timely fashion, then the nursing staff shall notify the Chief of the respective Service, Chief of Staff, or the Chief of Staff-Elect. The person contacted then shall be responsible for arranging the immediate attendance of a Medical Staff member in order to meet the needs of the patient in question.

1.2.3 Consultations

1.2.3.1 **Consultation Request Responsibility**: It is the responsibility of the attending Medical Staff member to call for a consultation whenever indicated or pursuant to individual Clinical Service Rules and Regulations. In addition to the attending Medical Staff member, each Clinical Service Chief shall be authorized to take steps to ensure that consultations are procured where indicated or required for patients admitted within his/her respective Service. Personal communication among the requesting and consulting physicians is required in all emergent cases and documented in the electronic medical record.

1.2.3.2 **Responsibility of Consultant**: An acknowledged consultation shall be performed and documented within twenty-four (24) hours of its request or at a time agreeable between the attending Staff member and the consultant. All consultations shall include the performance and recording of a patient examination, as well as the recording of the consultant's overall impressions and recommendations into the patient's medical record. The consultant's documented record summarizing his/her findings and recommendations is to be prepared immediately after the consultation. When a Staff member makes a consultation request to a consultant, that consultant, or a member of his/her group, shall perform all aspects of the consultation. When an operative procedure is recommended, this recommendation must be placed on the patient's chart before commencement of the recommended operation unless the operation is of an emergent nature.

1.2.3.3 A request by the attending or admitting physician that the patient's private physician be notified of the fact of the patient's admission or death is a professional courtesy, does not constitute a consultation request, and does not impose any obligation upon the private physician to respond in any way to the notification.

1.2.4 Utilization

The attending Medical Staff member is required to document the need for continued hospitalization after specific periods of stay as has been identified by the Utilization Management team/Physician Advisor of the Medical Staff. At a minimum, this documentation must contain the following:

1.2.4.1 An adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is insufficient);
1.2.4.2 The estimated period of time the patient will need to remain in the Hospital;
1.2.4.3 Plans for post-hospitalization care.

1.3 Orders by Staff Members

1.3.1 Electronic Orders

Except in the case of an emergency or planned or unplanned system downtime, all orders for medication, treatment, tests, and therapy shall be entered through computerized provider order entry (CPOE), subject to the following:

1.3.1.1 **Exclusions:** Certain orders or order types may be excluded from electronic entry as listed from time to time in a separate document. All orders shall exclude unapproved abbreviations.

1.3.1.2 **Appropriate Use:** Where possible all electronic orders shall be entered using discrete structured orders provided by the CPOE system. Free text entry of orders in a comment field is not allowed where discrete orders are readily available.

1.3.1.3 **Electronic Signatures**: Electronic signatures (i.e., the use of electronic passwords for authentication) are permitted, subject to such policies as the MEC and the Hospital may enact from time to time. Only the ordering physician, nurse practitioner or physician assistant may officially "sign" an order or entry.

1.3.2 Verbal and Telephone Orders
A verbal or telephone order shall be considered equivalent to an electronic order if dictated to an authorized recipient (as provided below) and then signed by the Staff member who placed such an order as defined above. All verbal and telephone orders may be authenticated by any physician familiar with the patient, but it is the ultimate responsibility of the attending physician to ensure they are authenticated at the time of the attending physician's daily visit. All orders and order authentications must include date, time, identifiable signature and provider number.

1.3.2.1 *Verbal orders* are face-to-face interactions and are only accepted in the case of an emergency or during a procedure when it is not possible for the practitioner to write the order.

1.3.2.2 *Telephone orders* are received over the phone and are only accepted to address a time-sensitive patient need when a delay to wait for the practitioner to have access to CPOE would likely affect patient care because of the time delay. Any individual accepting a verbal/telephone order from a provider must document the order and read it back and confirm it. Further, the order must be dated and timed by the individual accepting the order.

1.3.2.3 Recipients of Verbal/Telephone Orders
The following Hospital personnel are authorized to accept verbal/telephone orders only in their area of responsibility:

1.3.2.3.1 Registered Nurses,
1.3.2.3.2 Registered Occupational Therapists,
1.3.2.3.3 Registered Pharmacists,
1.3.2.3.4 Registered Dietitians,
1.3.2.3.5 Registered Medical Technologists,
1.3.2.3.6 Registered Medical Technicians,
1.3.2.3.7 Registered Physical Therapists,
1.3.2.3.8 Registered (Certified) Respiratory Therapists,
1.3.2.3.9 Registered Nuclear Medicine Technologists,
1.3.2.3.10 Registered Radiology Technologists,
1.3.2.3.11 Registered Ultrasound Technologists, and
1.3.2.3.12 Medical Social Workers.

1.3.3 Circumstances Where Orders Are Automatically Canceled

All medication and treatment orders shall be automatically canceled under the following conditions:

1.3.3.1 Upon the patient's being discharged from the Hospital.

1.3.4 Circumstances Where Orders Require Review

All medication and treatment orders shall be reviewed and a determination made regarding continuing, discontinuing and modifying each order under the following conditions:

1.3.4.1 Upon the patient's transfer to the Delivery Room, Operating Room, or any other area of the Hospital for purposes of performing an inpatient operative or surgical procedure;

1.3.4.2 Upon the patient's transfer between levels of care.

1.3.5 Illegible Orders

Orders that are illegible or incompletely written (e.g., fail to spell out clearly the name of the drug, its dosage, frequency of administration, and route of administration) shall not be carried out by the nurse until clarification has been obtained from the ordering Staff member. This clarification may be verbal but shall be subsequently documented and signed by the ordering Staff member.

1.4 Patient Drugs/Medication

1.4.1 Approved Drugs

All drugs used within the Hospital and Hospital-owned Medical Practices and Urgent Care Centers, with the exception of drugs used for bona-fide clinical investigational purposes, shall be listed in the United States Pharmacopoeia, National Formulary, and the Henry Ford Health Formulary and be approved as a Formulary Drug by Henry Ford Health Medication Management Committee as well as the Henry Ford Jackson Hospital MEC. Drugs under study for a bona-fide clinical investigation shall be approved by the Institutional Review Board.

1.4.2 Generic/Trade Usage

In all cases wherein a Medical Staff member orders a drug by trade name, the Pharmacist may automatically dispense the drug by its generic name unless the attending physician designates next to the name of the drug, "Dispense as written" or "DAW". In all cases wherein the Medical Staff member names a specific manufacturer when ordering a drug, the manufacturer's drug, if available, shall be dispensed.

1.4.3 Hospital Formulary

The Formulary is prepared and revised by the Pharmacy and Therapeutics Committee in conjunction with the Pharmacy. No new drug will be admitted into the Formulary or stocked in the Pharmacy, except for controlled research, before it has been authorized for marketing by the Federal Food and Drug Administration. Staff members may submit, in writing, evidence supporting the retention of a drug that is under consideration for deletion from the Formulary. In addition, written requests for additions to the Formulary may be submitted to the Pharmacy and Therapeutics Committee by any Staff member.

1.4.4 Medication Errors

Pursuant to the Public Health Code and other applicable state and federal statutes and regulations governing care and professional review, all actual or suspected medication errors shall be reviewed by the Pharmacy and Therapeutics Committee, the CMO, and, if investigational medication is involved, the Institutional Review Board for professional review and reduction of morbidity and mortality and improvement of patient care purposes.

1.4.5 Approved Pharmaceutical Nomenclature

Only those pharmaceutical abbreviations established by the Pharmacy and Therapeutics Committee shall be used in the writing of medication orders for patients. Abbreviations not included on the list must be clarified by the Pharmacy before the dispensing of the medication in question.

1.4.6 Non-Hospital Drugs

In order to minimize the possibility of drug overdose or unsuspected drug reaction, prescription drugs known to be possessed by patients at the time of or during admission shall be secured by the Hospital staff until patient discharge, unless otherwise ordered by the attending Staff member. If there is reason to believe an admitted patient has illegally obtained prescription or illicit drugs, the drugs will be secured by Hospital staff. The attending Medical Staff member and the Nursing Supervisor for the shift and unit shall be notified promptly, and they shall make such further investigation or take such action as is deemed appropriate under the circumstances.

1.4.7 Self-Administration of Medications

Self-administration of medications by patients shall be permitted, to the extent consistent with Hospital policy, as long as a specific written order by the patient's attending Medical Staff member authorizes such self-administration.

1.5 Medical Records

1.5.1 Responsible Party

The attending Staff member is responsible for the overall preparation and timely completion of his/her patient's medical record.

1.5.2 General Content of Medical Record

In general, the medical record shall include the following:
1.5.2.1 Chief complaint;
1.5.2.2 Present illness;
1.5.2.3 Systems review;
1.5.2.4 Social history;
1.5.2.5 Family history;
1.5.2.6 Past medical history;
1.5.2.7 Physical examination;
1.5.2.8 Clinical reports (if applicable);
1.5.2.9 Laboratory reports (if applicable);
1.5.2.10 Evidence of informed consent;
1.5.2.11 Documentation of all medical and surgical treatment;
1.5.2.12 Operative report (if applicable);
1.5.2.13 Progress notes;
1.5.2.14 Final diagnosis;
1.5.2.15 Condition on discharge;
1.5.2.16 Discharge summary;
1.5.2.17 Autopsy report (if applicable).

1.5.3 History and Physical Examination

For all inpatient and observation patients it shall be the responsibility of the admitting Staff member to see that a complete history and physical examination is recorded in the patient's medical record within twenty-four (24) hours of admission, except that for observation patients, the history and physical examination must be recorded in the patient's medical record within twenty-four (24) hours or prior to the patient's discharge, whichever comes first. A consultation will not suffice as an admitting history and physical examination. The H&P should include all pertinent findings resulting from an assessment of all pertinent body systems. An interval note with a review of systems is acceptable if the patient is readmitted within thirty (30) days for the same or a related problem.

1.5.3.1 This report shall be incorporated into the patient's medical record and signed by the attending Staff member.

1.5.3.2 **History and Physical Examination for All Surgical, and Any Other Patients Undergoing a Procedure Requiring an Informed Consent**: Unless an emergency surgery or procedure is indicated, all patients shall have a history taken and a physical examination performed and recorded in the medical record before the start of the surgery or procedure. The history and physical examination shall be between 30 days prior to, and 24 hours after, an admission, but before a surgical or other procedure. If there has been a condition change, an update must be recorded before the start of surgery.

In the case of an emergent surgery case, a subsequently dictated H&P is required in all records within 24 hours.

1.5.3.3 **Physical Examination for Newborn Infants**: Admitted newborn infants shall have a history taken and a physical examination performed and recorded by a qualified physician or qualified/neonatal nurse practitioner within twenty-four (24) hours after birth.

1.5.3.4 **History and Physical Examination for Obstetric Patients**: For inpatients delivered by C-section and inpatients who remain undelivered, a history and physical shall be documented within 24 hours of admission, but before a non-emergent C-section. For inpatients who have a normal vaginal delivery, or who present and remain as a Short Stay patient, the Nursing Obstetric Admitting Record and Hollister Prenatal Forms will suffice in lieu of a documented history and physical examination and shall be updated by the physician on the chart in the medical record if not delivered or on the delivery summary, if delivered. The update shall be done within 24 hours of admission. Obstetrical patients who did not receive prenatal care, or for whom prenatal care records are not otherwise available require completion of a complete history and physical and a record of such examination entered into the record prior to delivery, or in the case of emergent deliveries or C-sections within 24 hours of admission.

1.5.3.5 The following practitioners, all of whom must be credentialed by the Medical Staff, may complete history and physical examinations.

1.5.3.5.1 Inpatient, Outpatient, Observation and All Surgical H&Ps: A physician, nurse practitioner, certified nurse midwife or a physician assistant may perform and record the history and physical examination.

1.5.3.5.2 Other practitioners: Other non-physician practitioners credentialed by the Medical Staff may be privileged to perform H&Ps on an individual basis, based upon their training and experience. History and physical examinations performed by nurse practitioners must be co-signed by a qualified physician.

1.5.3.6 **History and Physical Examination for Non-Inpatient Services:**
Any procedure performed on an outpatient basis that requires an informed consent shall have a history taken and an examination performed.

1.5.3.7 **History and Physical Content Requirements for Inpatient, Observation and Non-Inpatient Services**: (Refer to table below.)

	Type of History	**Medications**	**Allergies**	**Type of Physical Exam**	**Impression and Plan**
Inpatient/ Observation	Detailed or comprehensive history: • Chief complaint • Extended history of present illness • Pertinent or complete past family and social history • Review of systems • Pertinent lab and x-ray review	Required	Required	Detailed or comprehensive examination: • General multisystem exam or extended or complete exam of affected body areas(s) • Includes heart and lungs exam	Required
Non-Inpatient services (e.g., outpatient invasive procedures with or without anesthesia/ sedation)	Focused history: • Problem pertinent review of systems	Required if not included in medical record	Required if not included in medical record	Focused examination: • Focused exam of affected body area(s) • Includes heart and lungs exam	Required
Please also refer to Imaging Services departmental guideline HFAH Imaging Services IR Procedure Documentation Guideline regarding the content required for the H/P examination to type of invasive procedure. The Imaging Services Clinical Service Chief shall approve any revisions to this policy.					

1.5.4 Informed Consent for Special Procedures or Surgery

The responsibility for discussing risks, benefits, alternatives, and complications for the purpose of securing consent for a service or procedure from the patient is and shall be that of the Staff member who performs or supervises the service or procedure. However, the process for signing of consent forms, including when signing is necessary, who may sign, and who must witness the signature, shall be as provided in a Hospital policy addressing this subject. Responsibility for a signed consent form shall be that of the Staff member performing the procedure for which the consent is obtained. In addition to the signed consent form, the medical record shall contain an entry by the Staff member who will be performing the procedure, setting forth that the risks, benefits, alternatives and possible complications have been discussed with the patient or his/her representative, demonstrating informed consent.

This note may appear on the consent form itself, in the physician progress notes, or in the history and physical.

1.5.5 Post-Operative Note

A post-operative progress note, which includes the procedures performed, a description of the findings, technical procedures used, specimens removed, post-operative diagnosis, estimated blood loss, and the name of the primary surgeon and any assistants, shall be entered in the medical record

immediately after surgery to provide pertinent information for use by any other care professionals who are required to care for the patient.

1.5.6 Operation Report

An operation report must be recorded in the medical record as soon as possible after surgery and should contain a description of the findings, the technical procedures used, the specimens removed, estimated blood loss, the postoperative diagnosis and the name of the primary surgeon and any assistant(s). The completed report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

1.5.7 Progress Notes

1.5.7.1 Progress notes shall be made daily on all patients admitted to the Hospital. The progress note shall contain sufficient detail to permit continuity of care, identify current or potential problems and reflect changes in condition as well as results of treatment.

1.5.8 Reports of Test Results

Reports on pathology and clinical laboratory examinations, Imaging Services and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures shall be completed promptly and filed in the medical record within twenty-four (24) hours of completion if reasonably possible. In addition, all diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record. This may also include any reports from facilities outside of the Hospital, in which case the source facility shall be identified on the report.

1.5.9 Pre-Anesthesia Evaluation

An anesthesiologist (or specified others as provided in the Anesthesiology Service Rules and Regulations) shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care within 48 hours, immediately prior to the administration of an anesthetic, except when an emergency does not reasonably permit this evaluation, it shall be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. This evaluation should include:

1.5.9.1 Reviewing the available medical record including medical history, anesthesia, drug, and allergy history.
1.5.9.2 Interviewing, if possible, given the patient's condition and performing a focused examination of the patient to: discuss the medical history, including previous anesthetic experiences and medical therapy and assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
1.5.9.3 Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care
1.5.9.4 Ordering appropriate perioperative medications
1.5.9.5 Ensuring that consent has been obtained for the anesthesia care including notation of anesthesia risk/benefits with the patient (or representative) according to established standards of practice along with the anesthetic plan
1.5.9.6 Documenting in the chart that the aforementioned elements have been performed

1.5.10 Post-Anesthesia Evaluation

The medical record shall contain a recording of post-anesthetic visits by an anesthesiologist or nurse anesthetist, including at least one note describing the apparent presence or absence of anesthesia-related complications, no later than 48 hours after surgery or a procedure requiring anesthesia services.

1.5.11 Obstetrical Records

The medical record for obstetrical patients shall include a prenatal record giving the history of past pregnancies, laboratory data, past medical and social history, physical findings and office visits. A durable, legible original or copy of an office or clinic prenatal record meeting Hospital medical record

requirements is acceptable. When a fetal heart monitor machine has been applied to an obstetrical patient, all fetal heart monitor strips shall remain a part of the mother's medical record regardless of the outcome of the mother's admission. As may be provided by Hospital policy, however, the fetal monitor strips may be filed by the Health Information Management Department in a separate, secure location from the mother's medical record.

1.5.12 Substance Abuse Records

The medical record for Substance Abuse Unit patients shall be stored separately from the acute care records of these patients due to the sensitive nature of their content.

1.5.13 Confidentiality and Preservation of Record

Subject to the provisions below, all medical records, including x-rays, fetal heart monitor strips, electrocardiograms, and other diagnostic tapes, are the property of the Hospital and shall not be removed from the Hospital unless authorized by the Hospital Counsel or unless so ordered by a Court of competent jurisdiction. Photocopies of a patient's record may be released pursuant to an order from a court of competent jurisdiction or pursuant to proper written authorization from the patient or his/her legal representative. In the event of a hospitalized patient, all previous records of a patient shall be made available to Hospital personnel and Staff members involved in the care and treatment of the patient. Access to medical records of Hospital patients may be afforded to Staff members for bona-fide quality management study and research. All research projects must include specific protocol for protecting patient confidentiality and be approved by the Institutional Review Board prior to the review of any records.

1.5.14 Stamp Signatures

Stamp signatures (rubber, scanned, typed, etc.) are not permissible where a Staff member's actual signature is required.

1.5.15 Final Diagnosis

Final diagnoses shall be recorded in full using a recognized system of disease nomenclature, without the use of symbols or abbreviations. The final diagnoses surgical procedures and any complications and/or co-morbidities will be listed on the summary preferably dictated on the day of discharge. In the event additional results or other pertinent data is forthcoming, the final diagnoses shall be documented in an addendum promptly.

1.5.16 Discharge/Transfer/Death Summary

All patient medical records must contain a discharge summary which includes all inpatients regardless of length of stay, as well as, observation patients. The summary shall include the primary, secondary and final diagnoses, any treatment and procedures performed, a review of the patient's hospital course including outcome of the hospitalization, disposition of the patient and provisions for follow-up care. Follow-up care provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

1.5.17 Completion of Medical Records

Significant clinical events shall be documented as soon as reasonably possible after occurrence and in compliance with the Tier 1 Medical Records Completion Policy. The records of discharged patients shall be completed within a period of time that will in no event exceed 30 days following discharge. A medical record shall ordinarily be considered complete when the required contents are authenticated, including a discharge summary and when all final diagnoses and any complications are recorded without use of symbols or abbreviations, at the time of or within 72 hours of the encounter/visit. Completeness implies the transcription of any dictated record content and its insertion into the medical record. No Staff member is permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another Staff member who is deceased or unavailable permanently or protractedly for other reasons.

1.5.18 Delinquency Policy

1.5.18.1 The MEC shall be responsible for developing a Medical Records Delinquency Policy. The Health Information Management Department shall be responsible for monitoring Medical Staff member compliance with the Policy and shall submit reports to the Quality Management Committee who shall enforce the Policy.

1.5.18.2 The Delinquency Policy, as approved by the MEC, shall be conspicuously posted in pertinent areas of the Health Information Management Department. Copies of the Delinquency Policy shall be made available to all members of the Medical Staff.

1.5.19 Medical Record Entries

1.5.19.1 Medical record entries must be electronic – entered directly into the electronic health record (HER) – or dictated, except in downtime or emergency situations. All documentation must be legible, dated, timed, and authenticated in a timely fashion by the person or persons responsible for providing or evaluating the service provided, consistent with the health system policies, procedure(s), and requirements for compliance.

1.6 Laboratory Specimens

1.6.1 The following shall be sent to the Pathology Service. The pathologist's authenticated report shall be made a part of the patient's medical record:

1.6.1.1 All tissues removed at surgical procedure are to be sent to the Laboratory unless the specimens by their nature or condition do not permit productive examination, and only when the quality of care of Medical Record documentation has not been compromised by the exception. Thus, some tissues, not related to the primary surgical procedure may be excluded (but these shall be listed categorically in the Rules and Regulations of the various surgical specialties and subspecialties and shall be reviewed at least annually in consultation with the Pathology Clinical Service, especially with regard to changes).

1.6.1.2 All representative materials from all bone marrow aspirations/biopsies, including smears and clots obtained for diagnostic evaluation shall be submitted to the Hospital Pathology Laboratory as a matter of routine for proper documentation and filing, so that these tissues can be available, therefore, for routine recall and review.

1.6.2 All specimens sent to the Laboratory shall be examined by a pathologist, or designee.

1.7 Medical Conflict Resolution

1.7.1 Notification of Attending Staff Member of Concern

In the event that a person who is a Staff member or Hospital professional employee becomes concerned that the diagnosis, treatment, or care of a patient by a Staff member may be inadequate or inappropriate, the concerned person shall attempt to notify and communicate his/her concerns and perceptions to the patient's attending Staff member (or designated alternate, if the attending Staff member is unavailable).

1.7.4 Medical Staff Action

In the event the Clinical Service Chief, Chief of Staff or designee has been notified of such concern through the Nursing Department or member of the organized Medical Staff, then the Clinical Service Chief, Chief of Staff or designee shall review the issues and possibly examine the patient and/or communicate with the patient's attending Staff member. The Chief of Staff, designee, or Clinical Service Chief shall arrange for any consultation that may appear appropriate in accordance with the Medical Staff Documents.

1.7.5 Further Action by the MEC

If the CMO continues to believe that further medical review is warranted, after the Chief of Staff, or designee has decided that no further MEC action needs to be taken, then the CMO shall so advise the

Vice President, Medical Affairs. The Vice President, Medical Affairs in turn may request that the entire MEC review the issues.

1.8 General Conduct of Care

In the event a practitioner appears to be incapacitated as a result of alcohol, drug abuse or prescription drugs, or appears to be mentally or emotionally incompetent, the Chief of Staff or designee shall act in accordance with the Medical Staff Documents.

2.0 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals (AHP) are individuals other than licensed physicians of medicine or osteopathy, podiatry, or dentistry, or Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, or Certified Nurse Midwives who are educationally and clinically prepared and maintain competency in a discipline which the Board of Trustees has determined by policy to allow to practice at HFJH.

AHPs must meet basic qualifications in order to provide specified patient care services as assigned in an appropriate Clinical Service under the overall direction of the Clinical Service Chief. The MEC shall establish qualifications required of members of the AHP category provided that such qualifications are not founded on an arbitrary or discriminatory basis and are in conformity with applicable State law. Professions eligible for AHP membership shall be established by the MEC and approved by the Board of Trustees.

2.1 Qualifications:

2.1.1 Allied Health Professionals (AHP)

Allied Health Professionals (AHP) consist of audiologists, psychologists, social workers, surgical assistants, surgical technologists, and RN first assistants. AHPs practice as dependent practitioners who are limited in their scope of practice, pursuant to relevant certification/licensing regulations and Hospital policies in rendering direct or indirect medical or dental care. They function under the supervision of a member of the HFJH Medical Staff possessing privileges to provide such care within the Hospital. Supervision of medical or dental care shall be defined in accordance with the definition of supervision as provided by relevant provisions of the Michigan Public Health Code and shall be defined by their clinical privileges. AHPs employed by the Hospital are processed through the Human Resources Department and shall follow its policies and procedures except when it is determined by the MEC that the Medical Staff Affairs Office can assist in this process. AHPs not employed by the Hospital will be processed through the Medical Staff Affairs Office. They also abide by the Medical Staff Bylaws and associated documents, and statutes governing licensure and certification.

2.2 Obligations and Citizenship Requirements

2.2.1 Each patient's general medical condition and care is the ultimate responsibility of a member of the AHP Staff.

2.2.2 AHPs are dependent providers, do not have direct patient care responsibilities, and shall not admit or discharge patients.

2.2.3 AHPs may serve, with vote, on Clinical Service Committees to which they are appointed

In order to exercise voting privileges, staff obligations and citizenship requirements must be met, including meeting attendance, committee assignments, etc., as applicable.

2.2.4 AHPs shall not hold Medical Staff office but may serve as Chair of Medical Staff committees to which they are appointed.

2.2.5 AHPs may attend meetings of the General Medical Staff, without vote.

2.2.6 AHPs shall attend meetings of the Medical Staff and/or Clinical Service of which s/he is a member if specifically requested by the Chief of Staff or Clinical Service Chief.

2.2.7 AHPs may attend any Hospital education program.

2.2.8 AHPs are expected to comply with quality assurance/performance improvement and patient safety activities required by the Hospital and Medical Staff.

2.2.9 AHPs must abide by the Medical Staff Bylaws and associated documents, as well as statutes governing licensure and certification.

2.2.10 Maintain, in good standing, a current professional Michigan license or certification, and Michigan Controlled Substance certification and DEA registration, if applicable.

2.2.11 Maintain professional liability insurance in the amount of $200,000/$600,000. The Medical Staff Affairs office at Henry Ford Jackson Hospital should be listed as a certificate holder on professional liability insurance certificates.

2.3 Rights of AHP Members

When the MEC has reason to question whether an AHP can function within his/her privileges because of a physical and/or mental health status, the AHP shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to the MEC as a prerequisite to further consideration of his/her application for appointment or reappointment, the exercise of previously granted privileges, or maintenance of his/her appointment.

No AHP is automatically entitled to membership on the AHP Staff or to the exercise of particular pclinical privileges merely because s/he is licensed to practice in Michigan or in any other state, or because s/he is a member of any professional organization or board, or because s/he had or presently has staff membership or privileges in another health care facility or in another practice setting.

Membership and privileges shall not be denied on the basis of sex (including gender identity, gender expression, and non-conformity with gender stereotypes), race, creed, color, national origin, religion, health status, ability to pay or source of payment, or on the basis of any other criteria prohibited by law.

The AHP shall provide specified patient care services to the Clinical Service to which s/he is assigned,

2.4 Basic Responsibilities for all AHPs

AHP ongoing responsibilities include:

2.4.1 Providing for high quality health care which includes but is not limited to the following activities:
2.4.2 Patient care within the parameters of their professional competence, as reflected in the scope of their clinical privileges;
2.4.3 Patient care within the framework of (implicit or explicit) clinically relevant and scientifically valid standards, guidelines, and criteria;
2.4.3 A continuing education program relevant to quality improvement;
2.4.4 A utilization review program to review both inpatient and outpatient services;
2.4.5 An organization-wide structure for the ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes, patient care review, and other required quality improvement activities appropriate to the AHP
2.4.6 Abiding by the Medical Staff Documents as they apply to the AHP and the Clinical Service(s) to which s/he belongs;

2.4.7 Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the AHP by the Clinical Service(s) and the MEC;
2.4.8 The AHP must conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteeing the security, privacy, and confidentiality of health information on all patients visited or studied.
2.4.9 Establishing (1) adherence to the ethics of his/her profession, and (2) ability to work cooperatively with members of the Medical Staff, nurses, and the Hospital Administration, and others so as not to adversely affect patient care, and that the functions of the Medical Staff and the Hospital will be able to operate in an orderly manner;
2.4.10 Preparing and completing medical records for all the patients to whom the AHP provides care within the Hospital within the time frames prescribed in the Medical Staff Documents;
2.4.11 Participate in such emergency service coverage or consultation panels as may be determined by the MEC and/or the Chief;
2.4.12 Retaining appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom s/he is providing services
2.4.13 Notifying the MEC immediately of any of the following:
- 2.4.13.1 The voluntary or involuntary relinquishing, revocation or suspension of his/her professional license/certification;
- 2.4.13.2 The imposition of terms of probation or limitation of practice, by any state;
- 2.4.13.3 Voluntary or involuntary loss of a healthcare organization affiliation or loss or restriction of privileges at any hospital or other healthcare organization;
- 2.4.13.4 The pending or commencement of a formal investigation, or the filing of charges by any healthcare organization or by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Michigan;
- 2.4.13.5 The filing of a claim against the AHP alleging professional liability;
- 2.4.13.6 The voluntary or involuntary surrender or reduction of privileges or license/certification prior to, or during, an investigation at another healthcare organization.

2.4.14 Any change of employment status.

2.5 Procedure for Appointment and Specification of Services

Applications for appointment, reappointment, and specified patient services shall be submitted and processed in the manner recommended by the MEC and approved by the Board. The MEC and/or other Medical Staff Committees shall approve all procedures regarding credentialing and privileging as well as scope of practice. Applicants shall be individually assigned to the Clinical Services appropriate to their professional education and shall be subject to the terms and conditions of appointment as specified.

The application shall include the following documentation:

2.5.1 The applicant's qualifications, including, but not limited to, professional education and experience, current licensure, current competence and continuing education information or other quality assessment information related to the clinical privileges requested by the applicant;
2.5.2 The specific clinical privileges desired by the applicant;
2.5.3 Peer references familiar with the applicant's current professional competence and character;
2.5.4 Previously successful or currently pending professional disciplinary actions or licensure limitations;
2.5.5 Voluntary or involuntary limitation, reduction or loss of or denial of clinical privileges at another hospital. The application form shall provide the opportunity for the applicant to offer explanatory information regarding the actions listed in this subsection;
2.5.6 Ability to perform privileges requested;
2.5.7 Final judgments or settlements against the applicant in professional liability actions.

2.6 Determination of Clinical Privileges for all AHPs

The following conditions shall apply to those applying for or currently holding AHP privileges: the MEC shall recommend to the Board the granting of clinical privileges to the AHP.

2.6.1 Clinical Privileges Application

By applying for clinical privileges, each applicant:

2.6.1.1 Signifies his or her willingness to appear for interviews concerning the application;
2.6.1.2 Authorizes consultation with others who have been associated with him/her and who may have information bearing on his/her competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
2.6.1.3 Consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
2.6.1.4 Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
2.6.1.5 Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
2.6.1.6 Consents to the disclosure to other hospitals and licensing boards, and to other similar organizations as required by law, any information regarding his/her professional standing or competence that the Hospital, Medical Staff or any individual may have, and releases the Medical Staff and the Hospital from liability for so doing to the fullest extent permitted by law;
2.6.1.7 Pledges to provide for continuous quality care for his/her patients The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When verification is completed, all such information shall be transmitted to the appropriate Clinical Service Chief.

2.6.2 Clinical Service Action

After receipt of the verified application, the Chief or appropriate committee of each Clinical Service to which the application is submitted shall review the application and supporting documentation and may conduct a personal interview with the applicant at his or her discretion. The Chief or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Credentials Committee within 30 days of the receipt of the application an electronic report and recommendation as to Clinical Service affiliation and clinical privileges to be granted, and any special conditions to be attached. The Chief may also request that the committee defer action on the application.

2.6.3 Credentials Committee Action

When appropriate or as needed, the Credentials Committee shall review and evaluate the application, the Clinical Service Chief's report and recommendations, and other relevant information. The Credentials Committee may interview the applicant and seek additional information. Within 30 days of the receipt of the application, the Credentials Committee shall transmit to the MEC its recommendations as to Clinical Service affiliation and clinical privileges to be granted, and any special conditions to be attached. The Committee may also recommend that the MEC defer action on the application.

2.6.4 MEC Action

At its next meeting after receipt of the Credentials Committee recommendation, the MEC shall consider and act on the recommendation. The MEC may request additional information, return the matter to the Credentials Committee for further investigation, defer action on the application, interview the applicant or recommend the granting or denial of the privileges requested. The MEC shall forward its recommendation to the Board for final approval.

2.6.5 Modification of Clinical Privileges

A request for modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request and approved by the relevant Clinical Service, the Credentials Committee, MEC and the Board.

2.6.6 Procedural Rights and Clinical Privileges

An AHP granted specific clinical privileges pursuant to the Medical Staff Documents shall be entitled to the procedural rights afforded by an AHP Fair Hearing Plan/Appellate Review in the Medical Staff Documents because a request for privileges is refused or because all or any portion of privileges granted are terminated or suspended. If a Henry Ford Health-employed AHP is terminated, privileges are likewise terminated and the Fair Hearing Plan/Appellate Review does not apply. The denial, termination, suspension or restriction of any temporary privileges does not entitle the practitioner to any of the procedural rights under the AHP Fair Hearing Plan/Appellate Review.

2.6.7 Bases for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the individual's education, training, experience, legally authorized scope of practice, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings where the individual has or had clinical privileges.

2.6.8 Term of Privileges

Privileges may be granted for a period not to exceed two years.

2.7 Temporary Privileges

Temporary privileges in this category can only be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time and after approval by the Board or its designee upon recommendation by the Chief of Staff or his/her designee. Temporary privileges are not to be routinely used for applications not completed in a timely manner. In addition, temporary privileges shall not be used to circumvent or expedite the credentialing process. Temporary clinical privileges may be granted to a person during pendency of that person's application for Medical Staff membership and privileges, provided that the procedure described in Section 2.8.1 below has been completed. This period shall not exceed 120 days.

The denial, termination, suspension or restriction of any temporary privileges does not entitle the practitioner to any of the procedural rights under the applicable Fair Hearing Plan/Appellate Review.

2.7.1 Application and Review

2.7.1.1 Upon receipt of a completed application and supporting documentation from an authorized practitioner to practice in Michigan, the Board or its designee, upon recommendation by the Chief of Staff or his/her designee, may grant temporary privileges to an applicant who appears to have qualifications, ability and judgment, but only on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Temporary privileges shall not be used to circumvent or expedite the credentialing process. Basic data for temporary privileges must include:

2.7.1.1.1 The Hospital's authorized representative's query of the National Practitioner Data Bank regarding the applicant for temporary privileges.

2.7.1.1.2 The Hospital's authorized representative's verification of the practitioner's current licensure, professional liability insurance, and DEA registration as applicable.

2.7.1.1.3 The Clinical Service Chief may contact a person who has recently worked with the applicant, has directly observed the applicant's professional performance over a reasonable time and provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care. The Clinical Service Chief may, at his/her discretion, interview the applicant.

2.7.1.1.4 The submission of a photo ID.

2.7.1.2 The applicant is otherwise eligible for the expedited credentialing process as evidenced by:

2.7.1.2.1 No current or previously successful challenge to licensure or registration;

2.7.1.2.2 Not having been subject to involuntary limitation, reduction, denial, loss of clinical privileges by any healthcare organization; and

2.7.1.2.3 Not having been subject to involuntary termination of Medical Staff membership at another healthcare organization.

2.7.1.2.4 Having a satisfactory determination by the Chief of Staff that there has been neither an unusual pattern of, nor an excessive number of, professional liability actions resulting in a final judgment against the applicant.

2.7.1.3 The applicant's file, which includes the evaluation of the Clinical Service Chief, is forwarded to the Credentials Committee Chair and Chief of Staff or designee who recommends the granting of temporary privileges. The Hospital President or its designee shall grant temporary privileges.

2.7.1.4 In the event of a disagreement between the Hospital President or its designee, the Credentials Committee Chair, and/or the Chief of Staff or his/her designee regarding the granting of temporary clinical privileges, temporary privileges shall not be granted until the matter is sent to the MEC for its recommendation. The recommendation shall then be forwarded to the Board for final approval.

2.7.2 Approval

The applicant's file, which includes the recommendation of the Clinical Service Chief, is forwarded to the Chief of Staff or designee who recommends the granting of temporary privileges. Once these requirements are met, the applicant may practice according to the authorization of the Board or its designee who may grant temporary privileges not to exceed 120 days.

2.7.3 General Conditions

2.7.3.1 If granted temporary privileges, the applicant shall act under the supervision of the Clinical Service Chief to which the applicant has been assigned, and shall ensure that the Chief, or the Chief's designee, is kept closely informed as to the applicant's activities within the Hospital.

2.7.3.2 Temporary privileges shall automatically terminate at the end of the designated period unless affirmatively renewed because of extenuating circumstances determined by the Clinical Service Chief and the Chief of Staff. The applicable procedure as set forth above shall be followed. As necessary, the appropriate Chief or designee shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member. Procedural rights under the Fair Hearing Plan/Appellate Review are not available to those holding temporary privileges.

2.7.3.3 Requirements for proctoring and monitoring including, but not limited to, those in this Section shall be imposed according to such terms as may be appropriate under the circumstances on any member granted temporary privileges by the Chief of Staff after consultation with the Service Chief or the Chief's designee.

2.7.3.4 All persons requesting or receiving temporary privileges shall be bound by the

2.7.4 Privileges in an Emergency

2.7.4.1 In the case of an emergency, any AHP, to the degree permitted by the scope of his/her license/certification and regardless of Clinical Service or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The AHP shall make every reasonable effort to communicate promptly with the Clinical Service Chief concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Clinical Service Chief with respect to further care of the patient. AHPs utilizing the form of emergency care shall promptly document in the medical record the circumstances of the emergency.
2.7.4.2 In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

2.8 Reapplication

An AHP whose application for privileges is denied shall not be eligible to reapply for one calendar year from the date of receipt of the denial. Any reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision no longer exists.

2.9 Provisional Status

2.9.1 Provisional Status

Initial membership and privileges, or any additional privileges once on staff, shall require a provisional status for a period of at least one year from the date privileges were initially granted.

The following shall be considered:

2.9.1.1 Complete all elements of the Focused Professional Practice Evaluation approved at the time of initial granting of privileges;
2.9.1.2 Demonstrate good faith in carrying out the obligations and citizenship requirements under the Clinical Service(s) required;
2.9.1.3 Meet the basic qualifications and responsibilities set forth in the Medical Staff Documents;
2.9.1.4 No current FPPE for cause;
2.9.1.5 No professional behavior issues, QM referrals, or quality of care issues

2.10 Focused Professional Practice Evaluation (FPPE)

All AHPs shall undergo a period of focused professional practice evaluation (FPPE) to evaluate her/his proficiency in the exercising of clinical privileges initially granted, and overall eligibility for continued appointment. FPPEs shall follow whatever frequency and format a Clinical Service Chief deems appropriate in order to adequately evaluate the AHP including, but not limited to: concurrent and/or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. FPPE results shall be reviewed by the Clinical Service Chief and a recommendation for continued appointment made to the Credentials Committee.

2.11 Reappointment

2.11.1 Reappointment Process

2.11.1.1 At least 150 days prior to the expiration date of the current staff appointment (except for temporary appointments), a link to the electronic reappointment application shall be emailed to the member requesting response within 30 days. If an application for reappointment is not received by the end of the month (30 days), the reappointment

application will not be accepted, and the completion of a new application will be required for staff membership and/or privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 2.6 above, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth in Section 2.6 above.

2.11.1.2 An AHP staff member who seeks a change in Staff status (if applicable) or modification of clinical privileges may submit such a request at any time upon a form developed by the MEC except that such application may not be filed within 90 days of the time a similar request has been denied.

2.11.1.3 Each applicant shall be subject to an in-depth review generally following the procedures set forth for the initial application process.

2.11.2 Criteria

Renewal of privileges shall be based on the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his/her patients, the individual's professional competence and judgment in the treatment of patients, judgment and clinical/technical skills as indicated by the results of quality review activities as well as peer recommendations; current licensure; compliance with the Medical Staff Documents and policies; cooperation with the System's other practitioners, providers and personnel; general attitude toward patients; professional liability insurance as described previously and current physical and mental health status. The individual shall submit any reasonable evidence of current health status that affects his/her ability to perform privileges requested that may be requested.

2.11.3 Credentials Committee

The Clinical Service Chief, or designee, shall review each AHP's application and make a recommendation to the Credentials Committee, who shall make a recommendation to the MEC concerning the application for membership and privileges. Each party shall review all pertinent information available on the applicant to determine its recommendations for initial appointment or reappointment, which shall not exceed two (2) years.

2.11.4 MEC

At the next regular meeting, and upon review of the Credentials Committee report and recommendations, or as soon as possible thereafter, the MEC shall make written recommendations to the Board concerning each applicant's membership and privileges.

2.11.5 Incomplete Applications

Failure without good cause to timely file a complete application for reappointment as specified in 2.12.1.1-2.12.1.3 above shall result in the automatic termination of the member's privileges and prerogatives at the end of the current appointment. The applicant shall be sent electronic notification prior to the 30-day reappointment deadline, that the reappointment application must be completed in its entirety by the end of the month, or they shall be deemed to have resigned membership on the AHP staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in the Fair Hearing Plan/Appellate Review shall not apply.

2.11.6 Effect of MEC Recommendation

2.11.6.1 **Favorable Recommendation**: When the recommendation of the MEC is favorable to the applicant, the MEC Chair shall forward it, together with all supporting materials, to the Board.

2.11.6.2 **Adverse Recommendation**: When the recommendation of the MEC is to revoke or reduce privileges, the MEC shall so notify the applicant by special notice of the decision and of the right to an APP Fair Hearing/Appellate Review. No such adverse recommendation shall be forwarded to the Board until after the APP has exercised or waived his/her right to a hearing as provided in the Medical Staff Documents.

2.12 Leave of Absence

2.12.1 Leave Status

A leave of absence is defined here as any absence from the Hospital over 45 consecutive days but less than one year, with the exception of maternity/paternity leave. A leave of absence of over one year shall result in an automatic termination unless contemplated leaves of longer than one year are acted upon by the Board of Trustees upon recommendation of the MEC. An AHP Staff member may obtain a leave of absence from the AHP Staff upon submitting a written request to the Chief of Staff, Credentials Committee, and Service Chief(s) stating the reason for the leave, the approximate period of leave desired, and coverage arrangements. The leave of absence will be acted upon by the Board of Trustees upon the recommendation of the MEC. During the period of the leave, the member shall not exercise clinical privileges and membership rights and responsibilities shall be inactive unless extenuating circumstances are approved by the MEC.

The obligation to complete medical staff applications shall continue, unless waived by the MEC.

2.12.2 Termination of Leave

At least 45 days prior to the termination of the leave of absence, if the leave is greater than three (3) months, or at any earlier time, the AHP Staff member shall request reinstatement of privileges by submitting a written notice to that effect to the Credentials Committee, which will be acted upon by the Board of Trustees upon recommendation of the MEC. The AHP Staff member shall submit a summary of relevant activities during the leave.

2.12.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement (after notification by certified mail) shall be deemed a voluntary resignation from the AHP Staff and shall result in automatic termination of membership, privileges, and prerogatives. An AHP member whose membership is automatically terminated under these conditions, shall not be entitled to the procedural rights provided in the applicable Fair Hearing/Appellate Review Plan. A request for AHP Staff membership subsequently received from an AHP so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

2.12.4 Medical Leave of Absence

Whether or not the member has the ability to request a leave, the MEC shall determine the circumstances under which a particular AHP Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. If the request does involve a pending or active disciplinary matter, the decision to grant the leave of absence shall be determined by the MEC. The request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a practice and safely exercising the clinical privileges requested.

2.12.5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the MEC. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions in this Manual, but may be granted subject to monitoring and/or proctoring as determined by the MEC.

2.13 Notification of Resignation

The Medical Staff Affairs Office must receive written notification of resignation from the Medical Staff or Allied Health Professional Staff a minimum of two months prior to the effective date of said resignation.

2.14 Suspension or Revocation of Privileges

The Chief of Staff may summarily suspend or revoke privileges for any reason, including without limitation, when she/he's failure to maintain current licensure or liability insurance in the required amounts and type described in the Medical Staff Documents after consultation with said physician, Chief(s) of the involved Clinical Service(s), MEC, or any one of these. A hearing, if requested, shall be limited to the question of whether the grounds for suspension or revocation as set forth have occurred. If a Henry Ford Health-employed AHP is terminated, membership and privileges are also terminated without benefit of the Fair Hearing Plan/Appellate Review.

2.15 Hearing Procedures

2.15.1 Triggering Events

The following recommendations of the MEC entitle the practitioner to an appeal under timely and proper request, except that if the AHP is employed by the Hospital and terminated, privileges also terminate without benefit of the Fair Hearing Plan/Appellate Review.

2.15.1.1 Denial or restriction of requested clinical privileges,
2.15.1.2 Reduction of clinical privileges,
2.15.1.3 Suspension of clinical privileges,
2.15.1.4 Revocation of clinical privileges.

2.15.2 Request for Hearing

2.15.2.1 **Hearing Request**: The CEO shall, by special notice, notify an affected AHP of the adverse recommendation and that s/he is entitled to a hearing. (If a Jackson Hospital-employed AHP is terminated, privileges are also terminated and the Fair Hearing procedures do not apply.) Within ten (10) calendar days after receipt of such special notice, the AHP must request a hearing. Such request shall be directed to the CEO by special notice. A failure to properly request a hearing shall be deemed an irrevocable waiver of that hearing.

2.15.2.2 **Effect of Waiver**: When the AHP waives a hearing, the unchallenged adverse recommendation of the MEC shall become and remain effective pending a final decision by the Board of Trustees. The CEO shall notify the affected AHP of his/her status by special notice.

2.15.3 Notice of Hearing

2.15.3.1 **Content**: Within fourteen (14) calendar days after receipt of an affected AHP's request for a hearing, the CEO shall notify the AHP, by special notice, of the scheduled date, time and place for such hearing. The notice shall also state in concise language the acts or omissions with which the AHP is charged, a list of charts being questioned, or any other reasons for the adverse recommendation. The notice shall require that the AHP provide to the MEC, at least ten (10) days prior to the hearing, a list of witnesses (if any) expected to testify at the hearing on the AHP's behalf.

2.15.3.2 **Hearing Date**: The hearing date shall not be less than thirty (30) calendar days, nor more than sixty (60) calendar days from the date of receipt of the request for hearing. A hearing may be postponed with the approval of the hearing committee for good cause.

2.15.4 Composition of the Hearing Committee

A Hearing Committee of three (3) persons, which shall consist of Medical Staff members, shall conduct the hearing and one (1) AHP selected by the Chief of Staff. The Committee shall designate a Chair. No Committee member shall have previously participated in the consideration of the adverse recommendation.

2.15.5 Conduct of Hearing

2.15.5.1 **Quorum**: All members of the Hearing Committee shall attend the hearing. The vote of the majority shall constitute the decision of the Hearing Committee.

2.15.5.2 **Role of Chair**: The Chair of the Hearing Committee shall preside over the hearing to determine the order of procedure, to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

2.15.5.3 **Procedure**: The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of affairs shall be considered, regardless of the existence of any common law or statutory rule which might make such evidence inadmissible in a court of law. Prior to or during the hearing, the affected AHP shall be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

2.15.5.4 **Hearing Record**: An accurate record of the hearing shall be kept by use of a court reporter, electronic recording unit, detailed transcription or the taking of minutes as determined by the Chair.

2.15.5.5 **Appearance**: The affected AHP must appear at the hearing. All parties to the proceeding may be accompanied by a member of the Medical Staff or another AHP in good standing, a member of the AHP local professional society, or an attorney. Such attorney or other person shall not make any statements on the record or ask any questions at the hearing but may advise the parties whom they represent. An AHP who fails to appear without good cause irrevocably waives his/her rights to the hearing.

2.15.5.6 **Effect of Waiver**: When an AHP waives a hearing, the unchallenged adverse recommendation of the MEC shall become and remain effective pending a final decision by the Board. The CEO shall promptly notify the affected AHP of his/her status by special notice.

2.15.5.7 **Burden of Proof**: The affected AHP must show that the grounds for the adverse decision lack any factual basis or that such basis or any action based thereon is arbitrary, unreasonable, or capricious.

2.15.5.8 **Hearing Rights**: The affected AHP shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue(s) of the hearing to rebut any evidence. If the AHP does not testify, s/he may be called and examined as if under cross-examination.

2.15.5.9 **Committee Representative**: The MEC shall appoint one of its members to present facts at the hearing in support of its adverse recommendation, and to examine witnesses.

2.15.5.10 **Conclusion**: The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing shall close upon conclusion of the presentation of oral and written evidence. The Hearing Committee may then, at its convenience, conduct its deliberations outside the presence of the affected AHP.

2.15.5.11 **Report**: Within fourteen (14) calendar days after final adjournment of the hearing, the Hearing Committee shall make a written report and shall recommend confirmation, modification, or rejection of the original adverse recommendation of the MEC. The Committee Chair shall forward the same together with the hearing record and all other materials to the MEC.

2.15.5.12 **Post-Hearing Recommendation or Decision**: The MEC shall review the materials and recommend to the Board the granting of certain privileges, which may include a change from Independent to Dependent status, or the denial of privileges. All recommendations must include the specific privileges to be granted and the recommended period, not to exceed two (2) years. The CEO shall notify the AHP of the recommendation by special notice. The MEC Chair shall forward the recommendation and supporting materials to the Board.

2.15.5.13 **Appellate Review and Board's Decision**: A written request for an appeal shall be delivered by the IAHP within 10 days to the MEC after receipt of the final recommendation of the Fair Hearing Panel to the AHP. If no such request is filed, the Board's decision is final. The only grounds for appeal after the hearing shall be:

2.15.5.13.1 Substantial noncompliance with the procedures required by the Medical Staff Documents or applicable law which has created demonstrable prejudice;

2.15.5.13.2 The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to this Section.

The Board of Trustees shall determine the appeal procedure, which may be patterned after the appellate review followed for a Medical Staff member and shall make a decision within 30 days after receiving all necessary information.

2.16 Corrective Action

2.16.1 Criteria for Initiation

(Hospital-employed AHP's shall be processed through the Human Resources Department for corrective action.) Any person may provide information to the appropriate Clinical Service Chief, Medical Staff Officers, Medical Staff or the Hospital officer about the conduct, performance or competence of an AHP. When reliable information indicates an AHP may have exhibited acts, demeanor or conduct, reasonably likely to be:

2.16.1.1 Detrimental to patient safety or to the delivery of patient care within the Hospital;
2.16.1.2 Contrary to the Medical Staff Documents, or to Clinical Service Rules and Regulations;
2.16.1.3 Below applicable professional standards; or
2.16.1.4 Considered aberrant behavior that compromises the quality of patient care provided by the individual or disrupts the ability of others to provide quality patient care, the Chief of Staff, a Clinical Service Chief, or the MEC may initiate a request for an investigation or action against the AHP. A request for an investigation must be in writing, submitted to the MEC and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate record of the reasons.

2.16.2 Investigation

If the MEC concludes an investigation is warranted, it shall direct an investigation be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, a Medical Staff Clinical Service, or standing or ad hoc committee of the Medical Staff. If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable.

The report may include recommendations for appropriate corrective action. The AHP shall be notified promptly that an investigation is being conducted and that s/he shall be given an opportunity to provide information in a manner and upon such terms, as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct an interview with persons involved. Such investigation shall not constitute a "hearing" as that term is used in the Fair Hearing Plan/Appellate Review, nor shall the procedural rules with respect to hearings apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

2.16.3 MEC Action

Within 30 days after the conclusion of the investigation, the MEC shall take action, which may include, without limitation:

2.16.3.1 Determining no corrective action be taken;
2.16.3.2 Deferring action for a reasonable time where circumstances warrant;
2.16.3.3 Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude Service Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected individual may make a written response that shall be placed in the individual's file.
2.16.3.4 Recommending the imposition of terms of probation or special limitation upon continued exercise of clinical privileges, including, without limitation, requirements for consultation or monitoring;
2.16.3.5 Recommending reduction, modification, suspension or revocation of clinical privileges;
2.16.3.6 Recommending limitation of any prerogatives directly related to the individual's delivery of patient care;

2.16.3.7 Taking other actions deemed appropriate under the circumstances.

2.16.4 Board Action

All records are referred to the Board for final approval.

3.0 MEDICAL RESIDENTS

3.1 Definition

The Medical Residents consists of physician residents regularly enrolled in an accredited post-graduate medical education program under the supervision of Medical Staff Members. Visiting Medical Residents consist of Physician Residents enrolled in another hospital's accredited post-graduate training program and will be accepted for rotations with an affiliation agreement. Residents are not Members of the Medical Staff and as such, are not entitled to the procedural rights outlined in the Fair Hearing Policy.

3.2 Qualifications

Medical Residents shall have either an Educational Limited License or Permanent License. The selection and enrollment of Henry Ford Jackson Hospital Residents shall be made annually by procedures determined and implemented by the Graduate Medical Education Department and the Residency Program(s) of the hospital.

3.3 Prerogatives

Medical Residents are not Members of the Hospital Medical Staff and shall not be granted specific Privileges. They shall, when requested serve on committees. Medical Residents are not entitled to any procedural rights set out in the Fair Hearing Policy. After successful completion of PGY 2 residency training, a graduate may apply for Medical Staff Membership if they have been selected to function as a moonlighting physician.

3.4 Responsibilities

Medical Residents shall carry out in a professional manner only those duties and responsibilities assigned by their GME program, Clinical Service, and supervising physician(s).

3.5 Supervision

During their training, Medical Residents are under the supervision of the Medical Staff member who is also participating in the Graduate Medical Education program. The supervising physician shall sign the resident's documentation. The attending physician shall enter a separate daily progress note and validate the resident's note by countersigning.

Attending/supervising medical staff members may change a statement made in the record by the Medical Resident and shall initial and date the change.

The attending/supervising medical staff members are responsible for all incomplete and or delinquent records assigned to the Medical Resident.

The attending/supervising medical staff member is required to provide a written formal evaluation of the medical resident who is assigned to them for a rotation.

3.6 Clinical Prerogatives

Clinical prerogatives and physician supervision requirements are defined in the Policy Manual for Graduate Medical Education Programs. The Regional Graduate Medical Education Committee shall approve any revisions to the Manual.

4.0 MEDICAL STUDENTS.

4.1 Definition

Medical Students are from accredited schools of medicine and osteopathy and are completing undergraduate medical education programs on third- or fourth-year clinical rotations.

4.2 Qualifications

Medical Students will be accepted from accredited schools that have signed an affiliation agreement or have a signed letter of agreement for a specific rotation. The Graduate Medical Education Department will manage the agreements and rotations.

4.3 Prerogatives

The prerogatives of a Medical Student shall be to provide specified patient care services under the supervision of Medical Staff physician or Medical Resident.

4.4 Responsibilities

Medical Students shall be:

4.4.1 Medical Students shall carry out in a professional manner only those duties and responsibilities assigned by their supervising physician(s).

4.5 Medical Student Supervision

Any contribution and participation of medical students to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirement set forth in the Tier 1 Medical Students Use of EMR (MEP 120) Policy. Also refer to the Tier 1 policy regarding sub-internship and approved Year 4 elective students.

5.0 REVIEW, REVISION, ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

Refer to Section 11.0 of the Core Bylaws.

ADOPTED by the Medical Staff on

March 16, 2023
Date

Samir Parikh, MD
Chief of Staff

Nicholas Dyc, MD
Secretary/Treasurer/Communications Officer

APPROVED by the Board of Trustees on

May 17, 2023
Date

Martha Fuerstenau
Chairman

Aaron Boatin
Secretary

Emily Moorhead
President of the Hospital

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Medical Staff Bylaws:
Organization and Functions Manual

Henry Ford Jackson Hospital

Revised June 2022

TABLES OF CONTENTS

1.0 DUTIES OF OFFICERS OF THE MEDICAL STAFF

(See Core Bylaws for Identification, Qualifications, Elections.)

1.1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. S/he shall be bonded. The duties of the Chief of Staff shall include, but not be limited to:

1.1.1 Enforcing the Medical Staff Documents, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated.
1.1.2 Calling, presiding at and being responsible for the agenda of all meetings of the Medical Staff.
1.1.3 Serving as Chair of the MEC, with vote.
1.1.4 Serving as a member of the Joint Conference Committee.
1.1.5 Serving as an ex officio member of all other Medical Staff committees. As an ex officio member of such committees, the Chief of Staff will have no vote, unless his/her membership in a particular committee is required by the Medical Staff Documents.
1.1.6 Interacting with the Medical Staff, CEO and Board of Trustees in all matters of mutual concern within the Hospital. The Chief of Staff shall be a voting member of the Board of Trustees.
1.1.7 Appointing, in consultation with the MEC, committee members for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by the Medical Staff Documents, and designating the chairs of these committees except where otherwise indicated.
1.1.8 Representing the views and policies of the Medical Staff to the Board of Trustees and to the CEO.
1.1.9 Being a spokesperson for the Medical Staff in external professional and public relations.
1.1.10 Performing such other functions as may be assigned to him/her by the Medical Staff Documents, by the Medical Staff or by the MEC.
1.1.11 Serving on liaison committees with the Board and Administration, as well as outside licensing or accreditation agencies.

1.2 Chief of Staff-Elect

The Chief of Staff-Elect shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. S/he shall be bonded. The Chief of Staff-Elect shall be a member of the MEC, the Quality Management Committee, the Credentials Committee and the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by the Medical Staff Documents or by the MEC. S/he shall serve as an ex-officio member of the Board of Trustees of the Hospital.

1.3 Immediate Past Chief of Staff

The immediate past Chief of Staff shall be a member of the Credentials Committee, shall chair the Bylaws Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by the Medical Staff Documents, or by the MEC. In the absence of the Chief of Staff, the Chief of Staff-Elect, and the Secretary/Treasurer/Communications Officer, the immediate past Chief of Staff may assume the duties and authority of the Chief of Staff.

1.4 Secretary/Treasurer/Communications Officer

The Secretary/Treasurer/Communications Officer shall assume the duties of the Chief of Staff in the absence of the Chief of Staff and the Chief of Staff-Elect. The Secretary/Treasurer/ Communications Officer shall be a member of the MEC and the Joint Conference Committee. S/he shall be bonded. The duties shall include, but not be limited to:

1.4.1 Collaborating with the Medical Staff Affairs Office to maintain appropriate Medical Staff records including:
1.4.1.1 Maintaining a roster of members.
1.4.1.2 Assuring accurate and complete minutes of all MEC and Medical Staff meetings.
1.4.1.3 Calling meetings on the order of the Chief of Staff or MEC.
1.4.1.4 Attending to all appropriate correspondence and notices on behalf of the Medical Staff.
1.4.2 Receiving and safeguarding all funds of the Medical Staff.
1.4.3 Rendering an annual financial report for presentation at the annual General Staff meeting. Providing for an annual audit of the books with an audit report submitted to the Medical Staff.
1.4.4 Keeping the Medical Staff updated throughout the year on topics of importance through appropriate media. It is expected that this would include, but not be limited to:
1.4.4.1 Publishing a periodic newsletter.
1.4.4.2 Sending e-mail/urgent faxes on current issues.
1.4.4.3 Sending out questionnaires to solicit Medical Staff opinions, when appropriate.
1.4.5 Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or MEC.

2.0 CLINICAL SERVICES, DUTIES OF THE CLINICAL SERVICE CHIEF, VICE-CHIEF

(See Core Bylaws for Organization, Functions, and Elections.)

2.1 Clinical Services

The current Clinical Services organized by the Medical Staff and formally recognized by the MEC include: Anesthesiology, Cardiology, Emergency Medicine, Family Practice, Imaging Services, Internal Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry, and Surgery.

2.2 Duties of the Clinical Service Chief

Each Chief shall have the following authority, duties and responsibilities, and the Vice-Chief (if elected within the Service), in the absence of the Chief, shall assume all of them and shall otherwise perform such duties as may be assigned to him/her:
2.2.1 Act as presiding officer at Clinical Service meetings.
2.2.2 Report to the MEC and the Chief of Staff regarding all professional, clinical and administrative activities within the Service.
2.2.3 Generally monitor the quality of patient care and professional performance rendered by members, allied health practitioners with clinical or medical training privileges, or contract services in the Service through a planned and systematic process and oversee the effective conduct of evaluation and monitoring functions delegated to the Service by the MEC and/or the Quality Management Committee.

2.2.4 Assist in assessment and improvement of the quality of care and services by ongoing monitoring of practice, retrospective patient care review, credentials review and privileges delineation, medical education, and utilization review, as requested by the appropriate committees.
2.2.5 Be a member of the MEC and give guidance on the overall medical policies of the Medical Staff and the Hospital and make specific recommendations and suggestions regarding the Service.
2.2.6 Assist, when asked, the MEC and the Credentials Committee with input concerning appointment and reappointment, criteria for clinical or medical training privileges, monitoring of specified services, and corrective action with respect to all persons with clinical privileges in his/her Service.
2.2.7 Enforce the Medical Staff Documents, as well as policies and regulations within his/her Service.
2.2.8 Implement within the Service the appropriate actions taken by the MEC.
2.2.9 Participate in every phase of administration of the Service, including cooperation with the nursing service and the Hospital Administration in matters such as personnel (including assisting in determining the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques.
2.2.10 Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Service as may be required by the MEC.
2.2.11 Assist the Credentials Committee as needed in its recommendation of delineated clinical or medical training privileges for Allied Health Practitioners within the Service.
2.2.12 Assist in the gathering, assessment and acting on information regarding patient and family satisfaction with the services provided, in cooperation with the management and staff.
2.2.13 Recommend to the MEC staffing levels, space and other resources needed by the Service.
2.2.14 Assess, approve, and recommend to the MEC off-site sources for needed patient care services not provided by the Service or the Hospital.
2.2.15 If there are no adequate hospital quality data for an individual physician, the following applies:
2.2.15.1 Participating (if applicable) in a peer review process that allows the delegation of the credentialing process to a Board-approved outside hospital in which the member practices if such arrangements can be made; and/or
2.2.15.2 Reviewing insurance company records on retrospective patient care reviews; and/or
2.2.15.3 Reviewing of office consultations which were the result of an inpatient referral or referral from the Emergency Service or other ancillary services.

2.3 Duties of the Vice-Chief

If a Vice-Chief is elected within the Service, s/he shall assume all duties and authority of the Chief in the absence of the Chief. S/he shall perform such other duties as the Chief may assign or as may be delegated by the Medical Staff Documents or by the MEC.

3.0 COMMITTEES

All standing and special committees as established by the MEC are described here. Medical Staff members of committees shall be appointed by the Chair of the committee, the Chief of Staff, the appropriate Clinical Service Chief and/or the MEC. All Medical Staff committees and Medical Staff representatives shall be responsible to the MEC.

3.1 General Provisions

3.1.1 Term of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of two years, and shall serve until the end of this period or until the member's successor is appointed, unless the member resigns or is removed from the committee.

3.1.2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the MEC.

3.1.3 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of the Bylaws is removed for cause, a successor shall be selected by the MEC.

3.1.4 Records and Reports

All committees in the Medical Staff Documents shall maintain a record of their proceedings and actions if attendance at the meeting was requested by the Chair. All committees, other than the MEC, shall report to the MEC.

3.1.5 Peer Review

Under the Medical Staff Documents, all committees formed by the Board, Medical Staff, or Clinical Service which are involved in professional review activity are protected by all applicable provisions of state and federal law, enacted or amended, relating to the confidentiality of peer and professional review functions and activities.

3.1.6 Committee Service by a Former Chief of Staff

Whenever the Medical Staff Documents require a former Chief of Staff to serve on a committee, s/he may do so without regard to current Staff category, shall have voting rights, and shall count toward a quorum.

3.1.7 Executive Session

Any Committee Chair may excuse all nonvoting members in order to have an executive session.

3.1.8 Subcommittees

It is the prerogative of the Chair to designate standing or special subcommittees to handle aspects of the committee's duties.

3.1.9 Delegated Functions of the MEC

Provision shall be made through assignment to Clinical Services, Service leaders, a Medical Staff Representative, Physician Advisor, Medical Staff or the Hospital Committees, for the effective performance of Medical Staff functions specified in this section, and of such other Staff functions reasonably delegated by the MEC.

These functions shall include but are not limited to:

3.1.9.1 Coordinating and reviewing quality improvement and monitoring activities of the Medical Staff. This includes a properly designed peer review process, as described in the Medical Staff Documents.
3.1.9.2 Coordinating and reviewing utilization review activities;
3.1.9.3 Coordinating and reviewing credentials investigations and recommendations for Staff membership and granting of clinical privileges;
3.1.9.4 Monitoring and evaluating care provided in, and developing clinical policy for, critical care units; patient care support services; emergency, outpatient, home care and other ambulatory care services;
3.1.9.5 Providing continuing education to match Medical Staff needs and supervising the Hospital's professional library services;
3.1.9.6 Requiring that patient medical records are complete, timely and clinically pertinent;
3.1.9.7 Developing and maintaining surveillance over drug utilization policies and practices;
3.1.9.8 Directing Staff organizational activities including Medical Staff Documents review and revision, Staff officer and committee nominations, liaison with the Board and Hospital Administration and review and maintenance of accreditation;
3.1.9.9 Investigating and monitoring infection surveillance, control, and prevention;
3.1.9.10 Promoting professional conduct and competent clinical performance on the part of all members.

3.1.10 Reporting of Delegated Functions of the MEC

Where the MEC has assigned performance of a Medical Staff function to a Clinical Service, Service leader, Medical Staff Representative, Physician Advisor, Staff committee or Hospital committee, the Service/Committee/ Medical Staff Representative has the responsibility to report to the MEC its activities on a schedule and in a manner determined by the MEC. Further, the Service/Committee/Staff Representative shall obtain approval of the MEC for any recommended policies or procedures that impact the Medical Staff. The MEC acts on all reports and recommendations.

3.1.11 Annual Self-Evaluation of Performance by Certain Committees
The Quality Management Committee, the Credentials Committee, and such other Medical Staff Committees designated from time to time by the MEC, shall perform an annual self-evaluation of its performance, accomplishments, and opportunities for improvement (including identification of obstacles and barriers to improvement), and shall report the results of the evaluation along with recommendations for improvement to the MEC. The self-evaluation process shall be proscribed in a policy* approved by MEC.

3.2 Bylaws Committee

3.2.1 Composition

The Bylaws Committee shall consist of the immediate past Chief of Staff who shall be the Chair, and the three (3) previous Chiefs of Staff. If a previous Chief of Staff is not available to serve on this committee, the current Chief of Staff may appoint an experienced Medical Staff member. All shall be voting members. Vacancies created by the departure of any of the former Chiefs of Staff shall be filled, whenever possible, by a previous Chief of Staff. The non-voting members shall consist of the Vice President for Medical Affairs, the Hospital Counsel, and the APP Director.

3.2.2 Duties

The duties of this Committee shall include:

3.2.2.1 Conducting a review every two (2) years of the Medical Staff Documents, as well as the policies, and forms promulgated in connection therewith;
3.2.2.2 Recommending to the MEC changes in these documents as necessary to reflect current Medical Staff practices and changes in legal, statutory, or regulatory requirements;
3.2.2.3 Receiving and evaluating for recommendation to the MEC suggestions for modification of the items specified in (1) above;
3.2.2.4 Presenting final MEC recommendations to the Medical Staff; and
3.2.2.5 Maintaining records/minutes and reporting to the MEC as scheduled.

3.2.3 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair.

3.3 Cancer Committee

3.3.1 Composition

The Chief of Staff shall appoint the Cancer Committee Chairperson. The Committee will consist of at least a physician representative from Medical Oncology, Surgery, Radiation Oncology, Diagnostic Radiology, and Pathology. The Cancer Committee Chair may be appointed to the position of Medical Director of the Cancer Center upon concurrence of Hospital administration. If the Medical Director of the Center is a physician other than the Cancer Committee Chairperson, the appointment shall be by mutual agreement of the Chief of Staff and Hospital administration. The Cancer Committee Chair is a two-year appointment. The Cancer Committee Chair, or, if delegated to the Chiefs of the respective Clinical Services, shall appoint other Committee members, who shall be voting members. Other non-voting members will include the cancer registrar, oncology nurse, social worker, quality management, and hospital administration representatives.

3.3.2 Duties

The duties of this Committee shall include:

3.3.2.1 Developing and evaluating the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer;
3.3.2.2 Promoting a coordinated, multidisciplinary approach to patient management;
3.3.2.3 Ensuring that educational and consultative cancer conferences cover all major sites and related issues;
3.3.2.4 Ensuring that an active supportive care system is in place for patients, families, and staff;
3.3.2.5 Monitoring quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;
3.3.2.6 Promoting clinical research;
3.3.2.7 Supervising the cancer registry and ensuring accurate and timely abstracting, staging, and follow-up reporting;
3.3.2.8 Performing quality control of registry data;
3.3.2.9 Encouraging data usage and regular reporting;
3.3.2.10 Ensuring that content of annual report meets requirements;
3.3.2.11 Publishing the annual report by December 31 of the following year;

3.3.2.12 Referring possible medical ethical issues to the Quality Management Committee;
3.3.2.13 Monitor effectiveness of community outreach activities, prevention and screening programs;
3.3.2.14 Monitor and evaluate full continuum of care and access to patient centered programs and services; and
3.3.2.15 Evaluate that patient outcomes of evaluation and treatment, quality improvements, performance and accountability measures are met and compliant with evidence-based guidelines.

3.3.3 Meetings/Reporting Relationship

The Cancer Committee shall meet at least quarterly and maintain minutes. The Committee shall report to the Quality Management Committee.

3.4 Credentials Committee

3.4.1 Composition

The members of this Committee of the Medical Staff shall consist of the Chief of Staff, Chief of Staff-Elect, the three (3) past Chiefs, and an at-large member recommended by the Chief of Staff and appointed by the MEC, and the Chief Nursing Officer or designee. The Chair of the Credentials Committee shall be the current Chief of Staff-Elect. When an application or matter regarding a physician is considered, the Chief of that Service may be invited to participate in the discussion and is expected to come to the meeting upon request. Vacancies created by the departure of any of the former Chiefs of Staff shall be filled, whenever possible, by a previous Chief of Staff. If this is not possible, the Chief of Staff shall appoint an experienced, active Medical Staff member. Non-voting members shall include the Vice President for Medical Affairs and a representative from Hospital Administration. (See also Credentials Procedure 1.0.)

3.4.2 Duties

The duties of this Committee shall include:

3.4.2.1 Reviewing and evaluating the qualifications of each individual applying for initial appointment or reappointment as Medical Staff members or initial granting, renewal or modification of clinical privileges for Staff members or Allied Health Professionals, and, in connection therewith, obtaining and considering the input of the appropriate Clinical Service Chief if indicated;
3.4.2.2 Reviewing and recommending action on all applications and reapplications for membership and status on the Medical Staff;
3.4.2.3 Submitting required reports to the MEC on the qualifications of each individual applying for membership or particular clinical privileges for Medical Staff members or Allied Health Professionals, including recommendations with respect to appointment, membership category, Clinical Service affiliation, clinical privileges and special conditions;
3.4.2.4 Investigating, reviewing and reporting on matters referred by the Chief of Staff or the MEC concerning the qualifications, conduct, professional character or competence of any applicant or Medical Staff member;
3.4.2.5 Maintaining records/minutes and reporting as scheduled to the MEC on its activities and the status of pending applications and
3.4.2.6 Performing such other functions as requested by the MEC.

3.4.3 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair, but not less than quarterly.

3.4.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the Credentials 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.

3.5 Institutional Review Board (IRB)

3.5.1 Composition

This Committee is composed of a minimum of eight (8) members with the Chair and Vice Chair of the Committee to be appointed by the Chief of Staff. At least three (3) members must be members of the Medical Staff appointed by the Chief of Staff. The composition shall also include a representative from the Hospital Administration, Nursing, Risk Management, and two community volunteers. Refer to the IRB's Manual of Standard Operating Procedures currently in effect for further details. This Manual is located in the Medical Staff Affairs Office.

3.5.2 Duties

The duties of this Committee include:

3.5.2.1 Reviewing, approving, and monitoring investigational studies and informed consents in accordance with Federal Food and Drug Administration guidelines;
3.5.2.2 Reviewing, approving, and monitoring the methods by which patient rights, responsibilities, and education are protected;
3.5.2.3 Maintaining records/minutes and reporting to the MEC as scheduled; and
3.5.2.4 Protecting the interest of the human subjects in research for which this Committee is responsible for overseeing.

3.5.3 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair, but not less than quarterly.

3.6 Nominating Committee

3.6.1 Composition

The Nominating Committee shall consist of the Chief of Staff, the Vice Chief of Staff and the immediate past Chief of Staff and the two (2) at-large members of the MEC. The Vice President for Medical Affairs shall also be a member of the Nominating Committee, but shall have no voting rights.

3.6.2 Duties and Functions

The duties involved in presenting to the Medical Staff qualified candidates for elective positions in the Medical Staff organization are to:

3.6.2.1 Consult with members of the Medical Staff and Administration concerning the qualifications and acceptability of prospective nominees.
3.6.2.2 Submit, at the appropriate times as provided in the Medical Staff Documents, one or more nominations for:
3.6.2.2.1 Each elective office of the Medical Staff to be filled, and
3.6.2.2.2 Such other elective positions or vacancies in any office or position as may be required by the Medical Staff Documents.

3.6.3 Meetings

The Nominating Committee shall meet as required to complete its functions and maintain minutes of its proceedings and actions. It shall report as requested to the MEC on its activities and the status of pending nominations.

3.6.4 Leadership Selection Criteria

3.6.4.1 Leadership criteria for Chief of Staff, Vice-Chief of Staff, Secretary/Treasurer/Communications, and Physician Board/Committee Member.

1. Active staff member in good standing for four (4) years.
2. 2 years' experience in a medical staff leadership position or equivalent.
3. Have received training in medical administrative activities and medical staff leadership or demonstrates willingness to attend training five days per year.
4. Demonstrated support of fulfilling the mission of the hospital and the medical staff.
5. During term of office agrees not to be a Medical Staff or Board leader (including Chief of Staff, Vice-Chief of Staff, Treasurer, Board or Board committee member, or Medical Executive Committee member) at any other health care system, and fully discloses any interest in a competing health entity prior to appointment.
6. Discloses all conflicts of interest as required by Board policy.
7. Recognizes and agrees to the commitment of time to perform Medical Staff duties and assumes responsibility for participation in ongoing education.
8. Demonstrated ability to work positively and communicate well with Medical Staff members, Administration and Board.
9. Recognizes responsibility and their role for communication with Medical Staff, Administration, and Board members

3.7 Surgical Service Committee

3.7.1 Composition

The Surgical Services Committee shall consist of the Chief and Vice Chief of Surgery, the Chief of Anesthesiology, either the Director of Anesthesia for Ambulatory Surgery or the Vice Chief of Anesthesiology, the Medical Director of Surgery, the Peri-Operative Medical Director, three (3) at-large representatives from the Surgery Clinical Service (appointed by the Chief of Staff), an at-large representative from the Obstetrics/Gynecology Clinical Service (appointed by the Chief of Staff), an at-large representative from the group of actively practicing Gastroenterologists (appointed by the Chief of Staff).

The Medical Director of Surgery will serve as Committee Chair. Additional voting members shall include the Vice President responsible for Surgical Services and the Director of Surgical Services.

Ex-officio members will serve for the duration of their service in their respective positions; at-large representatives may serve three (3) consecutive two-year terms. At-large representatives will be appointed such that their terms overlap.

3.7.2 Duties and Functions

3.7.2.1 Develop and evaluate policies and procedures implicating clinical issues in the Operating Room, subject to review and approval by the MEC.
3.7.2.2 Monitor and make recommendations to the MEC to improve the efficiency of the Operating Room.
3.7.2.3 Review reports of surgical activity and utilization and make recommendations to the MEC as requested.
3.7.2.4 Provide feedback to MEC upon request on operational and management issues.
3.7.2.5 Monitor the block scheduling system and related policies and procedures and provide periodic reports to MEC.
3.7.2.6 Monitor and evaluate safety issues relative to the Operating Room and provide periodic reports to MEC.

3.7.3 Meetings

The Committee shall meet at least quarterly and make recommendations to the MEC as appropriate. A record of the Committee's proceeding shall be maintained and reports made to the MEC, the Surgery, Obstetrics/Gynecology, and Anesthesiology Clinical Services and the Health System CEO.

3.8 Pharmacy and Therapeutics Committee

3.8.1 Composition

This Committee shall consist of at least three (3) members of the Medical Staff, two of whom shall be the Medical Director of Infectious Disease and the Physician Advisor for Tissue and Transfusion. The members and the Chair shall be appointed by the Chief of Staff. In addition, there shall be a non-voting representative from the Pharmacy Department, a non-voting representative from Nursing and a non-voting representative from Hospital Administration.

3.8.2 Duties

The duties of this Committee shall include:

3.8.2.1 Assisting in the formulation of professional practices and policies concerning the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital, including antibiotic usage;
3.8.2.2 Advising the Medical Staff and the Pharmacy on matters pertaining to the choice of available drugs;
3.8.2.3 Making recommendations concerning drugs to be stocked on nursing unit floors and by other services;
3.8.2.4 Periodically developing and reviewing a formulary or drug list for use in the Hospital;
3.8.2.5 Addressing prescribing or ordering and procuring medications not available in the Hospital;
3.8.2.6 Evaluating clinical data concerning new drugs or preparations requested for use in the Hospital;

3.8.2.7 Establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
3.8.2.8 Reviewing untoward drug reactions; and
3.8.2.9 Maintaining records/minutes and reporting to the MEC as scheduled.

3.8.3 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair, but not less than quarterly.

3.9 Quality Management Committee

3.9.1 Composition

The Quality Management Committee (QMC) is comprised of nineteen (19) members, consisting of twelve (12) voting members and seven (7) non-voting members.

3.9.1.1 Voting Members

The twelve (12) voting members shall consist of Medical Staff members providing a balanced representation of the main specialties areas of the Hospital. The members should consist of the Chief of Staff–Elect, one (1) experienced member each from Surgery (consisting of Surgery and Obstetrics/Gynecology Clinical Services), Medicine (consisting of Internal Medicine, Family Practice and Pediatrics Clinical Services), an adult Hospitalist, an Interventional Cardiologist or Cardiovascular Surgeon, six (6) additional experienced, active Medical Staff members, and the APP Director. Voting members are appointed by the Chief of Staff and approved by the MEC, based on the recommendations from the Committee Chair, and shall serve for a three year term with automatic renewals.

3.9.1.2 Non-voting Members

Non–voting members shall consist of the Chief of Staff, the Medical Director responsible for quality and patient safety, and the Hospital's lead executive or leader in the areas of medical affairs, nursing, compliance, legal affairs, and quality improvement. Non-voting members may serve on QMC as long as they hold that title.

3.9.1.3 Chair of QMC

The Chair of QMC will be appointed by the Chief of Staff from the voting members and shall be approved by the MEC. To be eligible for appointment as Chair, the member must have served on the Committee at some point in time for at least one year.

3.9.2 Purposes

The Quality Management Committee is recognized within the Hospital as the entity with the overall responsibility for performance-improvement activities designed to improve clinical and non-clinical processes that require Medical Staff leadership and participation. This Committee reviews and suggests modifications of activities of the System's Steering Committee for performance improvement.

3.9.3 Duties

The duties of this Committee shall include but are not limited to the following:

3.9.3.1 Recommending for approval of the MEC plans for maintaining and improving quality patient care within the Hospital. These plans include mechanisms to:

3.9.3.1.1 Establish systems to identify potential problems in patient care;
3.9.3.1.2 Set priorities for action on problem correction;
3.9.3.1.3 Refer priority problems for assessment and corrective action to appropriate Clinical Services or Committees;
3.9.3.1.4 Review reports of the results of quality assessment and improvement activities throughout the Hospital to determine whether there are opportunities for improvement of patient care; and
3.9.3.1.5 Individual peer review issues identified by the Committee may be reviewed by the Committee and referred to the MEC as appropriate. The MEC and/or the Chief of Staff may, at their discretion, refer individual peer review issues to the Committee for its review and recommendation.

3.9.3.2 The Committee shall maintain records/minutes and submit timely confidential reports to the MEC on the quality of medical care provided and on quality assessment and improvement activities conducted. The QMC shall submit summary reports to the MEC on a routine basis.
3.9.3.3 Designate at least one member of the Quality Management Committee to serve on the multidisciplinary Quality Committee of the Hospital.

3.9.4 Meetings

This Committee shall meet as frequently as needed in the judgment of the Chair, but not less than quarterly.

3.10 Other Medical Staff Committees/Medical Directors/Physician Advisors

3.10.1 Committees/Physician Advisors

Other Medical Staff committees/Physician Advisors may be appointed by the Chief of Staff/MEC from time to time as may be required to carry out the duties of the Staff. Such committees/Physician Advisors shall confine their activities to the scope of their assigned purpose and report findings and recommendations according to the directions given to them by the MEC. Individuals involved must be members in good standing of the Medical Staff during the tenure of their service.

Physician Advisors will be appointed by the Chief of Staff with approval by the MEC, for the following Committees: Advanced Cardiac Life Support, Medical Records, Continuing Medical Education, Infection Control, Tissue and Transfusion, Critical Care. Other Physician Advisors may be appointed as deemed necessary by the Chief of Staff with approval of the MEC.

3.10.2 Physician Advisors

3.10.2.1 Each Physician Advisor shall be a member of the active Medical Staff and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Advisor.
3.10.2.2 Each Advisor shall serve a two-year term unless s/he resigns, is removed from office by the MEC, or loses Medical Staff membership or clinical privileges in the area under direction. Physician Advisors shall be eligible to succeed themselves.
3.10.2.3 A list of the duties and scope of practice of each Physician Advisor, approved by the Medical Staff, shall reside in the Medical Staff Affairs Office.

Physician Advisors shall report at least quarterly at the General Staff meetings and on an "as-needed" basis to the MEC and, when necessary, to the Quality Management Committee.

3.10.3 Medical Directors

After consultation with the MEC, the CEO may appoint by contract a Medical Director to carry out the medico-administrative functions in the Hospital which may include, but not be limited to, such areas as the Intensive Care Unit, Infectious Diseases, Cardiology, Diabetic Clinic, etc. Such Directors shall confine their activities to the scope of their assignments and report findings and recommendations according to a schedule given to them by the MEC. Individuals must be members in good standing of the Medical Staff during their tenure. A scope of duties of each Medical Director can be found in Administration.

3.11 Committee Meetings and Quorum

Unless otherwise specified in the Medical Staff Documents, the number of Medical Staff members present [but not less than two (2) members] at a committee meeting after sufficient prior notice to all members shall be declared sufficient for the conduct of business.

4.0 CONFIDENTIALITY, IMMUNITY, AND RELEASES

4.1 Special Definitions

4.1.1 Information

The term "information" means all acts, communications, records of proceedings, reports, memoranda, recommendations, and other disclosures, whether in written or oral form, relating to professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, or professional ethics, or any other matter that might directly or indirectly affect patient care.

4.1.2 Representative

The term "representative" means the Hospital and its members, directors, officers, employees and other administrators, or any of them, the Medical Staff, each and every practitioner and Allied Health Professional with privileges and/or Medical Staff membership, any member, employee, designee, agent, committee, board or other entity of any of the foregoing, and any individual or entity authorized by any of the foregoing to perform information gathering or disseminating functions.

4.1.3 Third Parties

The term "third parties" means individuals and organizations who possess information, including but not limited to, a hospital or other health care institution and their respective members, directors, officers and other administrators or any of them, a practitioner, Allied Health Professional or other health professional, a medical staff, an organization of practitioners, allied health professionals of other health professionals, a PRO, a state or local board of medical or professional quality management, a state licensing board, any member, employee, designee, agent, committee, board or other such entity of any of the foregoing, and any individual authorized by any of the foregoing to perform information gathering or disseminating functions.

4.2 Authorization and Conditions

By applying for or exercising clinical privileges within the Hospital, an applicant:

4.2.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
4.2.2 Authorizes third parties and their representatives to provide information, including otherwise privileged or confidential information, concerning such practitioner or Allied Health Professional to the Hospital and its Medical Staff;
4.2.3 Agrees to be bound by the provisions of this Section and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under the Immunity from Liability Section of this Manual; and
4.2.4 Acknowledges that the provisions of this Section are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges within the Hospital.

4.3 Confidentiality of Information

4.3.1 General

Records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered within the Hospital, including, but not limited to, meetings of the Medical Staff, meeting as a committee of the whole, meetings of Clinical Services, meetings of committees established in the Medical Staff Documents, and meetings of special or ad hoc committees created by the MEC or by Clinical Services and including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential.

4.3.2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff Clinical Services, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Documents, and will be deemed disruptive to the operations within the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

4.4 Immunity from Liability

4.4.1 For Action Taken

Each representative of the Medical Staff and the Hospital shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or the Hospital.

4.4.2 For Providing Information

Each representative of the Medical Staff and the Hospital and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or the Hospital, or providing information to representatives of another health care organization, concerning such person who is, or has been, an applicant to or member of the Staff or who did, or does, exercise clinical privileges or provide services within the Hospital.

4.5 Activities and Information Covered

The confidentiality and immunity provided by these Sections shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

4.5.1 Application for appointment, reappointment, or clinical privileges;
4.5.2 Corrective action;
4.5.3 Hearings and appellate reviews;
4.5.4 Utilization reviews;
4.5.5 Other Clinical Service, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
4.5.6 Queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of Michigan, and similar queries and reports.

4.6 Releases

Each applicant or member shall, upon request of the Medical Staff or the Hospital, execute general and specific releases in accordance with the express provisions and general intent of these Sections. Execution of such releases shall not be deemed a prerequisite to the effectiveness of these Sections.

4.7 Indemnification

The Hospital shall indemnify, defend and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act of failure to act within the scope of peer and professional review functions or quality assessment activities, provided that such acts or omissions:

4.7.1 Were in good faith and without malice, and would entitle the member to immunity from liability under the Michigan Public Health Code; and
4.7.2 Did not arise out of discussions and/or decisions made during that portion of a meeting in which all representatives of Administration were excused or in which at least one member of Administration was not present; and
4.7.3 Arose out of the member's affirmative attempt to perform of his/her duties and obligations as a member of the Medical Staff and/or as a member of or participant in a committee or entity assigned a peer and professional review function under the Medical Staff Documents.

The Medical Staff or member may seek indemnification for such losses and expenses under the Medical Staff Documents provision, statutory and case law, any available liability insurance or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the Hospital's indemnification obligations hereunder. Jackson Hospital shall have no indemnification obligation as to acts or omissions that are not immune from liability under the Michigan Public Health Code.

5.0 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff or the Hospital without proper authority shall be subject to such disciplinary action as the MEC may deem appropriate.

6.0 REVIEW, REVISION, ADOPTION AND AMENDMENT OF ORGANIZATION AND FUNCTIONS MANUAL

Refer to Section 11.0 of the Core Bylaws.

ADOPTED by the Medical Staff on

June 16, 2022
Date

Rami Alzebdeh, MD
Chief of Staff

Imran Tarrar, MD
Secretary/Treasurer/Communications Officer

APPROVED by the Board of Trustees on

July 20, 2022
Date

Martha Fuerstenau
Chair

Aaron Boatin
Secretary

Emily Moorhead
President of the Hospital

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