PROFESSIONAL STAFF BYLAWS

Adopted February 1976
(Last Revised: July 22, 2009, September 23, 2009, December 16, 2009, January 27, 2010, May 26, 2010, December 20, 2010, May 16, 2012, July 25, 2012, December 11, 2013, February 25, 2015, September 30, 2015, May 25, 2016)

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF BYLAWS

It is recognized that the Professional Staff of Hurley Medical Center, appointed by the Board of Hospital Managers, is responsible for the quality of medical care provided to its patients, and must accept and assume the responsibility to see that the best interests of the patient are protected by concerted effort.

ARTICLE I – NAME

The name of this organization shall be the Professional Staff of Hurley Medical Center.

ARTICLE II – MEMBERSHIP

Membership on the Professional Staff of Hurley Medical Center is a privilege, which shall be extended only to competent physicians, dentists, psychologists, podiatrists, nurse midwives, certified registered nurse anesthetists (CRNA), advanced practice nurses (APN or NP), and physician assistants (PA) who continuously meet the qualifications, standards and requirements as stated herein. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges. Practitioners applying for privileges under the Moonlighting Category described in Article III, Section 7 shall not be granted membership in the Professional Staff of Hurley Medical Center and shall not be granted the same rights or given the same responsibilities as those who are granted membership in the Professional Staff.

Section 1 - Qualifications for Membership

A. The general qualifications for membership on the Professional Staff of Hurley Medical Center or for appointment to the Moonlighting Category shall be that the applicant is fully licensed without restrictions (or holds a Clinical Academic Limited license pursuant to the public health code and receives appropriate supervision in accordance with the public health code) to practice medicine, dentistry, podiatry, psychology, limited license psychologist (LLP)*, master's level therapy/counseling*, certified advanced practice nursing (CRNA, APN, NP, Nurse Mid-Wife), or as a physician assistant (PA) in the State of Michigan (CRNA, APN, NP, Nurse Mid-Wife, PA, Dentist, Podiatrist, Psychologist will sometimes be referred to as "practitioners") [*these individuals are pursuant to a specified contract with Hurley Mental Health Associates].

B. Except for individuals applying for appointment to the Moonlighting Category, all new applicants must be Board Certified within their specialty, or Board Eligible within the timeframe prescribed by their Specialty Board for obtaining/maintaining certification, and that Board Certification must be maintained for the duration of their Professional Staff membership. Board certification is by an American Board of Medical Specialties (ABMS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), American Board of General Dentistry or Pediatric Dentistry, American Board of Professional Psychology, American Board of Nurses Credentialing Center, National Coalition of Certification of Physician

Assistants (NCCPA)or in lieu of an American Board, a physician may be certified by the Royal College of Physicians & Surgeons of Canada (RCPSC). Board certification requirements are waived for those applicants that hold a Clinical Academic Limited License.

Requesting a Waiver/Exception:

Any request for a Waiver/Exception to the Board Certification requirement must meet the requirements as set forth below. An individual applicant may not request a waiver/exception of these requirements. Any current Professional Staff Medical Staff Member or HMC Vice President may request a waiver/exception. The requestor bears the burden of demonstrating exceptional and unusual circumstances. The request must, at a minimum, satisfy the following:

1. Demonstrated community need for a particular specialty.

2. Demonstrated difficulty in recruiting a particular specialty.

3. Narrowly written exception specifying the reason for the request and the reason why the requester believes that it is in the best interest of Hurley Medical Center patients to grant the request.

4. Review and consideration by the applicable department.

5. Review and approval by the Credentials Committee.

6. Review and approval by the Medical Executive Committee.

7. Review and approval by the Hurley Medical Center Board of Managers.

Waivers/Exceptions Granted:

1. In addition to the board certification exception granted to all applicants who remain board eligible in accordance with the expectations set forth by their applicable board, board certification requirements are waived for experienced physicians requesting privileges in the Department of Psychiatry, if all of the following are met:

    a) Physician has completed an ACGME/AOA recognized residence training program in psychiatry.

    b) In the last ten (10) years, physician has had at least two (2) years of experience in an inpatient/acute care psych unit, and can provide a letter of recommendation confirming the experience.

c) This exception and its applicability to new applicants must be re-evaluated by the Medical Executive Committee by December 31, 2017.

C. All new applicants and current staff members must have/maintain professional liability insurance of not less than $200,000/$600,000.

D. All new applicants and current staff members, except non-Forensic Pathologists and non-Interventional Radiologists must have/maintain a Federal DEA Certificate.

E. Applicants must be able to document their background and experience and demonstrate current competence, adherence to the ethics of their profession, and their ability to work with others with sufficient adequacy to assure the Professional Staff and the Board of Hospital Managers that any patient treated by them in the medical center will be given safe high quality of care.

F. No physician, dentist, psychologist, podiatrist, certified registered nurse anesthetist (CRNA), advanced practice nurse (APN or NP), physician assistant (PA) or nurse midwife shall be entitled to membership on the Professional Staff merely by virtue of the fact that he or she is duly licensed in the State of Michigan, that he or she is a member of any professional organization, that he or she holds certification by any professional Society or Board, or that he or she had in the past, or presently has, such privileges at another hospital. Any physician or practitioner appointed to an administrative position in the institution is subject to the same procedures as all other applicants for membership privileges.

G. When physicians and practitioners eligible for membership or delineated clinical privileges are engaged by the medical center to provide patient care services pursuant to a contract, their clinical privileges or scope of practice are defined through medical staff mechanisms.

H. Acceptance for membership on the Professional Staff or the acceptance of appointment into the Moonlighting Category, shall constitute the individual's agreement that he or she will strictly abide by the Bylaws, Policies and Procedures, and Rules and Regulations imposed by the Professional Staff or governing body of Hurley Medical Center, pledge to provide for the continuous care of his or her patients, and be subject to review as part of the performance improvement activities at Hurley Medical Center.

I. Members of both voting and non-voting categories should be accessible to the medical center within sixty (60) minutes.

Section 2 – <u>Responsibilities of Membership</u>

All members of the Professional Staff and individuals appointed to the Moonlighting Category agree/pledge to:

- Provide continuous care to his or her patients in the medical center, within the generally recognized professional standards of quality, safety, efficiency and appropriateness.
- Abide by the Bylaws, Policies and Procedures, and Rules and Regulations imposed by the Professional Staff or governing body of Hurley Medical Center, as well as Hurley Medical Center Standard Practices/Policies and Procedures, Rules and Regulations.
- Carry out responsibilities, for which he or she is appointed or elected, to his or her department, committee or the medical center.
- Abide by the ethical principles of his or her profession.
- Complete his or her medical records in a timely manner for all patients admitted to the medical center or for whom he or she provides care, including the performance of a history and physical by a physician, or other individual as provided in these Bylaws or Rules and Regulations or State law.
- Participate in Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) as part of the process of being granted and maintaining privileges.

Each MD/DO practitioner may voluntarily agree to participate in the supervision and education of residents/fellows, at the request of the director of a particular residency or fellowship program. It shall be understood that all of the patient care responsibility belongs to the attending physician who is participating with a member of the housestaff in the patient care. Members of the housestaff are encouraged to write orders on patients, with the assistance and supervision of the attending staff. This shall not prohibit members of the medical staff from writing orders. The supervision of residents and residency programs is under the direction of the program director and is coordinated through the Graduate Medical Education Committee (GMEC). Practitioners who elect not to participate in the supervision and education of residents/fellows, will not be in jeopardy with respect to his/her staff privileges. At the discretion of the Program Director or GMEC, a practitioner may be excluded from supervision and teaching of residents.

Non-MD/DO practitioners may not supervise allopathic/osteopathic physicians in training but may provide educational input to the resident trainee regarding care of the patient from their professional practice perspective.

Section 3 - History & Physical Examination

A clinically pertinent medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition,

must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The history and physical of each inpatient shall include, at a minimum, the following:

1) Identification data – at least two patient identifiers
2) Chief complaint or reason for admission
3) History of the present illness
4) Pertinent medical and surgical history
5) Medications with current dosages
6) Allergies / sensitivities
7) Pertinent social history and family history
8) Review of systems pertinent to reason for admission
9) Physical Exam pertinent to reason for admission
10) Results of pertinent diagnostic studies leading up to admission
11) Conclusion/impression/diagnostic considerations
12) Plan of care

Failure to complete the History and Physical as indicated above may result in cancellation of the procedure unless the physician states in writing that such a delay would be detrimental to the patient. If such is stated, the History and Physical is to be completed within 24 hours of the emergency procedure as documented by the physician. *(These provisions may be waived in extreme emergency, but a preoperative diagnosis shall be recorded in the medical record and the History and Physical completed within 24 hours post-procedure).*

Section 4 - Term of Appointment

All appointments/reappointments to the Professional Staff and/or granting of privileges shall be made by the Board of Hospital Managers and shall be for a term not to exceed twenty-four (24) months. The staff term commences on the first (1st) day of January and ends on the thirty-first (31st) day of December. Appointments in the Departments of Anesthesia, Emergency Medicine, Obstetrics & Gynecology, Pathology, Radiology, Radiation Oncology and Surgery will commence on the first (1st) day of January of odd numbered years and end on the thirty-first (31st) day of December of even-numbered years; appointments in the Departments of Medicine, Pediatrics, Psychiatry, and Psychology will commence on the first (1st) day of January of even numbered years and end on the thirty-first (31st) day of December of odd-numbered years.

Appointment to the professional staff shall be in accordance with the procedure for appointment/reappointment, which is attached to these Bylaws and incorporated by reference hereto.

ARTICLE III – DIVISIONS OF THE PROFESSIONAL STAFF

Section 1 - Categories

The Professional Staff shall be divided into Voting and Non-Voting Categories. It is expected that Voting staff members (Active With Vote) will attend fifty percent (50%) of their departmental meetings and fifty percent (50%) of the general medical staff meetings to be eligible to vote at staff and departmental levels. Non-Voting members (Active Without Vote, Provisional, Affiliate, Courtesy, and Emeritus Retired) will not be

eligible to vote at staff or departmental levels, but may vote at committee levels. Provisional members are expected to attend fifty percent (50%) of their department meetings and fifty percent (50%) of the general medical staff meetings.

For a Medical Staff member to advance, change and/or maintain an Active membership status, physician members in the Departments of Medicine, Surgery, and Obstetrics/Gynecology must have demonstrated twelve (**12)** inpatient consults, inpatient admissions, or inpatient/outpatient surgeries in the immediate twelve (12) month period. Members in the Department of Pediatrics must have demonstrated a minimum of eight (**8)** inpatient admissions, inpatient consults, inpatient newborn examinations, or performed inpatient/outpatient surgeries in the immediate twelve (12) month period. For Department of Emergency Medicine, the member must have worked twelve (12) shifts in the immediate twelve (12) month period. For the Departments of Anesthesia, Radiology and Pathology twelve (12) cases per year shall be the minimum requirement. Individuals who are dual members of Departments (Medicine/Pediatrics) must have demonstrated activity of twelve (**12)** admissions, consults, inpatient newborn examinations or performed surgeries, in the immediate twelve (12) month period. Members who do not meet this requirement will have their status changed to Staff Category as applicable and appropriate.

In considering attendance, there are no excused absences. Attendance shall be "present" or "absent."

Section 2 - Provisional Staff

The Provisional Staff shall consist of new Professional Staff members (physicians, dentists, psychologists, podiatrists, or nurse midwives, CRNAs, PAs, APNs/NPs). The provisional practitioner will only be advanced to any other staff category status, by the Professional Staff Credentials Committee, providing focused professional practice evaluation (FPPE) criteria have been met as described in the Credentialing Privileging Rules and Medical Staff policy.

Provisional Staff members shall be assigned to a clinical department, and shall be subject to the Bylaws, Rules and Regulations of the staff, and their department. Provisional Staff members shall not be eligible to vote nor hold office, but may be appointed to committees with vote.

Section 3 - Active Staff With Vote

The Active Staff With Vote shall be those physicians, dentists, psychologists, podiatrists, or nurse midwives who regularly admit patients to the medical center, have shown an active interest in the medical center and contributed to its progress and/or regularly care for patients in the medical center. It is expected that members of the Active Staff will have, in the previous two (2) years, demonstrated professional behavior, good citizenship and stewardship as a medical staff member (participation in committee meetings, special projects of the medical staff and medical center, attendance at departmental and medical staff meetings, timely medical record completion, etc.), attended fifty percent (50%) of the regular general medical staff meetings, fifty percent (50%) of the departmental business meetings of the department to which they are assigned and otherwise continue to meet qualifications for membership.

Members of the Active Staff With Vote shall be appointed to a specific department, may hold office in accordance with Article V of these Bylaws, and shall participate in the activities of the medical center. Active Staff With Vote members who do not maintain professionalism, stewardship, record completion timeliness, attendance requirements, and quality/utilization expectations shall be automatically transferred to the Active Without Vote category and are subject to corrective action in accordance with these Bylaws and the Hurley Medical Center Bylaws.

Members of the Active Staff shall be privileged to admit patients and to exercise clinical privileges as may be granted. In addition, they shall be required to participate in committee functions, to supervise provisional appointees to the department and accept teaching assignments, if requested, and to discharge other staff functions as may be required. Members of the Active Staff should be accessible to the medical center within sixty (60) minutes.

Chief of Staff, Vice Chief, Secretary, Members at Large, Departmental Chairs, Vice Chairs, and medical coordinators for subspecialty areas and standing committee chairs must be current members of the Active Staff.

Exceptions to these conditions may be permitted only upon ratification of a recommendation by the Chief of Staff to the Medical Executive Committee (MEC) and subsequent approval by the governing body.

Section 4 – <u>Affiliate Staff (Allied Health)</u>

The Allied Health Staff shall be those Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Medical Social Workers in specified job capacities (individual or family psychotherapy).

Members of the Allied Health Staff may care for patients and exercise clinical privileges under the responsibility and supervision of a physician. They shall be eligible to vote on matters presented to the committees to which they are assigned, but are not eligible for voting at their department and general staff meetings other than election of the Affiliate Members at Large. Members of the Allied Health Staff shall not be eligible for nomination or election as Chief of Staff, Vice Chief of Staff, Secretary, or departmental chair, vice chair, or medical coordinator for a specialty area.

Allied Health Staff shall be eligible for nomination and election to an Affiliate Member at Large position. The Affiliate Member At Large position shall have a vote on the MEC.

Section 5 - Active Without Vote Staff

The Active Without Vote Staff shall consist of those Professional Staff members, eligible as herein provided, who wish to admit patients to the medical center, but who are not actively involved in medical staff affairs and are not major contributors to the fulfillment of medical staff functions due to practicing primarily at another hospital or in an office-based specialty, or do not meet criteria to become an Active With Vote Staff member, but who wish to remain affiliated with the medical center for consultation, call coverage, referral of patients, or other patient care purposes. The Active Without Vote Staff shall not be eligible to vote or hold office, but may serve on committees and may attend

medical staff and department meetings.. Changes from Active Without Vote Staff to Active With Vote may be requested at any time but may only occur subsequent to review of admission/consultation volume criteria and may only occur at time of reappointment or by recommendation and concurrence of Department Chair, Credentials Committee, and Chief of Staff

Section 6 - Courtesy Staff (Members Only)

The Courtesy Staff shall consist of those Professional Staff members, eligible as herein provided, who do not practice in the medical center but still desire to maintain medical staff appointment to provide continuity of care to their patients or to satisfy a criterion of medical staff membership and access to in-network hospital services that may be required for participation in managed care organization panel(s).

The Courtesy Staff category is a membership-only category of the Medical Staff with no clinical privileges, limited medical staff responsibilities and prerogatives. As Professional Staff members, the Courtesy Staff may be appointed to a specific department, accept committee appointments but shall not be privileged to admit or directly care for patients in the inpatient setting, perform any procedures, hold office, or vote at departmental or staff levels. They shall be allowed to visit their patients in the medical center, review their patients' medical records, consult with staff caring for their patients, but are not permitted to write orders or give verbal or telephone orders, progress notes, or make other notations in the medical record. Professional staff members in this category must establish appropriate referral and coverage arrangements with an Active With Vote or Active Without Vote staff member for the medical care of his/her patients that require medical center services or that patient(s) shall be admitted to staff and/or hospitalist service. They must also be available to members providing inpatient care for their patients. Members in this category must be fully credentialed as specified in the Policies & Procedures for Credentialing & Privileging and continuously meet criteria for medical staff membership.

Since no clinical privileges are granted, Courtesy Staff shall not be subject to the requirements for focused professional practice evaluation (FPPE) or ongoing professional practice evaluation (OPPE).

Section 7 – Moonlighting Staff

The Moonlighting Category is restricted to those practitioners enrolled in a graduate medical education program and engaged to provide medical services outside of the graduate medical education program.

Appointment to this category shall only be considered when the applicant has received a written offer of Moonlighting employment from the Hospital or a physician group with a current call contract with the Hospital.

Individuals designated within this category are not considered members of the Professional Staff, shall not be afforded the rights and responsibilities of Professional Staff membership, and shall only practice within the scope of service specifically approved for them by the Board of Managers. Appointment to this category is entirely discretionary and may be rescinded at any time by the Board of Managers.

Individuals within the category shall not be subject to the Hearing and Appellate Review procedures prescribed for the members of the Professional Staff.

A. Qualifications for Moonlighting Status. In addition to the general qualifications specified above, individuals applying for privileges in this category must provide evidence of the following:
    1. Obtain prior approval from his/her residency program and provide documentation of approval to the Medical Staff Office at the time the credentialing process begins.
    2. Assure ongoing residency program approval, in accordance to residency program policies; and provide requisite documentation to the Medical Staff Office prior to the approval's expiration date.
    3. Appointment shall automatically terminate upon the earlier of 1) the termination or expiration of the contract covering the Moonlighting employment, or 2) the completion of or exit from the hospital's graduate medical education program.
B. Regardless of the above, any appointment in this category shall be no longer than a term of up to two (2) years. While in this category, the Moonlighting Practitioner may not be appointed to the Professional Staff under a different category of membership. However, upon the Moonlighting Practitioner's termination of appointment in this category, the previously designated Moonlighting Practitioner shall be free to apply for membership and/or privileges in any medical staff category in which he or she is qualified.
C. Moonlighting Staff may NOT:
    1. Admit patients to the hospital
    2. Participate in the Department's call schedule
    3. Vote or hold office
D. Obligations of Moonlighting Staff:
    1. Support the patient care mission of Hurley Medical Center by providing treatment for patients presenting to the facility seeking medical care regardless of the patient's ability to pay for such services
    2. Participate in the quality/safety/utilization review activities of Hurley Medical Center
E. Observation and Evaluation. Practitioners in the Moonlighting category will be observed and evaluated in accordance with the Focused Professional Practice Evaluation (FPPE) Policy.

Section 8 - <u>Emeritus Retired Staff</u>

Emeritus staff membership may be granted to those members of the Professional Staff (physicians, dentists, psychologists, podiatrists, or nurse midwives) who have rendered long, useful, and honorable service to the profession and to the medical center, who have attained seventy (70) years of age, and who thereby merit this distinction. Members of the Emeritus Retired Staff shall be those physicians, dentists, psychologists, podiatrists, or nurse midwives who have no admitting or clinical privileges but who maintain an interest in the medical center and the Professional Staff.

ARTICLE IV – ALLIED HEALTH STAFF

Section 1 - <u>Definition of Allied Health Staff</u>

The Allied Health Staff shall consist of appropriately licensed, registered or certified clinicians, physician assistants, nurse practitioners, advanced practice nurses, nurse anesthetists, and other licensed, registered or certified healthcare professionals who have been approved to provide specified patient care in the medical center or hospital affiliate entity. They shall be considered members of the Allied Health Staff as a subdivision of the Professional Staff but shall not be eligible to vote nor hold office unless otherwise specified in these Bylaws; they may be assigned to committees and vote at that level.

Credentials of the Allied Health Staff shall be reviewed by the Professional Staff Credentials Committee on an individual basis.

Applications/requests for privileges and scope of practice will be reviewed by a practitioner of similar background/training where possible, and by the supervising physician or member of the supervising physician's department, as necessary or required.

Provisional appointment: a period of one (1) year is required before advancement to Affiliate Staff category, or until the professional practice evaluation period criteria has been met/completed or recommended by the Professional Staff Credentials Committee. Provisional members shall be assigned to a clinical department and subject to the Bylaws, Rules & Regulations of the staff and their department. Provisional members who are also employed by the medical center must comply with and meet employee designated responsibilities, and employee probationary requirements. Termination of employment with the medical center will terminate membership and privileges on the Medical Staff. Such termination shall not be subject to ratification by the Hurley Professional Staff nor shall it entitle the affected Practitioner to a Hearing or Appeal otherwise provided under the Professional Staff Bylaws.

Allied Health Staff whose membership/clinical tasks end due to medical center employment reasons are eligible for re-application/re-instatement of membership. Employment reference, license verification [NPDB (National Practitioner Data Base), OIG (Office of Inspector General)], and other credentials verification will be requested and performed at this time also. Appointment to the professional staff shall be in accordance with procedure for Appointment and Reappointment, which is appended by these Bylaws and incorporated by reference hereto. All Physician Assistants, Nurse Practitioners, Advance Practice Nurses and Certified Registered Nurse Anesthetists must provide their own Collaborating and/or Supervisory Practice Agreement with a physician member of the Professional Staff.

Section 2 - <u>Clinical Tasks (Scope of Practice)</u>

Members of the Allied Health Staff shall be assigned to a clinical department and clinical tasks granted shall be consistent with the individual qualifications, experience and capabilities of the applicant.

Members of the Allied Health Staff shall not be privileged to admit patients to the medical center under their name and must provide patient care under the direction of a member of the Professional Staff. The extent to which members of the Allied Health Staff may write orders and progress notes will be consistent with the duties and responsibilities

described in their individual job description or the rules and regulations of their respective departments. A patient's medical history and physical examination may be performed by an Allied Health Staff member who has been granted specific clinical privileges to do so through the medical staff process.

Allied Health Staff must converse with the Supervising/Collaborating Physician and document the conversation on all admissions, discharges, and patient condition on a daily basis, or as defined in the approved supervisory/collaborative agreement, and act within scope of practice as defined by state law. As added measures to improve patient safety and quality of care, Allied Health Staff must demonstrate continuous compliance with this communication and exert their best efforts to maintain and improve communication with supervising/collaborative physicians. These communication efforts and compliance must be appropriately documented in the medical record. Problematic or non-compliant communication concerns shall be brought to the attention of the Department Chair, Chief of Staff, Chief Quality Officer, and/or hospital administration leadership personnel immediately. Where an immediate patient care or patient safety concern is involved, the physician's alternate coverage or Chain of Command shall be followed. Any changes or amendment to the supervisory/collaborative agreement must be approved by the Professional Staff Credentials Committee.

Members of the Allied Health Staff shall participate in department quality improvement and committee functions as requested by the individual departments. They shall not be entitled to vote nor hold office, unless otherwise specified in these Bylaws, Rules and Regulations.

Members of the Allied Health Staff will be subject to the biennial reappointment process of their respective department. Recommendation for reappointment and renewal of clinical tasks will be based on the allied health staff member's demonstrated current competence. Members of the Allied Health Staff employed by the medical center or hospital affiliated entity shall be subject to annual performance appraisal specified by the medical center Human Resources system and biennial reappointment of the Professional Staff. Members of the Allied Health Staff shall be governed by the applicable Bylaws, Rules and Regulations of the Allied Health and Professional Staff of Hurley Medical Center.

Membership of the Allied Health Staff who are discharged from the medical center or affiliate hospital entity for disciplinary reasons shall terminate with their discharge and shall not be entitled to a hearing or appeal otherwise provided under the Hurley Professional Staff Bylaws.

ARTICLE V – OFFICERS AND COMMITTEES

Section 1 - Qualifications of Officers

Only members of the Active Staff With Vote who are Board Certified within their specialty shall be eligible to hold office, and that Board Certification must be maintained for the duration of their term of office.

Section 2 - Officers and Method of Election

The officers of the Professional Staff shall be:

- Chief of Staff
- Vice Chief of Staff
- Secretary
- Three (3) Members-at-Large
- Two (2) Affiliate Members-at-Large (Allied Health Practitioner)

Officers of the Professional Staff shall be elected in the following manner: A nominating committee composed of five (5) Active staff members and two (2) Affiliate members shall be selected by the MEC. The members of the Nominating Committee shall not be members of the MEC. The nominating committee shall select nominees for the offices of Chief of Staff, Vice Chief of Staff, Secretary, three (3) Members at Large, and two (2) Affiliate Members at Large to the MEC. The nominating committee shall determine a candidate's willingness to have his or her name placed in nomination, and verify his or her eligibility for the office. The nominating committee shall present its proposed slate of candidates to the General Staff at the May meeting in even-numbered years.

Additional nominations for any of the offices may be made from the floor at the May meeting of the General Staff. Nominations shall be closed at the conclusion of the May meeting. Any candidate whose name is placed in nomination from the floor must be present to accept or reject such nomination. The slate of officers will be voted upon at the December meeting of the General Staff.

In the event a decision is made by the MEC to mail ballots to eligible voters, the ballots shall be mailed at least fifteen (15) days prior to the December meeting of the General Staff, to be returned as designated on the ballot.

The nominees for Chief of Staff, Vice Chief of Staff and Secretary who receive the simple majority of the votes cast by the eligible voters shall be declared elected to such office. Each of the three (3) nominees for Members at Large and Affiliate Member at Large to the MEC must also receive a simple majority of the votes cast by the eligible voters, and in such event shall be declared elected to such office. In the absence of a majority, the normal procedure of repeated balloting will occur until a simple majority is obtained.

Section 3 - Term of Office

The Chief of Staff, Vice Chief of Staff, Secretary, three (3) Members at Large and two (2) Affiliate Members at Large to the MEC shall hold office during the next two (2) calendar years or until a successor is elected, should they resign or otherwise leave office. The term of office for Chief of Staff, Vice Chief of Staff, Secretary, three (3) Members at Large and two (2) Affiliate Members at Large to the MEC shall be limited to four (4) terms (consecutive or non-consecutive).

Section 4 - Duties of Officers

The Chief of Staff shall serve as the Chief Executive Officer of the Professional Staff, and his or her duties shall be:

- To call, preside at, and be responsible for the agenda for all meetings of the Professional Staff;
- Serve as Chair of the MEC;
- Serve as an ex-officio member of all other Professional Staff committees;
- Be responsible for enforcement of the Professional Staff Bylaws, Rules and Regulations;
- Appoint members annually to all standing and special committees, except the MEC, or other committees whose membership is specified by these Bylaws;
- Represent the views, policies, needs and grievances of the Professional Staff to the Board of Hospital Managers and to the medical center President/CEO;
- Represent the policies of the Board of Hospital Managers to the Professional Staff and report to the governing body on the maintenance of quality and patient safety with respect to the Professional Staff's delegated responsibility to provide medical care;
- Represent the Professional Staff in its external professional and public relations;
- Be responsible for assuring that the Professional Staff is aware of, and strives to meet, all requirements and standards of accrediting bodies and agencies;
- Is responsible for all performance improvement/quality of care and patient safety activities.

The Vice Chief of Staff shall have the authority and assume all the duties in the absence of the Chief of Staff. He or she shall automatically succeed the Chief of Staff, if or when the Chief of Staff fails to serve for any reason.

The Secretary shall keep accurate and complete minutes of all staff meetings, call meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties, which ordinarily pertain to his or her office. Where there are funds to be accounted for, he or she shall also act as Treasurer.

Members at Large shall:

- Participate as a member of the MEC through attendance at monthly meetings and special meetings as scheduled or requested.
- Represent the general membership on issues of interest or concern, particularly those that arise outside of the standing committee structure.
- Listen to membership and communicate their issues, needs and interests to the MEC.
- Identify potential problems and opportunities.
- Work effectively with MEC, Administration and Board of Hospital Managers in the mission, vision, goals, and values of the organization.

Section 5 - <u>Procedure for Removal of Officers and Vacancies in Office</u>

A petition for recall may be initiated by twenty-five (25) percent of the Active With Vote Staff who feel that a staff officer is not performing his or her duties in the prescribed manner, incurs mental and/or physical impairment impeding fulfillment of the officer, or

fails to maintain qualifications for the position. Such petition shall be signed and presented to an officer who shall call a special meeting of the Professional Staff within fifteen (15) days. The charges against the officer shall be summarized at such meeting and mailed to the Active With Vote Staff with a ballot to vote for or against recall of the officer. The ballot shall be returned to the medical center by Certified Mail within ten (10) calendar days. Recall shall occur if the majority of the Active and Associate Staff has voted in favor of the recall.

Vacancies in the office of Vice Chief of Staff, Secretary or Member-at-Large to the MEC shall be filled upon nomination by the Chief of Staff and approval by the MEC. Once appointed to the vacant position, the appointee shall serve until the end of the term of the vacated office.

Section 6 - <u>Committees</u>

Committees shall be standing and special. Standing committees shall include but not be limited to: Blood Utilization Review Committee, Cancer Committee, Credentials Committee, Medical Executive Committee, Infection Control Committee, Medical Records Committee, OR Committee, and the Pharmacy and Therapeutics Committee.

The membership of all Professional Staff committees shall be appointed by the Chief of Staff, except where there are specific directions indicating other methods of selection (GMEC). Chairs for each of these committees shall be appointed. Committees may elect their chairs as stated in Article VII, Section 4, but the Chief of Staff must approve the elected individual.

A. The **Medical Executive Committee (MEC)** shall consist of the duly elected officer of the Professional Staff, to wit:

- Chief of Staff, who shall act as chair of the committee
- Vice Chief of Staff
- Secretary, who shall act as the recording secretary
- Chairs of the following departments:
  - Anesthesia
  - Emergency Medicine
  - Medicine
  - Obstetrics and Gynecology
  - Pathology
  - Pediatrics
  - Psychiatry
  - Psychology
  - Radiation Oncology
  - Radiology
  - Surgery
- Three (3) Active With Vote Members at Large
- Two (2) Affiliate Members at Large
- Chair of the GMEC (ex-officio with privilege of voting)
- Chief Quality Officer
- Chief Medical Officer

- Housestaff Association President or designee

In the event a member of the MEC who is a Chair of a Department is unable to attend a meeting of this body, the Vice-Chair of the Department or designee shall be his or her representative with the full rights of the MEC member. In order to conduct business at the MEC, a simple majority (50% +1) of voting members must be present.

The duties of the MEC shall be:

- seeks out the views of the Professional Staff on all issues including those relating to quality and safety and accurately conveys those views to the Board of Managers.
- coordinate the activities and general policies of the various departments and to act on behalf of the Professional Staff, subject to such limitations as may be imposed by the staff;
- implement policies of the Professional Staff not otherwise the responsibility of the departments;
- receive and act upon reports and recommendations from medical staff committees, clinical departments, and assigned activity groups;
- provide liaison between the Professional Staff, the medical center President/CEO and the Board of Hospital Managers;
- fulfill the accountability of the Professional Staff to the governing body for the medical care provided to patients in the medical center;
- ensure that the Professional Staff is kept informed of the accreditation, licensing and certification programs and of the accreditation, licensing and certification status of the medical center;
- make recommendations to the governing body regarding:
    - medical staff structure
    - mechanism used to review credentials and delineate individual clinical privileges
    - recommendations of individuals for professional or allied health staff membership, assignment to departments, and for delineated clinical privileges for each eligible individual
    - participation of the medical staff in organization performance improvement and patient safety activities;
    - mechanism by which professional or allied health staff members may be terminated;
    - mechanism for fair-hearing procedures
- take steps to ensure professionally ethical conduct and competent clinical performance on the part of the members of the staff, including the initiation of corrective or review measures;
- report the activities of the MEC to the General Staff at each of its meetings.

The MEC should meet at least ten (10) times per year (preferably monthly) and maintain a permanent record of its proceedings and actions. Activities of the Staff shall be reviewed at subsequent General Staff meetings

The Medical Executive Committee is empowered to represent and act for the medical staff in the interval between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. The medical Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Medical Staff, any Rules and Regulations and Medical Staff Policies & Procedures to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws. The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions listed above.

The MEC, as representatives of the medical staff, will make its best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Medical Center, and the members of the medical staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the medical staff, the medical staff shall present their recommendations to the MEC in a written petition signed by at least ten percent (10%) of the voting members of the medical staff. The medical staff officers shall meet with the members of the medical staff representing the medical staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff, the representatives of the medical staff or the Chairperson of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process. In the event a resolution cannot be agreed upon by the members of the Joint Conference, the members will agree on implementing an additional conflict resolution process, which may include mediation.

B. The **Cancer Committee** shall consist of representatives from all medical specialties involved in the care of the cancer patients within the limits of those disciplines available to the institution. These shall include, but not be limited to representatives from:

- Medical Oncology
- Internal Medicine
- Diagnostic Radiology
- Radiation Oncology
- Obstetrics and Gynecology
- Pathology
- Pediatrics
- Surgery
- Hurley Medical Center Cancer Liaison Physician Representative to the American College of Surgeons

The Committee should also include members from:

- Medical Center administration
- Nursing service
- Quality management
- Social service

- Rehabilitation
- Cancer registry

Responsibilities of the Cancer Committee shall be to plan, initiate, stimulate and assess the results of cancer activities in the institution. The Committee should meet at least quarterly, and preferably monthly, as an entity separate from conferences or tumor boards and document its activities and attendance. The Cancer Committee should be concerned with the entire spectrum of care of cancer patients admitted to the institution and shall:

- ensure that patients have access to consultative services in all disciplines;
- be responsible for assuring that educational programs, conferences and clinical activities cover the entire spectrum of cancer;
- perform an audit role regarding patient care, either directly or by review of audit data supplied by other committees;
- actively supervise the cancer database for quality control of abstracting, staging and reporting.
- Report results of reports and assessments to the governing body at least annually.

C. The **Credentials Committee** shall consist of:

Members of the Professional and Allied Health staff, selected so as to ensure representation from the major specialties and the entire staff.

Its duties shall be to investigate the credentials of all applicants for membership and to make recommendations in conformity with these Bylaws, to review all information available regarding the competence of staff members, and as a result of such reviews, to make recommendations for the granting of privileges, appointment, reappointment, and the assignment of members to the various departments.

In addition, it shall be the duty of the Credentials Committee to review recommendations of departmental chairs regarding the work of Provisional Staff members and make recommendations to the MEC regarding their continued staff status.

- The Allied Health Professionals Credentials Sub-Committee shall be appointed by the Credentials Committee Chair. Permanent members of the Committee shall include representatives of the Allied Health Professionals staff, current Chief Quality Officer, Credentials Committee Chair (ex officio), Chief of Staff (ex officio), two (2) medical staff representatives, and the Medical Staff Coordinator or designee (ex officio and non-voting).

Duties:

The Allied Health Professionals Credentials Sub-Committee shall:

- evaluate and make recommendations to the Credentials Committee regarding the need for services that could be provided by types of allied health professionals;
- develop and recommend policies for each type of allied health professional permitted by the Board of Managers to practice in the medical center or health system. Such policies shall specify training, education and experience requirements for applicants, the scope of practice or clinical privileges to be granted, any conditions that apply to the practitioners functioning within the medical center or health system, any ongoing supervision requirements, and malpractice insurance requirements;
- review the qualifications of all allied health professionals who apply for permission to practice in the medical center or health system, interview such applicants as may be necessary, and make a written report of its findings and recommendations to the Credentials Committee;
- review, as questions arise, all information available regarding the clinical competence and/or professional conduct of allied health professional applicants and, as a result of such review, make a written report of its findings and recommendations to the Credentials Committee.

Meetings, Reports and Recommendations:
The Allied Health Professionals Credentials Sub-Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall make a report of its recommendations after each meeting to the Credentials Committee, through the Committee Chair. The chair(s), or designee, of the committee shall be available to meet with the Credentials Committee on all recommendations that the Allied Health Professionals Credentials Sub-Committee may make.

D. The **Joint Conference Committee** shall consist of:

- Representatives of the Medical Staff as specified by the Bylaws of the Governing Body.
- Representatives from the Board of Hospital Managers, as specified in the Bylaws of the governing body.

The Joint Conference Committee shall be a medico-administrative liaison committee and the official point of contact between the Professional Staff, the Board of Hospital Managers, and the Medical Center President. Committee meetings may be called by the Chief of Staff, Board of Hospital Managers, or the Medical Center President.

E. The **Professional Medical Staff Well Being Committee (Well-Being Committee)** shall be appointed by the Chief of Staff and shall consist of not less than three (3) nor more than five (5) members (including the Committee Chair) of the Professional Staff. The committee shall:

A. identify and support professional medical staff members with impairments and shall be non-punitive in approach;
B. provide a mechanism for self-referral;
C. provide a mechanism for education and referral of the affected professional medical staff member;
D. provide confidentiality with respect to the affected professional medical staff member and any individual making a referral to the Professional Medical Staff Well-Being Committee;
E. evaluate the credibility and monitor the affected professional medical staff member;
F. report to the Professional Medical Staff.

Whenever a member of the Professional Staff appears at the medical center with the intention of directly or indirectly participating in patient care, and in the opinion of medical center staff (nursing, resident, or professional medical staff member) appears at that time to be impaired, a member of the Professional Medical Staff Well-Being Committee will be immediately notified and asked to come to the medical center, meet with the professional medical staff member in question, and assess the situation. If there is difficulty in contacting a member of the Professional Medical Staff Well-Being Committee, the Department Chair, a Staff Officer, the Chief Medical Officer, the Chief Quality Officer or Chief of Staff may be contacted.

If the Professional Medical Staff Well-Being committee member, Department Chair, Staff Officer, Chief Medical Officer, Chief Quality Officer, or Chief of Staff feels that impairment or intoxication exists, a urine and/or blood sample will be immediately obtained under direct supervision and subsequently evaluated for possible mood-altering substances. If a medical problem is believed to be present, appropriate evaluation will be recommended or requested. Hospital Standard Practice regarding Drug Free Workplace additionally outlines the corporate policy and consent document to be used in these instances.

If the urine or blood sample obtained under these circumstances is positive for mood altering substances, then the matter will be brought before the Professional Medical Staff Well-Being Committee. The professional medical staff member involved will have an opportunity to appear before the Professional Medical Staff Well-Being Committee to explain any mitigating circumstances. If the situation is not appropriately resolved, then chemical dependency evaluation should be recommended and treatment considered. A second test for mood altering chemicals may be recommended at this time.

If the second sample obtained as above is positive for mood altering substance, then chemical dependency evaluation and treatment will be required in an inpatient setting

F. The **Medical Records Permanent Audit Committee (MR-PAC)** shall consist of:

- three (3) members of the Active Staff, (at minimum)
- one (1) member of the Affiliate Staff
- representation from administration and nursing shall be ex-officio members on the Committee

- GMEC or GMEC Chair appoints two (2) resident members
- Housestaff President or designee

The medical record administrator shall attend all meetings of this Committee.

The duties of the Medical Records Committee shall be to review records to assure that they contain sufficient information to justify the diagnosis and to assure that the record meets documentation standards of patient care. They shall also conduct and review records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof. The Medical Records Committee shall also provide guidance and tracking of compliance with accrediting, licensing and certification standards. They shall also review and have oversight for medical records deficiency, delinquency and sanctions thereof.

G. The **Medical Staff Conduct and Procedures Committee (Conduct & Procedures)** shall consist of an odd number (i.e. 5, 7, 9) of a cross section of no less than five (5), but not greater than nine (9) members of the Active Staff, appointed by the Chief of Staff. All members shall be voting members of the committee.

Other guests or consultants may be invited or queried as needed to provide additional input, including a representative from the department to which the affected physician or practitioner belongs. The Chief of Staff, Chief Quality Officer, Chief Medical Officer and Executive Vice President and General Counsel shall be non-voting members of the committee. The purpose of the committee shall be to review reports, or review matters of staff member conduct, ethics and other matters as shall be referred by the Chief of Staff or MEC, interview physicians, practitioners and other appropriate individuals when applicable, and make recommendations to the MEC when a quality of care issue (including issues of behavior) is not resolved by the referring source. Organization policy regarding Professional Staff Code of Conduct shall also inform the committee in carrying out its duties.

H. The **Pharmacy and Therapeutics Committee (P&T)** shall exist as a committee of the medical staff and consist of:

- representatives from the Professional Staff
- at least one (1) member from:
  - Pharmacy
  - Nursing service
  - Administration
  - Housestaff President or designee

The responsibilities of this committee shall include the development and surveillance of all drug utilization policies and practices within the medical center in order to assure appropriate clinical results and a minimum potential for hazard to ensure patient safety. Responsibilities also include participation and oversight in compliance with licensure, accrediting and certifying standards, rules and regulations. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage,

distribution, use, safety procedures, and other matters relating to drugs and drug safety in the medical center. Pharmacy and Therapeutics Committee activities shall be reported to the MEC. Policies and practices reflecting the above responsibilities shall be recommended to the MEC for action and recommendation to the Governing Board.

I. The **Infection Control Committee (ICC)** shall consist of:

- Infectious Disease Specialty Physicians [minimum of three (3)]
- at least one (1) representative from each of the clinical departments
- Nursing service
- Pathology
- Administration
- Housestaff President or designee
- other appropriate medical center services such as, but not limited to OR, Sterile Services, Ambulatory Care areas, Respiratory Therapy

The ICC shall be responsible for the surveillance of inadvertent medical center infection potential, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the medical center's activities. ICC activities, actions, and policies and procedures shall be reported and recommended to the MEC for action and recommendation to the Governing Board.

J. The **Graduate Medical Education Committee (GMEC)** will be responsible for monitoring, advising and implementing policies regarding the quality of education and work environment for residents. Policies and procedures will include the following:

- stipend and position allocation,
- communication with program directors,
- resident duty hours,
- resident supervision,
- communication with the medical staff,
- curriculum and evaluation,
- resident status,
- oversight of program accreditation,
- management of institutional accreditation,
- oversight of program changes,
- experimentation and innovation,
- oversight of reductions and closures and vendor interactions.

The GMEC will have authority for all aspects of graduate medical education training at Hurley Medical Center and shall consist of:

- Chief of Staff, who shall sit without vote
- Graduate Medical Education program Directors, all of who shall sit with vote, for:

- Emergency Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Pediatric Dentistry
- Pediatrics
- Combined Internal Medicine/Pediatrics
- Diagnostic Radiology
- Transitional Year Programs
- Geriatric Medicine Fellowship
- Five (5) additional representatives of the Professional Staff, appointed by the Chief of Staff, with vote
- One (1) representative from Michigan State University College of Human Medicine, with vote
- Director of Research, with vote
- Medical Psychology & Behavioral Sciences, with vote
- President, Hurley Medical Center Housestaff Association (or designee), with vote
- Three (3) resident physicians nominated by their peers; one (1) of which will be the nominated Resident Well-Being Chair (three (3) members with vote)
- President & Chief Executive Officer, Hurley Medical Center
- Vice President/Chief Medical Officer, who shall sit with vote
- Academic Officer/Designated Institutional Official member (voting member)
- Resident Well-Being Community Faculty Advisor (voting member)

Selected experts may be called upon when needed. The Committee shall meet on a monthly basis, a minimum of eight (8) times per year, and must have a quorum of eleven (11) members to conduct official business. The chair may call special meetings with whatever frequency is necessary and whenever appropriate. The GMEC shall report its deliberations to the MEC. The Chair and Vice Chair of the GMEC shall be a Hurley Medical Center based Program Director of an ACGME (Accreditation Council for Graduate Medical Education) accredited program, elected in the same fashion as a Department Chair.

K. The **Medical Staff Education Committee** (MSEC) shall oversee all Professional Staff Continuing Medical Education and Institute for Continuing Medical Education sponsored by Hurley Medical Center. The duties of the Committee are:

- establish a written statement of Hurley Medical Center's Continuing Education mission;
- identify and analyze the Professional Staff's continuing medical education needs in an ongoing fashion;
- monitor the objectives, design, and implementation of all educational offerings;
- evaluate the effectiveness of all continuing medical education programs, thereby facilitating future educational planning (see Accreditation Manual of ACCME [Accreditation Council for Continuing Medical Education]).

The MSEC shall also ensure compliance with the Michigan State CME Committee (Continuing Medical Education) and ACCME.

Membership of the MSEC shall consist of the following representatives, who shall have the privilege of voting unless otherwise specified:

- Chief of Staff
- Chief Quality Officer Director of CME and/or Academic Officer
- Three (3) Professional Staff members
- Chair, GMEC, or the committee's designee
- President, Hurley Medical Center Housestaff Association or designee
- Director of Library Services
- Director of Research
- AHP Representative

The Coordinator of Continuing Medical Education shall be a non-voting member. Additional committee members may be appointed to the committee as deemed necessary and appropriate to carry out functions of the MSEC to meet its responsibility or accreditation requirements.

The Chair shall be appointed by the Chief of Staff with approval from the Medical Executive Committee.

The MSEC shall report its deliberations to the MEC. The chair may call meetings/special meetings with whatever frequency is necessary and whenever appropriate.

L. The **Operating Room (OR) Committee** shall be charged with and have oversight for establishing, reviewing and enforcing policies which govern the operating room, recovery room (PACU), pre-op holding, ambulatory surgery and all anesthetizing and procedural areas (as well as where moderate sedation is administered), and shall intervene and mediate in all matters including, but not limited to:

    - sterile processing
    - instrument selection and recommendations for purchase
    - surgical patient flow
    - scheduling/boarding/recovery

The OR Committee shall be a standing medical staff committee, with appointments made by the Chief of Staff. The Chair shall be appointed by the Chief of Staff.

Committee membership shall include, but not be limited to:

- Chair or Medical Director Department of Anesthesia (designated chair unless otherwise specified or assigned
- Chair, Department of Surgery or designee
- Two (2) members from the Department of Surgery
- Chair, Department of Obstetrics & Gynecology or designee

- Two (2) physicians from the Ambulatory Surgery unit/area (GI, Pulmonary, Radiology)
- Administrator for Surgical Services
- OR Nurse Manager
- Manager/Coordinator (CRNA) Anesthesia Services
- Nurse Manager of the Ambulatory Surgery Unit
- Director, Sterile Services
- Vice President responsible for surgical services
- Housestaff President or designee

The OR Committee shall meet at least six (6) times per year.

The OR Committee is a valuable part of the performance improvement, and patient safety program of the medical center and as such, the OR Committee shall make regular reports to the Surgery and OB Departments and to the Performance Improvement Coordinating Council and MEC. The ultimate responsibility for the quality of care maintained in the operating room through the OR Committee shall be the Board of Hospital Managers, who shall assign any immediate matters of quality and operations in operating room, recovery room (PACU), pre-op holding, ambulatory surgery and all anesthesia and procedural areas (as well as where moderate sedation is administered) to the Quality Management Committee.

Policies established by the OR Committee may only be overturned by the President/CEO or designee. An individual medical staff department may not unilaterally or in concert with another department decline to follow policies and directives established by the OR Committee.

ARTICLE VI – MEETINGS

Section 1 - Regular Meetings and Annual Meeting

Two (2) regular meetings of the Professional Staff shall be held each calendar year. One (1) meeting shall be held in May, the other in December. The agenda of these meetings shall include a report from the MEC on the activities of the MEC and the medical work in the medical center, reports from administration, any other business deemed necessary and important by the Chief of Staff.

The December meeting shall be designated the Annual Meeting. At this meeting retiring officers, standing, and special committees shall make such reports as may be desirable and deemed necessary/appropriate by the Chief of Staff.

Section 2 - Special Meetings

Special meetings may be called at any time by the Chief of Staff by request of the Board of Hospital Managers, or by request of the MEC. Special meetings may also be called upon receipt of a petition signed by at least ten (10) active members of the Professional Staff. Within fifteen (15) days after receipt of the request by the Medical Staff Office Coordinator, or designee and Chief of Staff, arrangements will be made for such meeting. No business, other than that which is stated in the notice of the meeting, will be conducted at any special meeting.

Section 3 - Notice of Special Meetings

Notice of a special meeting shall be provided either electronically, by facsimile or USPS to all members of the Professional Staff not less than ten (10) days in advance of the date of the special meeting, with postings outside the Medical Staff Office, Medical Staff Lounge and Surgical Lounge.

Section 4 - Quorum of General Staff Meetings

Twenty percent (20%) of the total Active Staff With Vote membership shall constitute a quorum.

Section 5 - Agenda

The agenda at any **regular meeting** shall be:

- Call to order
- Review activities of the MEC since the last meeting
- Report from the Chief of Staff
- Report from Medical Center President/CEO
- Old business
- New business
- Report of the Chief Quality Officer
- Report of the Chief Medical Officer
- Good and welfare
- Adjournment

The agenda at any **special meeting** shall be:

- Reading of notice calling the meeting
- Transaction of business for which the meeting was called
- Adjournment

Section 6 - Role of Ex-officio Members

Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except that they may not be counted in determining the existence of a quorum. Ex-officio members shall have the privilege of voting unless otherwise specifically provided elsewhere.

Section 7 - Minutes

Minutes of regular and special meetings of the Professional Staff and its departments and committees shall include a record of attendance of members and vote taken. Minutes shall be maintained for all medical staff meetings.

ARTICLE VII – ORGANIZED DEPARTMENTS AND SPECIALTY AREAS

Section 1 - Division of Services

To promote efficiency and coordination among the various branches and specialties of medical practice, the services shall be divided into the following departments/specialty areas:

- Department of Anesthesia
- Department of Emergency Medicine
- Department of Family Practice
- Department of Medicine
    - Allergy
    - Cardiology
    - Critical Care
    - Dermatology
    - Endocrinology
    - Gastroenterology
    - Geriatrics
    - Hematology
    - Infectious Diseases
    - Internal Medicine
    - Nephrology
    - Neurology
    - Physical Medicine and Rehab
    - Pulmonary Diseases
    - Rheumatology
- Department of Obstetrics & Gynecology
- Department of Pathology
- Department of Pediatrics
    - Adolescent Medicine
    - Allergy/Immunology
    - Cardiology
    - Critical Care
    - Gastroenterology
    - General Pediatrics
    - Hematology/Oncology
    - Infectious Diseases
    - Metabolism/Endocrinology
    - Neonatology
    - Nephrology
    - Neurology
    - Physical Medicine & Rehab
- Department of Psychiatry
- Department of Psychology
- Department of Radiation Oncology
- Department of Radiology
    - Diagnostic Radiology
    - Nuclear Medicine
    - Interventional Radiology
- Department of Surgery
    - Bariatric Surgery
    - Cardiothoracic Surgery
    - Dentistry and Oral Surgery (oral/maxillofacial)
    - General Surgery
    - Hand Surgery

- Neurosurgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pediatric Surgery
- Peripheral Vascular Surgery
- Plastic/Reconstructive Surgery
- Podiatry
- Trauma
- Urology

Section 2 - Organization of Departments

Each department shall be organized as a division of the staff as a whole and shall have a department head (designated Chair), who shall be responsible to the Chief of Staff, through the MEC, for the functioning of the department and shall have general supervision over the clinical work falling within his or her department, whether it be staff service or private. It shall be the privilege and duty of each Department Chair to confer with any member of the Professional Staff in any case or cases in which the welfare of the patient or the reputation of the medical center seems to him or her to require it. In case of the inability to reach a satisfactory conclusion, the matter shall be referred to the Chief of Staff for resolution who may, if he or she deems necessary, refer the matter to the MEC.

Each department shall elect a Vice Chair who shall have the duties and responsibilities of the Chair in his or her absence, and shall automatically succeed the chair if and when he/she fails to serve or is unable to serve for any reason.

Unless otherwise appointed, the Vice Chair of a Department shall act as the Quality/Patient Safety/Performance Improvement Chair for said department and shall be responsible for the oversight and conduct of performance improvement activities within the department.

Section 3 - Qualifications of Chairs/Vice Chairs of Departments and Medical Coordinators for Designated Specialty Areas

The Chairs and Vice Chairs of the Departments of Family Practice, Medicine, Obstetrics & Gynecology, Pediatrics, Psychiatry, Psychology, and Surgery shall be members of the Hurley Medical Center Active Staff, elected by members of their department, eligible as hereinbefore provided. They shall be Board Certified in their “core” specialty, and that Board Certification must be maintained for the duration of their term of office as Chair or Vice Chair. The Chairs and Vice Chairs of the Departments of Anesthesia, Emergency Medicine, Pathology, and Radiology may be appointed by the Professional Corporation of the Department after consultation and agreement with Hurley Medical Center’s Administration. Where the Board of Managers Constitution and Bylaws or exclusive contract provides for another method of election or appointment of the Chair or Vice Chair, the Bylaws or contract language shall supersede these Bylaws, as applicable. The Chair and Vice Chair shall be members of the Hurley Medical Center Active Staff With Vote, Board Certified in their “core” specialty, and that Board Certification must be maintained for the duration of their term of office as Chair or Vice Chair.

Medical Coordinators for designated specialty areas shall be members of the Hurley Medical Center Active Staff, elected by members of their department, eligible as hereinbefore provided. They shall be Board Certified within their specialty or Board Eligible/Admissible within the timeframe prescribed by their Specialty Board for obtaining/maintaining certification, and if there is a second specialty, the individual must be at least Board Eligible/Admissible in the second specialty. Board Certification/eligibility/admissibility must be maintained for the duration of their term of office as Medical Coordinator.

Section 4 - Manner of Election – Departmental Chairs, Vice Chairs, and Medical Coordinators for Designated Specialty Areas

Not earlier than September 1 and not later than November 30 of odd-numbered years, each clinical department and standing medical staff committee through their Voting Staff members, shall elect a Chair and Vice Chair of their respective department, and medical coordinators for designated specialty areas in their departments. Nominations may be made from the floor at that September or October departmental meeting, or submitted in writing no later than seven (7) days prior to that September or October departmental meeting, and vote shall be by ballot at the November departmental meeting. In the event a departmental meeting is not held in November, ballots will be submitted to the Medical Staff Office by a designated date and time in October or November, but shall be received no later than November 30th. Ballots received after this date and/or time shall be considered null and void. In the event a department is in default in exercising this privilege, it shall become the prerogative of the MEC to designate a Department Chair, Vice Chair, or Medical Coordinator for a designated specialty area. A position description complete with requisite duties, qualifications, skills and minimum requirements of the office shall be provided to the department prior to the submission of nominations. All nominees must meet the minimum specified requirements as specified in Article VII, Section 3 of these Bylaws and be deemed capable and competent to discharge the duties of the office to which they are nominated. Unless otherwise specified in these Bylaws, Chairs of the Standing Committees shall be elected in the same manner as described for Departmental Chairs, Vice Chairs, and Medical Coordinators.

Section 5 - Term of Office of Chairs, Vice Chairs, and Medical Coordinators for Designated Specialty Areas

The terms of the departmental chairs, vice chairs, and medical coordinators for designated specialty areas shall begin in January of the following calendar year and shall continue for a period of two (2) years.

Section 6 - Removal of Chairs, Vice Chairs, or Medical Coordinator for Designated Specialty Areas

Removal of a departmental chair, vice chair, or medical coordinator for a designated specialty area or Medical Staff Committee may be initiated by a majority vote of the active staff of his/her clinical department. This recommendation would then be acted upon by the MEC and by the Board of Hospital Managers. If the Chair, Vice Chair, or Medical Coordinator for a designated specialty area is removed, a new Chair, Vice Chair, or Medical Coordinator for a designated specialty area shall be selected by an election of that department and confirmed by the Board of Hospital Managers. Unless

otherwise specified in these Bylaws, Chairs of the standing committees shall be removed in the same manner as described for Departmental Chairs, Vice Chairs. The Chief of Staff reserves the privilege of removal of a Standing Committee Chair. This action requires approval of the MEC and Board of Hospital Managers as described above.

Section 7 - Duties of Chairs, Vice Chairs, and Medical Coordinators for Designated Specialty Areas

A **departmental chair** shall serve as a member of the MEC and be responsible for:

- all clinically related activities within their department;
- all administratively related activities within their department, unless otherwise provided for by the medical center;
- continuing surveillance of the professional performance of all individuals in their department who have delineated clinical privileges;
- recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided within their department;
- development and implementation of policies and procedures that guide and support the provision of services within their department;
- assessing and recommending to the relevant medical center authority off-site sources for needed patient care services not provided by the department or the organization;
- integration of the department or service into the primary function of the organization;
- coordination and integration of interdepartmental and intradepartmental services;
- recommendation for a sufficient number of qualified and competent persons to provide care or service;
- determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;
- continuous assessment and improvement of the quality of care and services provided;
- maintenance of quality control programs, as appropriate;
- orientation and continuing education of all persons in the department or service;
- recommendations for space and other resources needed by the department or service;
- implementing, within their department, actions recommended by the MEC;
- initiating corrective action, investigating clinical performance and ordering required consultations as may be appropriate/necessary;
- enforcement of the Professional Staff Bylaws, Policies and Procedures, and Rules and Regulations within their department;
- recommendations concerning initial appointment and classification, reappointment, delineation of privileges or corrective action to the MEC and to the Board of Hospital Managers;
- participating in budget planning and all other reasonable duties requested by the MEC, President and Chief Executive Officer, or the Board of Hospital Managers.

A **departmental vice chair** shall:

- be willing to discharge the function of the office of chair; act in the absence of the chair of the department and perform such other duties as may be requested by the chair;
- coordinate the quality management/performance improvement/patient safety program of the department (departmental quality management chair), except in those areas where this position is appointed/designated by the departmental chair.

A **medical coordinator for a designated specialty area** shall:

- be responsible for the general supervision of the clinical work within the area;
- assist in quality management, performance improvement, patient safety within the area;
- participate in the review of clinical privileges within the area and make recommendations with respect to clinical privileges to the department;
- organize meetings with other staff members assigned to his/her area, as may be needed, and report to the department when appropriate;
- be responsible for teaching, education, and research within his or her area.

Section 8 - Departmental Meetings

Each department shall conduct regularly scheduled business meetings to address departmental activities. The date, time, location and frequency of the meetings may be determined by each individual department; however, there shall be no less than six (6) meetings per year.

The departmental business meeting will be conducted by the Chair of the department. In his or her absence, the meeting will be conducted by the Vice Chair of the department, or his or her designee.

The departmental business meeting agenda may include, but is not limited to:

- complaints/requests from department members and others;
- patient care issues;
- requests for new equipment or new procedures;
- review of reports from quality assurance, utilization review, nursing, or other ancillary services;
- MEC recommendations for educational program;
- any other issues that may affect or be of interest to the department.

Minutes from each departmental business meeting will be submitted to the Chief of Staff prior to the next MEC meeting. Formal actions taken by the department are forwarded to the MEC for their approval.

Departmental business meetings where peer review activities are conducted as part of the peer review functions and activities of the Medical Staff shall be privileged and protected by MCLA 330.1143a, 333.531, 331.533, 333.20175, 333.21513. Provisions of the Health Care Quality Improvement Act and Patient Safety Act of 2007 shall apply to Departmental meetings as applicable.

ARTICLE VIII - RULES AND REGULATIONS, POLICIES AND PROCEDURES

The Rules and Regulations, Policies and Procedures are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and policies and procedures. In cases of documented need for an urgent amendment necessary to comply with law or regulation, the MEC may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the professional staff. In such cases, the professional staff will be immediately notified by the MEC and have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Professional Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the MEC and the Professional Staff shall be implemented. If necessary, a revised amendment will then be submitted to the Board of Managers for action and shall adopt such Rules and Regulations and Policies and Procedures as may be necessary for the proper conduct of the medical work in the medical center. Such rules and regulations and policies and procedures may be amended at any regular or special meeting of the Professional Staff, without previous notice, by a simple majority of the voting members present. Such rules and regulations, policies and procedures and such amendments shall be effective when approved by the Board of Hospital Managers. These Rules and Regulations and Policies and Procedures may not be unilaterally amended by the Professional Staff or by the Board of Hospital Managers.

Any significant changes to the Rules and Regulations, and/or Policies and Procedures will be communicated in writing to the Professional Staff members, and other individuals who have delineated membership or privileges.

ARTICLE IX - RULES FOR PROCEDURE

In all matters of procedure not otherwise provided for, Robert's Rules of Order shall be the recognized parliamentary authority.

ARTICLE X - AMENDMENTS

The Professional Staff adopts and amends the Professional Staff Bylaws, Rules & Regulations, and Policies & Procedures. The Bylaws may be considered for amendment by a petition signed by ten (10) or more members of the Active Staff With Vote forwarded to the MEC for recommended action. The MEC may at that meeting determine that the Chief of Staff shall schedule a special call meeting to vote on the amendment. In this instance, the special call meeting shall be scheduled within fourteen (14) days of the MEC action. If there is no special meeting, notice for voting shall be forwarded to the Medical Staff in writing within fourteen (14) days of the MEC session. Such notice shall include the recommended Bylaws amendments and a ballot. In the instance of a ballot vote, three (3) options shall be offered:

- yea
- nay
- request for Medical Staff meeting to discuss

If ten percent (10%) of the Active With Vote Staff vote to request a Medical Staff meeting, this shall constitute a petition and a special meeting shall be called in accordance with Article VI, Section 2 (a). The adoption of an amendment shall require a two-thirds (2/3) vote of the voting members present at the MEC meeting, or in the

instance of a ballot vote by the Medical Staff, a two-thirds (2/3) vote of those voting members returning their ballot. The amendments shall be effective when approved by the Board of Hospital Managers. Proposed Bylaws may also originate by the Board of Hospital Managers. These bylaws may not be unilaterally changed by the Board of Hospital Managers or the Professional Staff without approval from the other body.

Any proposed changes to the Professional Staff Bylaws, Rules and Regulations, and/or Policies and Procedures will be communicated in writing to the Professional Staff members, and other individuals who have delineated membership or privileges following the process indicated above.

ARTICLE XI - DUES AND ASSESSMENTS

Dues and assessments may be imposed by a vote of the Active Professional Staff for purposes to be determined by the Professional Staff. Such dues and assessments will be made to the Active, Affiliate, Courtesy, Consulting, and Provisional staffs. Failure to pay such staff dues and assessments shall result in loss of staff membership and/or privileges. Personal hardship cases will be individually reviewed by the MEC. Initial application, reappointment application, lost re-application documents and late application fees shall be imposed as recommended by the Professional Staff Credentials Committee and approved by the MEC. Failure for the responsible party to pay these assigned fees may result in non-appointment or reappointment. This shall be considered an incomplete application at the time of potential appointment and a voluntary resignation in the case of reappointment.

ARTICLE XII - PLEDGE AGAINST DISCRIMINATION

In accordance with the Civil Rights Act of 1964, the Professional Staff at Hurley Medical Center pledges non-discrimination in the granting of Professional Staff privileges on the basis of age, sex, race, political affiliation, disability as defined by the Americans With Disabilities Act, ethnic background, national origin, color or sexual orientation.

ARTICLE XIII - REVIEW OF BYLAWS

These Bylaws, Rules and Regulations shall be reviewed as necessary to determine compliance with current regulatory, accrediting and certification standards and that they conform to Bylaws of the Board of Hospital Managers.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF

POLICIES AND PROCEDURES FOR

CREDENTIALING/PRIVILEGING

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and policies & procedures, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

SECTION 1 - APPOINTMENT/REAPPOINTMENT/PRIVILEGES

1.1 - Procedure for Appointment

Except as provided in Section 1.2 New Privileges, Section 1.3 – Telemedicine, Section 1.4 – Temporary Privileges, and Section 1.5 – Disaster Emergency Privileges, which applications shall follow the respective processes outlined therein, applications for appointment/reappointment shall be processed in accordance with the procedure outlined herein. All applications for appointment to the Professional Staff shall be in writing, signed by the applicant, and submitted on a form as prescribed by the governing body. The application shall require detailed information concerning the applicant's professional qualifications and shall contain the name of at least three (3) persons who have knowledge of the applicant's professional competence and ethical character. One of the three (3) individuals must be a peer individual who currently has membership on the Professional Staff. The applicant will also be required to disclose:

- Whether they have ever been convicted of or pled guilty or nolo contendere to a felony or misdemeanor;
    - Where the applicant has a felony or misdemeanor history, timeframes as described in MCLA 333.20173a shall provide guidance.
- Whether they have ever received any type of sanction, or are currently under investigation by any hospital, or other professional healthcare organization;
- Whether their staff membership at any hospital or other professional healthcare organization was ever diminished, relinquished, suspended, or revoked, voluntarily or otherwise;
- Whether their clinical privileges at any hospital or professional healthcare organization were ever diminished, relinquished, suspended, or revoked, voluntarily or otherwise;
- Any relinquishment of licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise;
- Any previously successful, or pending challenges to any licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise;
- Any investigation, suspensions, or revocations of any licenses, registrations, licenses to practice, or controlled substance certificates in any state, district, or jurisdiction, voluntarily or otherwise;

- Whether they were subjected to any disciplinary action, such as imposition of consultation requirements, suspension/termination of staff membership, focus review or monitor of practice patterns by any professional healthcare organization;

- Whether they were subjected to any corrective action by any professional healthcare organization, such as restriction of admitting/clinical privileges, due to failure to complete medical records;

- Any health problems (illness or disability) which caused them to be away from their practice for more than two (2) weeks or which rendered them unable to care for their patients;

- In terms of professional liability actions, whether they have received any Notices of Intent to Sue; whether any Judgments have been rendered against them; whether there have been any settlements; and whether there are any cases pending. The application shall also require the applicant to disclose his present and prior professional insurance carriers and the limits of his present policy, with its expiration date. All new applicants shall be required to have/maintain professional liability insurance of not less than $200,000/$600,000;

- Collaborating and/or Supervisory Practice Agreements shall be provided for all Physician Assistants, Nurse Practitioners, Advanced Practice Nurses, Certified Registered Nurse Anesthetists, Limited Licensed Psychologists (LLP), Social Work Therapists, and Master's Level Counselors (LPC, et al);

- Certificate of Completion of Hurley's HIPAA (Health Insurance Portability and Accountability Act) learning module;

- Practitioner shall provide Hurley Medical Center with written notice immediately should any individual providing services pursuant to these Bylaws be subject to suspension, debarment or investigation regarding eligibility to participate in the Medicare and/or Medicaid Program.

The Medical Center may require an applicant to submit evidence that he or she is mentally and physically capable of carrying out the duties and responsibilities of staff membership.

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

The applicant shall release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to medical center representatives in response to their inquiry regarding the applicant's health, emotional stability, and other qualifications for staff appointment and clinical privileges.

The applicant shall authorize and consent to medical center representatives providing information to other hospitals, medical associations, licensing boards and other organizations, including information provided in accordance with the Health Care Quality Improvement Act of 1986, concerned with provider performance and quality,

appropriateness, and efficiency of patient care services rendered, with any information relevant to such matters concerning him or her, and releases medical center representatives from liability for so doing.

The application for membership shall be reviewed by the Professional Staff Credentials Committee. A departmental credentials committee or the Department Chair shall interview the applicant, if appropriate. The Department Chair or departmental credentials committee shall make a recommendation for appropriate clinical privileges based upon this review and/or interview, and the entire application shall be forwarded to the Professional Staff Credentials Committee.

The Professional Staff Credentials Committee shall investigate character, qualifications, and standings of the applicant. If the departmental chair or departmental credentials committee has not interviewed the applicant, the Professional Staff Credentials Committee may opt to require an interview. The Professional Staff Credentials Committee shall submit a report of their findings to the MEC. The MEC shall review the recommendations of the Professional Staff Credentials Committee and forward their recommendations, along with a copy of the recommendations of the Professional Staff Credentials Committee, to the Board Quality Management and Accreditation Committee, which will review the reports, findings, information from medical staff members and recommendations of the Credentials Committees and forward its reports, information and recommendations to the Board of Hospital Managers.

The Board of Hospital Managers may accept the recommendation of the MEC or refer it back for reconsideration. In the latter case, the Board of Hospital Managers shall instruct its Secretary to state the reasons for such action; and the MEC shall reconsider the application.

When the application has been acted upon favorably as outlined, the applicant will then be placed on the Provisional Staff for an initial period of one (1) year.

Should the MEC formulate a recommendation which, if ultimately ratified by the Board of Hospital Managers would be adverse to the applicant, the Chief of Staff shall immediately notify the applicant by notice as provided for in the "Fair Hearing Plan" referred to in Section 3.

1.2 - <u>New Privileges:</u>

All newly appointed practitioners and all existing practitioners who have been granted new privileges shall be subject to a period of focused professional practice evaluation. The evaluation period will be for a period not less than three (3) months and/or until five (5) procedures or six (6) admissions have been evaluated. If fewer than five (5) procedures or less than six (6) admissions have occurred during the three (3) months, the evaluation period may be renewed for additional periods not to exceed the eight month OPPE period. Practitioners who do not meet the FPPE requirements within eight months will be automatically advanced to ongoing monitoring with a mandated FPPE on any patient contacts until the minimum requirements have been met. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner’s evaluation for reappointment.

A period of focused review will be conducted for**:**

- ALL newly appointed practitioners
- ALL existing practitioners who have been granted NEW privileges

Focused Professional Practice Evaluation (FPPE) is a process whereby the hospital will evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at Hurley Medical Center.

1. The FPPE plan will be practitioner specific. It should include the general elements described for OPPE (ongoing practitioner practice evaluation) as well as the specialty-specific indicators identified in the Departmental Rules and Regulations and any special medical privilege criteria for those privileges, which he/she has been granted.
2. In the event that there is no peer available on staff or when a conflict of interest makes local peer review inadvisable, the medical staff will refer to an external peer reviewer.

3. One or more of the following elements will be utilized for each privilege:
    - Outcomes
    - Complications
    - readmissions
    - quality of documentation
    - returns to the Operating Room
    - unplanned readmissions

4. Methods for evaluation may include:
    - chart review
    - direct observation
    - statistical review
    - proctoring

1.3 - <u>Telemedicine Privileges</u>

Telemedicine privileges may be granted by relying on a distant-site hospital or telemedicine entity's credentialing/privileging process <u>only</u> under the following circumstances:

1) The distant-site hospital is a Medicare-participating hospital/Joint Commission Accredited or Compliant Hospital and has a written agreement, which includes Peer Review disclosure and protection provisions, with Hurley Medical Center for the provision of telemedicine services.

2) The distant-site hospital provides a current list of the distant-site physician or practitioner's privileges at the distant site hospital.

3) The distant-site telemedicine entity, through a written agreement, which includes Peer Review disclosure and protection provisions, with Hurley Medical Center for the provision of telemedicine services, provides services that comply with 42 CFR 482.12(e) and that permit Hurley Medical Center to comply with the applicable Medicare Conditions of Participation for contracted services.

4) The distant-site telemedicine entity's medical staff credentialing/privileging process and standards meet, at a minimum, the standards of 42 CFR 482.12(a)(1) through (a)(7) and 42 CFR 482.22(a)(1) through (a)(2).

5) The individual physician or practitioner providing telemedicine services is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services.

6) The distant-site physician or practitioner holds a license issued or recognized by the State of Michigan.

7) For distant-site telemedicine physician or practitioners granted privileges and providing telemedicine, Hurley Medical Center conducts internal reviews of his/her performance of those privileges and sends to the distant-site hospital or telemedicine entity such performance information ofr its use in the performance appraisal of the distant-site physician or practitioner. The information so provided must include, a minimum, all adverse events that have resulted from the telemedicine services provided by the distant-site physician or practitioner to Hurley Medical Center's patients and any complaints Hurley Medical Center has received about the distant-site physician or practitioner.

1.4 - Temporary Privileges

The Chief Executive Officer (CEO), or designee, may grant temporary privileges upon recommendation of either the applicable department chair, president of the medical staff, or other authorized medical staff officer. Such privileges may be granted only to fulfill an important patient care need.

Requests for temporary privileges will be in writing and state the circumstances of urgent patient care need. If one is found to be present, a note or record will be made reflecting the circumstances warranting a consideration of the request. Background checks, to be queried regarding the practitioner prior to the recommendation for being eligible for the granting of temporary privileges, shall include, but not be limited to:

- Current or pending license to practice within the state
- Relevant training or experience
- Current competence
- Ability to perform privileges requested
- Malpractice insurance
- Freedom from prior disciplinary actions by any healthcare-related organization
- Freedom from prior criminal conviction
- Absence of a pattern of malpractice suits raising concern about competence

- Freedom from current sanction by a branch of the federal or state government.
- In all cases, the CEO or designee may not grant temporary privileges unless all necessary information has been verified using these sources, but not limited to:
    - National Practitioner Data Bank
    - Michigan Department of Community Health – "Verify a License" (http://www.dleg.state.mi.us/free/)
    - Federation of state medical boards (electronic service)
    - American Medical Association (AMA) or American Osteopathic Association (AOA) Masterfile (electronic or fax service)
    - Office of Inspector General cumulative sanctions report (electronic service)
    - American Board of Medical Specialists or AOA verification of board status (if applicable)
    - Telephone or written references from at least three (3) individuals who have first-hand knowledge of the applicant's clinical abilities (at least one (1) of whom must have been identified by Hurley Medical Center or be a member of the medical staff at Hurley Medical Center)
    - Telephonic or written confirmation of past practice (when the applicant has a very extensive history of past practices, the institution will ask about most recent practices)

Under no circumstances will the CEO or designee grant temporary privileges for more than thirty (30) days without a written record of the pressing community or patient care need to be met by such action. A single thirty (30) day extension of temporary privileges will be permitted. Under no circumstances will any practitioner provide service under temporary privileges for more than sixty (60) days.

Temporary privileges will not be permitted in circumstances of an incomplete application or necessary incomplete verifications, performance data and other required information. Temporary privileges will not be granted until the applicant has agreed in writing to abide by the institution's Professional Staff Bylaws, Policies and Procedures and Rules and Regulations.

All grants of temporary privilege will automatically expire at the end of the time period for which they were granted. The practitioner shall be informed at least two (2) weeks in advance and advised to make other arrangements for his or her patients currently in the medical center or in need of hospitalization should it be anticipated that the temporary privileges will expire and the requisite information or processes for initial privileges have not been completed.

Unless otherwise required by state or federal regulations or statute, or medical staff bylaws or policies, denial of a request for temporary privilege or natural termination of existing temporary privileges will not give rise to the Fair Hearing Plan. (Formal denial of a request for appointment or privileges or termination of existing appointment or privileges will trigger the provisions of the Fair Hearing Plan, unless otherwise specified in the Fair Hearing Plan.)

Upon receipt of a written request, an appropriately licensed practitioner who is not an applicant for membership may be granted temporary privileges for the care of one (1) or more specific patients provided he or she supplies the following: The practitioner must submit evidence of current licensure, insurance, as well as training and current

competence, verified through recommendations. Temporary privileges shall not be granted to a practitioner for the care of more than six (6) patients in any calendar year.

1.5 - Disaster Emergency Privileges

In the event the emergency management disaster plan is activated, and the need for additional assistance in meeting patient care has been identified by the Chief Executive Officer/designee or Chief of Staff/designee, the medical center policy regarding the granting of disaster emergency privileges to medical staff personnel meeting this requirement or needs of the disaster emergency will be enacted.

The individual responsible for the administration of this policy shall be the Chief Executive Officer/Chief of Staff or their designee.

In addition to a valid government-issued photo identification (i.e driver's license or passport), at least **one** (1) of the following must be produced for an individual to be considered eligible to function as a volunteer licensed independent practitioner (LIP) through emergency disaster privileging:

- Primary source verification of licensure
- Photo identification card from a health organization that clearly identifies professional designation.
- Presentation and confirmation by a current medical center or medical staff member with personal knowledge regarding practitioner's identity and ability to act as a licensed independent practitioner during a disaster.
- Identification and verification that the individual is a member of a Disaster Medical Assistance Team (DMAT), **if appropriate**
- Identification and verification that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances

The individual will be identified as a volunteer physician by the presence of their own medical center ID badge as well as a Special Visitor badge secured from the Medical Center.

The emergency disaster privilege practitioner shall also agree to practice only under the direction of an existing member of the medical staff. The emergency medical staff applicant shall be paired with a current medical staff member from whom he/she will receive DIRECT supervision. A Disaster Emergency Physician shall be appropriately supervised at all times. Upon discontinuation of the need for additional assistance in meeting patient care (as determined by the CEO/Chief of Staff or designee), regardless of the continuation of the disaster/emergency, the emergency privileges granted to the practitioner pursuant to the policy shall expire.

1.6 - Clinical Privileges

Every member of the Professional Staff at Hurley Medical Center shall be granted specific clinical privileges.

Every initial application for staff appointment must contain a request for specific clinical privileges. The evaluation of such requests shall be based on the applicant's

education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications and current competence in the clinical privileges he or she requests.

Biennial redetermination of clinical privileges and the increase or curtailment of same shall be done in the same manner as described in Section 1.4.

Requests for additional clinical privileges must be in writing and state the type of privilege desired and the applicant's relevant recent training and/or experience. Such requests shall be processed in the same manner as requests for initial clinical privileges.

Clinical privileges for dentists, psychologists, podiatrists and nurse midwives shall be as described in their individual department rules and regulations.

1.7 - Procedures for Ongoing Professional Practice Evaluation (OPPE) and Reappointment

All practitioners are required to participate in Ongoing Professional Practice Evaluation (OPPE) as a means of assessing the practitioner's clinical competence and professional behavior. The OPPE Cycle will occur every eight (8) months. Information resulting from the OPPE will be used to determine whether to continue, limit, or revoke any existing privileges or initiate a problem specific focused review.

If during the OPPE review, a practitioner has been identified as requiring further monitoring, the practitioner will be required to undergo a FPPE to further assess current competence as defined in the FPPE Policy.

At the end of the Staff Term, as defined in Article II, Section 3 A, of the Bylaws, Staff members will be required to reapply for renewal of their staff membership and clinical privileges.

The "Application for Reappointment to the Professional Staff" will be mailed to all members whose appointment is scheduled to expire, showing pertinent information currently on file. Staff members will be required to update the information and the clinical privileges and return the reappointment form to the medical center in a timely fashion. Staff members who fail to apply for reappointment to the staff shall be considered to have resigned and in so doing will waive the right of hearing and appeal as outlined in the Fair Hearing Plan.

October 1st of the reappointing year shall be considered the deadline for receipt of all requested information from the applicant. After this date, there will be no further attempts to collect this information from the applicant by the Medical Staff Office.

Staff members who apply for reappointment or at any time during their appointment period shall be obligated to report immediately, whether since their last application:

- they received any felony or misdemeanor convictions or plead guilty or nolo contendere to a felony or misdemeanor. (Lapsed timeframe in accordance with law, shall prevail.)
- they received any type of sanction, or are currently under investigation by any hospital or other professional healthcare organization;
- their staff membership at any hospital or other professional healthcare organization was diminished, relinquished, suspended, or revoked, voluntarily or otherwise;
- their clinical privileges at any hospital or other professional healthcare organization were diminished, relinquished, suspended, or revoked, voluntarily or otherwise in accordance with law;
- there was any relinquishment of licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise.
- there were any previously successful, or are any pending challenges to any licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise;
- there were any investigations, suspensions, or revocations of licenses, registrations, licenses to practice, or controlled substance certificates in any state, district, or jurisdiction, voluntarily or otherwise;
- they were subjected to any disciplinary action, such as imposition of consultation requirements, suspension or termination of staff membership, focus review or monitor of practice patterns by any professional healthcare organization;
- they were subjected to any corrective action by any professional Healthcare organization, such as restriction of admitting and/or clinical privileges, due to failure to complete medical records;
- they had any health problems (illness or disability) which caused them to be away from their practice for more than two (2) weeks or which rendered them unable to care for their patients;
- they received (in terms of professional liability actions) any notices of Intent to sue; had any judgments rendered against them, including final judgments/settlements; and whether there are any cases pending;
- Collaborating and/or Supervisory Practice Agreements shall be provided for all Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists, Limited Licensed Psychologists (LLP), Social Work Therapists, and Master's Level Counselors (LPC, et al);
- Certificate of Completion of Hurley's HIPAA (Health Insurance Portability and Accountability Act) learning module

Practitioners shall provide Hurley Medical Center with written notice immediately should any individual providing services pursuant to the Hurley Professional Staff Bylaws be subject to suspension, debarment or investigation regarding eligibility to participate in the Medicare and/or Medicaid Program.

Information, as part of Ongoing Professional Practice Evaluation (OPPE), will be gathered from all pertinent sources, such as but not limited to:

- Performance Improvement Committees
- Blood Utilization Review, if available

- Drug Utilization Review
- Medical Records Review
- Utilization Review
- Patient Clinical Information System Usage
- National Practitioner Data Bank
- professional license verification
- any other source that will assist in completing a profile of the staff member's hospital practice, including a profile of procedures performed, and current competence for the privileges requested.
- Patient complaint data
- Malpractice claims

The information will be forwarded to the departmental credentials committee who shall review the information and make a recommendation to the Professional Staff Credentials Committee regarding the renewal of the appointment, renewal of clinical privileges, and staff category. The Professional Staff Credentials Committee will review the information submitted from the department and transmit its recommendation to the MEC and to the Board of Hospital Managers.

A recommendation to deny or limit (shorten) reappointment shall be considered and may be made for any of the following:

- Failure to abide by the Bylaws, Rules and Regulations of the staff, including failure to complete patient's medical records in a timely manner.
- Conduct disruptive to the proper operation of the medical center;
- Any felony conviction (with timeframe considerations in accordance with law.)
- Professional inadequacies demonstrated during the preceding staff year(s), such as, but not limited to:
    - Patient neglect;
    - Inadequate and/or inappropriate work-up;
    - Inadequate and/or inappropriate treatment for which he or she is not adequately prepared or trained to perform;
    - Unnecessary admissions
    - Unjustified length of hospital stay
    - Evidence of continued and/or repeated courses of treatment that are inadequate or inappropriate according to the standards of the profession in the community;
    - Physical and/or mental disability which affects or tends to affect the practitioner's ability to practice his or her profession
    - Malpractice settled judgments aggregate greater than three (3) in a two (2) year period or five (5) in a period greater than or equal to a five (5) year period
    - Malpractice settled judgments aggregate threshold of greater than $400,000 in a two (2) year period or an amount equal to or greater than $1 Million in a five (5) year period.

Any staff member who is absent from his or her practice for more than thirty (30) consecutive business days because of illness or impairment will be required to submit evidence that he/she is mentally and physically fit to carry out the obligations of staff membership before resuming hospital privileges. An

evaluation/recommendation regarding his/her current health status may be requested by the Chief of Staff, a Staff Officer, the Chief Executive Officer, Chief Quality Officer, Chief Medical Officer, or department chair. The Medical Center and/or Medical Staff Office reserves the right to request an independent medical evaluation to determine fitness to perform privileges as requested prior to resuming patient care activities in the hospital system. Submission of evidence alone that the practitioner is mentally or physically fit shall not entitle the practitioner to resumption of hospital system based activity.

The Professional Staff Credentials Committee shall make written recommendations to the MEC concerning the reappointment and/or renewal of clinical privileges for each staff member being considered. The MEC shall review the recommendations of the Professional Staff Credentials Committee and forward their recommendations, findings, information from medical staff members and Credential Committees reports to the Board Quality Management and Accreditation Committee, which reviews the reports, information and recommendations and forwards its reports, information and recommendations to the Board of Hospital Managers. When non-reappointment and/or non-renewal or reduction of clinical privileges is recommended, the reasons for such recommendations shall be documented in writing. In no case shall this report be delayed for more than three (3) months after the MEC has forwarded its recommendations to the Board of Hospital Managers.

If the Department Credentials Committee or the Professional Staff Credentials Committee, in the process of reviewing the staff member's activity, determines that his or her practice patterns or behavior do not meet the standards of the profession, they may recommend that steps be taken to correct the situation. They may recommend:

1. Counseling by the departmental chair or departmental Performance Improvement Committee
2. A letter of admonition or reprimand
3. A letter of warning
4. Imposition of probationary status or assignment of monitors to closely evaluate his or her practice for a specified period of time
5. Non-reappointment

In any case where the above is recommended (1, 2, 3 or 5), or a reduction in clinical privileges is recommended, the staff member concerned shall have the opportunity of appeal, in accordance with the Fair Hearing Plan appended hereto.

1.8 - **Continuing Education Requirements**

Upon request, all staff members at Hurley Medical Center shall be required to show evidence of having attained continuing education in approved programs each calendar year upon request, and designate that they are in pursuit of credits, in accordance with State licensure requirements.

All staff members are required to maintain continuing education credits that relate in part to: patient care, medical/clinical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and/or systems based practice.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF

POLICIES AND PROCEDURES FOR

DISCIPLINE OR CORRECTIVE ACTION

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and policies & procedures, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

Section 2 – Discipline or Corrective Action

2.1 - Corrective Action

Whenever the activities or professional conduct of any staff member with clinical privileges is considered to be beneath the standards of the Professional Staff or are considered to be disruptive to the operations of the medical center, corrective action against said staff member may be requested by: Any officer of the Professional Staff, the chairperson of any clinical department, the chairperson of any standing committee of the Professional Staff, the President & CEO, Chief Quality Officer, Chief Medical Officer, or by the Board of Hospital Managers.

All reports of misconduct shall be in writing and shall be supported by reference to the specific activities or conduct that constitute the grounds for requesting the corrective action.

Whenever the MEC has directly received and considered such a request, the MEC shall forward it to the Chief of Staff's office.

The Physician Code of Conduct Policy (Standard Practice 0175) shall be followed.

When the complaint is addressed by the Conduct and Procedures Committee, the staff member shall have an opportunity for an interview with the Conduct and Procedures Committee. Prior to, and at such interview, he/she shall be informed as to the nature of the concerns. At such interview, he/she shall be informed of the concerns, and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be considered preliminary in nature, and none of the provisions of the Fair Hearing Plan shall apply. A record of this interview shall be made by the committee. The Conduct and Procedures Committee shall, within fifteen (15) days of completion of the investigation, send a recommendation to the MEC if recommendation is anything greater than counseling or verbal reprimand. In instances where the recommendation is counseling or verbal reprimand, the Chair of the Conduct and Procedures Committee, the Chief of Staff, Chief Quality Officer, or Chief Medical Officer (or designees) will provide the recommendation to the MEC. The recommendation of the Conduct and Procedures Committee may be:

- to reject or modify the request for corrective action;
- to issue a warning
- to issue a letter of admonition or a letter of reprimand;
- to recommend terms of probation or a requirement for the assignment of monitors to review the staff member's work for a specified period of time, or imposition of proctoring;
- recommendation for suspension or revocation of clinical privileges (individually or in toto);

- recommendation for revocation or suspension of staff membership; that a previously imposed summary suspension be terminated, modified or sustained.

A staff member against whom a complaint has been made or has been the subject of a Conduct and Procedures action may request an appearance before the MEC prior to the MEC action on the recommendation of the Conduct and Procedures Committee. The action of the Conduct and Procedures committee recommendation will be considered at the next regularly scheduled meeting of the MEC, unless the recommendation is anything greater than counseling or reprimand. In the event the recommendation is greater than counseling or reprimand, the affected practitioner shall be entitled to request that the MEC hold a hearing on the matter within ten (10) days. If the Conduct and Procedures committee recommends a summary suspension of the practitioner's privileges, the practitioner has ten (10) calendar days from the date of notice to request an appearance before the MEC. Upon receipt of said notice, the Medical Executive Committee must be convened within ten (10) calendar days of request by the practitioner.

The affected member may attend the special or regular meeting to provide any information necessary and pertinent to the deliberation of the MEC in the instance of the summary suspension. If, at the time of the MEC meeting (special or regular), the MEC recommends reduction, suspension or revocation of clinical privileges, or suspension from the Professional Staff, the staff member involved shall be entitled to request an appeal, as provided in the Fair Hearing Plan. A notice of recommendation shall be provided to the affected practitioner immediately following the MEC's meeting, outlining the following:

- statement of proposed action
- brief statement of facts, findings on which the action is recommended
- recommendations the practitioner must fulfill, if applicable
- any requirements of compliance, if applicable
- statement of Fair Hearing rights and process
- statement that affected practitioner must notify the President/CEO, in writing, within 30 days of receipt of the notice of recommendation of his/her desire for a Fair Hearing.

At its discretion, the MEC may modify or reject the Conduct and Procedures Committee's recommendation and select any one of the actions below:

- to reject or modify the request for corrective action;
- to issue a warning
- to issue a letter of admonition or a letter of reprimand;
- to recommend terms of probation or a requirement for the assignment of monitors to review the staff member's work for a specified period of time, or imposition of proctoring;
- to require counseling, specific program participation (i.e. CME or anger management), evaluation and treatment;
- recommendation for suspension or revocation of clinical privileges (individually or in toto);

- recommendation for revocation or suspension of staff membership;
  that a previously imposed summary suspension be terminated, modified or sustained.

All notices to staff members whose privileges are affected shall be sent Certified Mail, Return Receipt Requested or personal service. Records reflecting the date of service shall be maintained.

Failure of a practitioner to comply with requests by a peer or person designated within the Professional Staff Bylaws, Policies and Procedures, Rules and Regulations or Hurley Medical Center Standard Practice or any of the following instances will result in a Summary Suspension of the practitioner:

- physical or behavioral health evaluation
- submission of bodily fluid or tissue samples for evaluation (in connection with a Professional Staff Member Well-Being referral),
- noncompliance with committee recommendations for evaluation or treatment,
- refusal to comply with a corrective action recommendation (as described in this Section or in conformance with a Professional Staff Member Well-Being referral/investigation.

The affected practitioner must agree to the recommended plan of the committee and consent to communication with the Chief Quality Officer, Chief Medical Officer, Chief of Staff, and/or Chair of the Well-Being Committee from the person treating the practitioner. Failure of the member to agree to these parameters will result in an Automatic Suspension.

2.2 - <u>Summary Suspension</u>

The ranking officer of the MEC, the chair of a clinical department, the President & CEO, the Chief Quality Officer or Chief Medical Officer shall have the authority, in urgent situations where a Practitioner's conduct poses a realistic or a recognizable threat to patient care or safety which requires immediate action, to summarily suspend any or all of the clinical privileges of a staff member. This summary suspension shall be immediately effective.

The staff officer or the departmental chair involved shall make necessary arrangements to provide for proper and necessary patient care during the period of suspension. The suspended staff member is expected to confer with the staff member who has been designated to replace him or her as considered necessary for the safeguard of the suspended staff member's patients.

Any staff member whose privileges have been summarily suspended shall be entitled to request that the MEC hold a hearing on the matter within ten (10) days. Subsequent to this notice, the MEC shall convene within 10 days of this notice to consider the action. Otherwise, the action will be considered at the next regularly scheduled Medical Executive Committee meeting. The affected member may attend the special or regular meeting to provide any information necessary and pertinent to the deliberation of the MEC in the instance of the summary suspension. If , at the time of the MEC meeting (special or regular), the MEC recommends the continuation of the summary suspension, the staff member involved shall be entitled to request an appeal, as provided in the Fair

Hearing Plan. A notice of recommendation shall be provided to the affected practitioner outlining the following:

- indication of proposed action
- brief statement of facts, findings on which the action is recommended
- recommendations the practitioner must fulfill, if applicable
- any requirements of compliance, if applicable
- statement of fair hearing rights and process
- statement that affected practitioner must notify the President/CEO, in writing, within 30 days of receipt of the notice of recommendation of his/her desire for a Fair Hearing.

The terms of the summary suspension, as recommended by the MEC, shall remain in effect pending a final decision by the Board of Hospital Managers.

All notices to staff members whose privileges are affected shall be sent Certified Mail, Return Receipt Requested or personal service. Records reflecting the date of service shall be maintained.

2.3 - <u>Automatic Suspension</u>

A temporary automatic suspension, in the form of withdrawal of a staff member's admitting privileges, his or her right to exercise clinical privileges previously granted, and his or her right to render consultation services, shall be imposed for any of the following reasons:

- Failure to complete patient medical records within twenty eight (28) days following the discharge of a patient;
- Failure to complete an admitting history and physical within twenty-four (24) Hours of admission or prior to surgery;
- Failure to complete any operative report immediately following surgery;
- Failure to respond to a request for information from hospital committees or Executive Office within a period of time specified;
- Notification from the State Board of Licensing and Regulation that his/her license has been suspended, or that he/she has been placed on probation by that body.
- Conviction of any felony or conviction of a misdemeanor involving the practice of medicine or healthcare.
- Failure to request reinstatement as provided in 2.4 below

Any temporary automatic suspension, as specified above, which extends beyond sixty (60) calendar days, will become permanent after recommendation by the MEC and ratification by the Board of Hospital Managers.

A staff member whose privileges are forfeited in this manner is not entitled to a hearing or appeal otherwise provided under the Hurley Professional Staff Bylaws and may have the right to reapply.

2.4 - Leave of Absence

A member of the Professional Staff may request, in writing, a leave of absence. The leave of absence may not exceed the length of time of his or her current appointment. If the leave of absence exceeds the term of the current appointment, he or she may reapply through normal channels for reappointment to the staff. During the period of leave, the Practitioner shall not exercise clinical privileges at the medical center, and membership prerogatives and responsibilities shall be in abeyance.

If the Leave of Absence extends past the current appointment time period, the staff member shall be considered to have voluntarily resigned. Upon desire to reinstate membership and privileges, the former staff member may reapply through normal channels for reappointment.

A staff member who has been granted a Leave of Absence shall, at least forty-five (45) days before he or she intends to return to his or her practice in the hospital or one of its affiliate organizations, request reinstatement to the staff. The staff member shall submit a written summary of his or her relevant education and or activities during the period of the leave of absence. Should the Leave of Absence extend beyond a normal OPPE period (8 months), in addition to the specifications already established in the Bylaws, the practitioner will need to undergo a period of focused review (FPPE) upon reinstatement. The Professional Staff Credentials Committee shall review the information and make a recommendation to the MEC and Board of Hospital Managers concerning the reinstatement of the staff member's membership and privileges. Failure to request reinstatement or to provide the requested summary of activities shall result in automatic termination of Staff membership without a right of hearing or appeal. A request for Staff membership subsequently received from a Staff member so terminated shall be submitted and processed in the same manner as applications for initial appointment.

2.5 - Medico-administrative Positions

Physicians, dentists, psychologists, podiatrists or nurse midwives employed by the medical center in an administrative capacity, whose duties involve clinical responsibilities, shall be required to obtain and maintain staff membership unless otherwise indicated in the Professional Staff Bylaws or Hurley Medical Center Bylaws. Any physician, dentist, psychologist, podiatrist, or nurse midwife so employed by the medical center shall not have his or her Professional Staff membership terminated without the same due process provided in the Fair Hearing Plan.

Termination of his or her medico-administrative duties shall not in and of itself affect his or her status as a Professional Staff member.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF

POLICIES AND PROCEDURES FOR

FAIR HEARING

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and policies & procedures, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

SECTION 3 – FAIR HEARING PLAN

3.1 Notice of Intended Action

When a Professional or Allied Health Staff member receives a Notice of Recommendation that, if ultimately ratified by decision of the Board of Hospital Managers, will adversely affect his or her appointment to, or status as, a member of the Professional or Allied Health Staff, or his or her exercise of clinical privileges, he or she shall, upon request made within thirty (30) days of the receipt of Notice of Recommendation, be entitled to request a hearing before a hearing officer or panel appointed by the Board of Hospital Managers. Such Notice of Recommendation shall state:

- That professional review action has been proposed to be taken against the staff member.
- The reasons for the proposed action.
- That the staff member has the right to request a hearing.
- That the staff member has thirty (30) days from the date of notice sent to request a hearing.
- A summary of rights at the hearing:
  - right to representation (by attorney or otherwise)
  - right to have a record made of the proceedings and receive a copy upon payment of reasonable charges
  - right to call, examine and cross-examine witnesses – live and through deposition hearing
    - testimony is limited to a maximum of eight (8) hours unless more live testimony is deemed essential to a meaningful hearing, at the sole discretion of the hearing officer; however, deposition testimony, relevant to the subject matter of the hearing, may be taken and submitted to the hearing panel
  - right to present relevant evidence, whether admissible in court or not
  - right to submit a written statement at the close of the hearing
  - right to receive the written recommendations of the hearing panel or officer including the basis for recommendation
  - right to receive a written decision with a statement of the basis for such from the Board of Hospital Managers

3.1.2 Notice of Recommendation

The Notice of Recommendation shall be served by Certified Mail, Return Receipt Requested, or personal service. Records reflecting the date of service shall be maintained.

3.2 Response to Notification

In the event such staff member desires a hearing before a hearing officer or panel appointed by the Board of Hospital Managers, as provided in Section 3.1, above, the staff member shall notify the President & CEO of his or her desire for a Hearing, in writing, within thirty (30) days of receipt of the Notice of Recommendation that his or her appointment to, or status as a member of the Professional Staff, or his or her exercise of clinical privileges may be adversely affected.

3.3 Scheduling of Hearing

Upon receipt of notice of request for hearing, as provided in Section 3.2, the President & CEO shall within thirty (30) calendar days from the date of notice of request, schedule a hearing before a hearing officer or panel appointed by the Board of Hospital Managers and notify the staff member in writing of the date, time and place of such hearing at least ten (10) days before such hearing.

The Notice of Hearing shall include a list of witnesses expected to testify on behalf of the recommending body, and shall be served by Certified Mail, Return Receipt Requested, or personal service.

3.4 Hearing Rights

At such hearing the affected staff member shall be entitled to the following rights:

- Right to representation (by attorney or otherwise)
- Right to have a record made of the proceedings and receive a copy upon payment of reasonable charges
- Right to call, examine and cross-examine witnesses
  Live hearing testimony is limited to a maximum of eight (8) hours unless more live testimony is deemed essential to a meaningful hearing, at the sole discretion of the hearing officer; however, deposition testimony, relevant to the subject matter of the hearing, may be taken and submitted to the hearing panel
- Right to submit a written statement at the close of the hearing
- Right to receive the written recommendations of the hearing panel or officer including the basis for recommendation
- Right to receive a written decision with a statement of the basis for it from the Board of Hospital Managers**.**

3.5 Hearing Officer

The hearing officer or panel shall preside at such hearing and shall determine the order or procedure and shall assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The hearing officer or panel shall determine the relevance of evidence for purposes of its admissibility. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or representation of evidence.

3.6 Decision by Board of Hospital Managers

Upon completion of the hearing, the Board of Hospital Managers shall, within fourteen (14) calendar days, consider the matter before them and render its decision. The Board of Hospital Managers shall cause a copy of their official action, which shall include its decision and the basis for it, to be served on the affected staff member, in writing, by Certified Mail, Return Receipt Requested, or by personal service.

3.7 Failure by Staff Member
Nothing contained herein shall diminish or otherwise affect the application or effect of Article 2.2, Sections a, b, and c. The failure of the affected staff member to request the hearing provided for, within the time limits provided for, shall constitute a waiver of his or her right to such hearing. The failure of the affected staff member to appear at the requested hearing without good cause shall constitute a waiver of his or her right to such hearing.

3.8 Hearing Officer or Panel
The Board of Hospital Managers has the discretion to select either a hearing officer or panel for the fair hearing. The hearing officer or panel selected by the Board of Hospital Managers shall not include persons in direct economic competition or interest with the affected staff member. The hearing panel shall be selected from a pool of medical staff members identified by the Professional Staff as being willing to serve in that capacity. When necessary, due to inability to identify Hurley Medical Center Professional Staff members consistent with Subsection 3.8C, members of the panel may be selected from persons who are not members of Hurley Medical Center's Professional Staff but who are licensed practitioners. The panel shall be composed of an odd number of members, but not greater than seven (7). The hearing officer shall be a person with the necessary background and experience to assure adequate due process for the affected staff member.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF

GENERAL RULES AND REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and policies & procedures, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

SECTION 1 - GENERAL RULES AND REGULATIONS

I. CONSULTATIONS

Required Consultations

Chairs of any department may, whenever they deem it necessary, require any member of their department to obtain a consultation. Consultations should be obtained when requested by a patient or their guardian or legal representative, where appropriate, or when services needed are outside of the attending's clinical privileges.

Except in an emergency, consultation with another qualified physician is required in:

- Amputations above the mid-metacarpal/tarsal level
- Cases in which, according to the judgment of the physician or dentist
    - Patient is not a good risk for operation or treatment
    - Diagnosis is obscure
    - There is doubt as to the best therapeutic measures to be utilized
    - All cases of critical illnesses or severe complications
    - Cases when services needed are outside of the attending's clinical privileges
    - All premature infants (not under the care of a neonatologist)
        - Under four (4) pounds
        - Suffering from infections
        - Those who fail to gain in one (1) week
        - Obstetric care, pregnancy evaluation and ongoing care (for non-privileged obstetricians)

Consultants

Consultants must be well qualified to render an opinion in the field in which their opinion is sought. Consideration should be given to the consultant's training, experience, and competence.

Essentials of a Consultation

A consultation report shall be completed within the timeframes specified for consultation. If the consultation report is dictated, a written consultation response including the consultant's impression and plan of treatment must be documented in the Consultation Record.

Consultation Types – Consultations will be three (3) types:

EMERGENT/STAT, URGENT and ROUTINE.

- **Urgent** consults shall be expected to be done as soon as possible, but not greater than twelve (12) hours. When writing orders for emergent or urgently needed consultation on seriously ill patients, the provider, as specified in the

bylaws, **must** contact the consultant to ascertain his/her availability and to explain the urgent nature of the patient.

- **Routine** consults shall be expected to be done within a 24 (twenty-four) hour period.

Consultation Categories

The attending physician must specify on the patient chart which of the three (3) following consultation categories is applicable:

- Consult only (examine the patient and provide an opinion and advice);
- Consult and assume care of the patient; or
- Consult and assist in the management of the illness.

Note: When writing a consult or management order, identify the name of the physician to perform the service rather than the physician group to which they belong (i.e. GI, Pulmonary).

Note: If the category is not designated, the default shall be "consult and assist" in management of the illness.

Consultations shall be legibly handwritten or dictated.

Consultation content shall include:

- Date and time of reply
- Notation that the patient was examined and/or medical record reviewed
- Salient findings of the reason for consultation, history and physical findings
- Consultation, when indicated, must be recorded prior to surgery
- Psychology and Psychiatry consultation findings must include mental status examination (MSE), suicidality/homicidality assessment, a diagnosis according to DSM-IVR or DSM-IV criteria
- Impression
- Recommendation
- Authentication (signature)
    - The document must be signed, dated and timed by the author or his legal partner (printed, followed by the signature), or if written/dictated by a medical student or resident, must also be signed, dated and timed by the attending/supervising physician (printed, followed by the signature).

Note: When a full consultation report is dictated, a brief written Consultation shall be documented on the Consultation Record immediately following examination and shall include: presumptive diagnosis(es), pertinent findings and recommendations.

II. ORDERS AND ORDER SETS

A. Departmental order sets (DOS) or order sets as approved by the Department or MEC are acceptable. These order sets should be reviewed on a periodic basis, at least biennially.

B. Where selections or choices in the standing orders exist, the practitioner must specify which selection. The practitioner may not leave the choice to the Nurse or other non-Medical Staff or GME credentialed practitioner with an appropriate privilege to enact.

C. Standing orders (personal order sets [POS]) are prohibited, except as approved by individual medical departments and/or the MEC. These order sets must be reviewed at each reappointment period. Failure to review and renew these order sets in proximity to reappointment shall inactivate order set use.

   Use of a "favorites listing" where the orders most frequently used by the practitioner/department are presented to the medical staff member for selecting or building patient specific orders, are NOT the same as Standing Orders, Personal Order Sets, or Departmental Order Sets. This favorites listing does not require periodic review

D. Recommended changes to order sets related to formulary medications, industry availability, drug indication, and safe medical practice may be made subsequent to review by the P&T Committee and approved by the MEC and direct notification to the physician.

E. Protocol orders for Nursing/Patient Care Services

   a. To facilitate patient care, a specific set of orders that define physician directed or physician approved orders to follow (i.e. xray post PICC line insertion, hypoglycemia protocol, PTT/platelet laboratory evaluation post heparin change, SCD placement post surgery) must be approved by the Medical Executive Committee and reviewed on an periodic basis, at least biennially.
   b. These orders may be reviewed by any other committee or department in the medical center, but must ultimately be approved by the Medical Executive Committee.

F. Delegated Orders comprise those orders that may be carried out by the allied health practitioner staff pursuant to authorization by the supervising/collaborating physician, recommendation of the Credentials Committee and Medical Executive Committee and granting of the privilege by the Board of Managers.

III. REVIEW OF RECORDS

Except for the Chair of a Department (or their designee) Medical Coordinators for specialty areas, members of the Department of Pathology, Chief Medical Officer, Chief Quality Officer, Chief of Staff, review committees, or teaching faculty on teaching service in performance of assigned duties, no other attending physician shall review a patient's case history nor attend a patient in any manner unless authorized to do so by the attending physician, Chair, or Chief of Staff. Exceptions will be made in emergency situations arising in the absence of the attending physician, in which case medical center personnel may request the services of any physician available to render emergency service. It is understood that hospital records may be used for scientific, educational, and statistical purposes by members

of the staff, provided proper consent has been obtained and as applicable per prevailing law and regulation.

IV. ADMISSION OF PATIENTS

Only an attending physician (MD/DO), dentist or podiatrist can order the admission of a patient. A Resident Physician, Nurse Practitioner or Physician Assistant may write this order and subsequent orders defining the care of the admitted patient, on behalf of the physician, pursuant to a conversation with a/the physician ordering the admission. But, a Nurse Practitioner or Physician Assistant is not delegated the authority to admit a patient without a physician's express order or consent.

All patients admitted to Hurley Medical Center shall be under the daily care and responsibility of a physician (MD or DO), dentist, podiatrist, or nurse midwife member of the Medical Staff with admitting privileges as described in the Professional Staff Bylaws.

The Medical Staff member with admitting privileges may utilize a licensed and Hurley Medical Center Medical Staff, GME credentialed practitioner (i.e. resident, fellow, physician assistant, midwife, nurse practitioner, certified registered nurse anesthetist) in rendering daily care, but the responsibility of the patient's daily care remains with the Medical Staff with admitting privileges.

The orders that define the patient care provided by the responsible Medical Staff member or supervised licensed practitioner are pursuant to the scope of privileges granted by the Governing Body upon recommendation of the Medical Staff.

V. DISCHARGES

Only a physician (MD/DO), physician's alternate, dentist, or podiatrist can order a patient's discharge. A Resident Physician, Nurse Practitioner or Physician Assistant may write this order and additional discharge orders defining the post hospital care of the discharged patient, on behalf of the physician, pursuant to a conversation with a/the physician ordering the discharge. Patients demanding to be released from the medical center without recommendation by the attending physician and/or alternate shall be required to sign a special form. It shall also be documented in the Progress Note that the patient left against medical advice.

Where the patient chooses to leave against medical advice, the physician or alternate physician will inform/advise the patient of the risk, benefits and alternatives of this decision and conversation is documented.

VI. ALTERNATE PHYSICIANS

A. Members of the Professional Staff shall designate alternates within their discipline for coverage when they are not available. This shall be reviewed by the physician member on a biennial basis commensurate with reappointment. When physicians are unavailable for call, they must notify the Admitting Department and their alternate.

B. Physicians may not designate “Staff Service” or “Physician Coverage Service” as their alternate without current prior written approval of the Staff Service Attending or Program Director, or Physician Coverage Service attending.
C. If a patient presents to the Emergency Department, and it is determined that neither the attending physician nor the alternate is available, the patient will be assigned to the appropriate staff service.
D. A physician may not delegate coverage to an Affiliate member of the Professional Staff (Allied Health Practitioner).

VII. ASSIGNMENT OF PHYSICIANS TO STAFF PATIENTS

A. Staff patients are those ED and Clinic patients who do not name an attending physician or whose physician is not available for continuous care during the medical center period.
B. All staff patients shall be attended by members of the Professional Staff and assigned to the department/specialty area concerned with the treatment of the disease that necessitated admission. Patients requiring admission who have no attending physician shall be assigned to members of the staff on duty in the department/specialty area concerned with the patient’s illness.

VIII. TRANSFER OF PATIENTS TO OTHER PHYSICIANS

A. Patients admitted under the name of an attending physician other than their own choice, as sometimes is the case when the admission is processed through the Emergency Department, have the right to request transfer to a physician of their choice. The requested physician may refuse care of the patient, but that physician will continue to be responsible until another physician accepts responsibility for the care of the patient.
B. Patients admitted under the name of the physician of their choice may transfer to another physician on staff at Hurley Medical Center after discharge of the original physician by the patient or the patient’s legal representative and documented acceptance of care by the requested physician.
C. Patients may request a medical staff member attend their care; however, if no prior physician/consultant/patient relationship exists, the physician/consultant shall not be obliged to care for that patient.
D. An attending physician may not transfer or change the responsibility of the medical care of a patient to another physician without obtaining the other physician’s consent to the transfer. This transfer shall be indicated on a Consultation Sheet, in the “Requested Disposition of Case – Section B – Assume Care of this Patient.” The Consultation Sheet must be signed by both physicians and will become a part of the patient’s records.

IX. TISSUE EXAMINATION

All tissue removed surgically in the operating room and all biopsies taken throughout the medical center must be sent to the pathologist of this medical center for examination, except as provided in the Department of Pathology Rules and Regulations.

X. PHOTOGRAPHS

Photographs may be taken provided the proper consent forms are executed by the patient or their legal representative.

XI. NEW FORMS

All new forms pertaining to patient care must be approved by the Medical Record/Permanent Audit Committee.

XII. PROFESSIONAL MEDICAL STAFF WELL-BEING COMMITTEE

The Professional Medical Staff Well-Being Committee shall be appointed by the Chief of Staff and shall consist of not less than three (3) nor more than five (5) members (including the Committee Chair) of the Professional Staff. The committee shall:

A. identify and support professional medical staff members with impairments and shall be non-punitive in approach;
B. provide a mechanism for self-referral;
C. provide a mechanism for education and referral of the affected professional medical staff member;
D. provide confidentiality with respect to the affected professional medical staff member and any individual making a referral to the Professional Medical Staff Well-Being Committee;
E. evaluate the credibility and monitor the affected professional medical staff member;
F. report to the Professional Medical Staff.

Whenever a member of the Professional Staff appears at the medical center with the intention of directly or indirectly participating in patient care, and in the opinion of medical center staff (nursing, resident, or professional medical staff member) appears at that time to be impaired, a member of the Professional Medical Staff Well-Being Committee will be immediately notified and asked to come to the medical center, meet with the professional medical staff member in question, and assess the situation. If there is difficulty in contacting a member of the Professional Medical Staff Well-Being Committee, the Department Chair, a Staff Officer, the Chief Medical Officer, the Chief Quality Officer or Chief of Staff may be contacted.

If the Professional Medical Staff Well-Being committee member, Department Chair, Staff Officer, Chief Medical Officer, Chief Quality Officer, or Chief of Staff feels that impairment or intoxication exists, a urine and/or blood sample will be immediately obtained under direct supervision and subsequently evaluated for possible mood-altering substances. If a medical problem is believed to be present, appropriate evaluation will be recommended or requested. Hospital Standard Practice regarding Drug Free Workplace additionally outlines the corporate policy and consent document to be used in these instances.

If the urine or blood sample obtained under these circumstances is positive for mood altering substances, then the matter will be brought before the Professional Medical Staff Well-Being Committee. The professional medical staff member involved will have an opportunity to appear before the Professional Medical Staff Well-Being Committee to explain any mitigating circumstances. If the situation is not appropriately resolved, then chemical dependency evaluation should be recommended and treatment considered. A second test for mood altering chemicals may be recommended at this time.

If the second sample obtained as above is positive for mood altering substance, then chemical dependency evaluation and treatment will be required in an inpatient setting acceptable to the professional medical staff member in question and to the Professional Medical Staff Well-Being Committee.

Failure of a professional medical staff member to comply with requests for evaluation by a peer or for samples for evaluation under these circumstances, or noncompliance with committee recommendations for evaluation or treatment will result in a Summary Suspension.

The affected professional medical staff member must agree to the recommended treatment plan of the committee and consent to communication with the Chief Medical Officer, Chief Quality Officer, Chief of Staff, and/or Chair of the Well-Being Committee from the person treating the professional medical staff member. Failure of the professional medical staff member to agree to these parameters will result in a Summary Suspension.

XIII. FORMULARY OF ACCEPTED DRUGS

A. The Formulary of Accepted Drugs represents therapeutic agents accepted for use at Hurley Medical Center for those categories of drugs that have undergone formal review. All drugs listed represent therapeutic agents accepted for use at Hurley Medical Center for those categories of drugs that have undergone formal review. All drugs listed in the Formulary are approved under procedures adopted by the Professional Staff.

1. Request for Non-Formulary Drug Evaluation
    i. A "Request for Non-Formulary Drug Evaluation," obtainable from the Pharmacy Department, must be completed by a member of the attending staff, or by a house officer with an attending staff's countersignature, as the first stop in requesting a new drug to be used in the institution.
    ii. The request is forwarded to the Director of Pharmacy for inclusion in materials to be reviewed at the next monthly meeting of the Pharmacy & Therapeutics Committee.
    iii. The request is reviewed by the Pharmacy & Therapeutics Committee and a decision made to approve or disapprove inclusion of the drug in question.

2. Therapeutic Drug Classifications/Equivalents
    i. The Pharmacy & Therapeutics Committee shall appoint an ad hoc Formulary Subcommittee periodically to undertake review of therapeutic drug classifications to identify drugs not used and to recommend therapeutic equivalents, which may result in deletion of drugs from the Formulary.
    ii. These therapeutic reviews shall be carried out in cooperation with the medical or surgical division where these agents are most frequently employed.

3. Procedure for Handling Non-Formulary Drug Orders
    i. When a non-formulary drug is prescribed for an inpatient, a pharmacist will contact the prescribing physician and indicate the drug is not stocked due to its non-formulary status.
    ii. If appropriate, the pharmacist will recommend pharmacologically similar agents, which are stocked.
    iii. If the physician has a medical reason for using the non-formulary drug, the pharmacy will obtain a supply of the drug for that particular patient.
    iv. The usual manner of obtaining the drug is by borrowing from another hospital, or purchasing from a local wholesale supplier.

B. INVESTIGATIONAL DRUGS

Investigational drugs must be approved for use by the Institutional Review Committee before they may be introduced into clinical use. Protocols and other information regarding their use should be provided to the Pharmacy Department and to the nursing unit where they are to be used. Proper orientation of the house officers and nursing staff must be given before investigational drugs are used.

XIV. EMERGENCY DECISIONS

Decisions concerning emergency medical situations not covered by the Rules and Regulations may be made by the Chief of Staff, in consultation with the President & Chief Executive Officer of the medical center, Chief Medical Officer or Chief Quality Officer. If time permits, this shall be done after consultation with appropriate members of the Professional Staff. Such decisions shall be brought to the MEC, at their next regular meeting, for final disposition.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF
ADMITTING RULES AND REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and policies & procedures, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

SECTION 2 – ADMITTING RULES AND REGULATIONS

I. TYPES OF ADMISSIONS (SOURCE) – DEFINED

A. Pre-board – a Reservation made at least 24 hours in advance of the patient's admission.
B. Clinic/Ambulatory Care (non-Emergency Room or Urgent Care) Area – a reservation made by a physician for immediate admission.
C. Emergency Room – A reservation made by the emergency staff for patient's immediate admission.
D. Routine/Direct – A reservation made by a physician for a patient to be admitted that day.

II. ADMISSION TO THE HOSPITAL - DEFINED

A. When the following criteria are satisfied, the patient is considered a hospital admission even though he may leave immediately upon arrival to the unit: (in this situation, the Nursing Notes shall show the reason for discharge.
   1. It is the intention to admit the patient
   2. Reservation has been made with the unit
   3. Patient arrives on the unit

B. Newborns
   1. All infants born within the limits of the hospital property shall be registered as a hospital birth.
   2. All infants born beyond the limits of the hospital property but still attached to the placenta shall be listed as a hospital birth. The time of admission to the hospital shall be the birth time on all records.
   3. All infants born beyond the limits of the hospital property and completely detached from the placenta shall be a direct admission.

C. All patients admitted to Hurley Medical Center shall be under the daily care and responsibility of a physician (MD or DO) member of the Medical Staff with admitting privileges. The Medical Staff member with admitting privileges may utilize a licenses and Hurley Medical Center Medical Staff, GME or Human Resources credentialed practitioner (i.e. resident, fellow, physician assistant, midwife, nurse practitioner, certified registered nurse anesthetist) in rendering daily care, but the responsibility of the patient's daily care remains with the Medical Staff with admitting privileges.

The orders that define the patient care provided by the responsible Medical Staff member or supervised licensed practitioner are pursuant to the scope of privileges granted by the Governing Body upon recommendation of the Medical Staff.

III. PHYSICIANS ELIGIBLE TO ADMIT

A. Physicians who have been appointed by the Board of Managers to practice at Hurley Medical Center and granted privileges.
B. Dentists and Podiatrists may only admit patients jointly with a physician member of the staff. The dentist is responsible for the part of history and physical examination that relates to dentistry. The podiatrist is responsible for the part of the history and physical examination that relates to podiatry. The physician member of the staff is responsible for the general history and physical examination.
C. A history and physical performed by an individual not credentialed by Hurley Medical Center Professional Staff must be reviewed, validated and authenticated by a Hurley Medical Staff member.
D. A Hurley Professional Staff credentialed Allied Health Practitioner processing the credentials to perform an H&P may perform the H&P under the appropriate supervising/collaborating physician. A relationship between that AHP and physician must be defined in writing and on file in each practitioner's file in the Medical Staff Office.

IV. PHYSICIANS/PRACTITIONERS INELIGIBLE TO ADMIT

A. Physicians off-staff for medical record deficiencies.
B. Physicians off-staff for lack of admission note and/or history and physical examination, operative reports, consultation reports on an inpatient.
C. Physicians off-staff may not admit a patient as a staff patient, nor may they admit under the name of another physician. These patients may be admitted to the hospitalist service or the Staff service in accordance with Medical Staff Bylaws, Departmental rules as approved by the Medical Executive Committee and Board, or in accordance with prevailing hospital policy.
D. Member of the Allied Health Staff shall not be privileged to admit patients to the medical center under their name and must provide patient care under the direction of a member of the Professional Staff.
E. Members of the Allied Health Practitioner Staff may admit patients under their name if this admitting privilege is recommended by/from the Medical Executive Committee and granted by the Board of Managers.

V. GENERAL RULES FOR BED RESERVATIONS

A. Medical beds shall be assigned according to medical requirements. Emergencies will be admitted to the accommodation desired if that

accommodation is available and will be moved to the accommodation desired on a "first-come, first-served basis."

B. Physicians will be questioned concerning the need for isolation. (See Infection Control Standard Practices)

VI. BED RESERVATION FOR ADMISSION TO CORONARY CARE UNIT

A. The physician will make reservation with nursing personnel on the Coronary Care Unit; personnel on CCU will notify the Admitting Office of the reservation.

VII. BED RESERVATION FOR ADMISSION TO MEDICAL INTENSIVE CARE UNIT

A. The physician will make reservations with the charge nurse on Intensive Care. Nursing personnel on ICU will notify the Admitting Office of the reservation, stating the necessary information.

B. If no beds are available, the ICU Attending shall be contacted to assist with appropriate evaluation and placement of the patient or transfer of any current ICU patient to another location.

VIII. BED RESERVATION FOR ADMISSION TO NEURO-TRAUMA INTENSIVE CARE UNIT

A. The physician will make reservations with the charge nurse on Neuro Trauma Unit. Nursing personnel on Neuro Trauma will notify the Admitting Office of the reservation, stating the necessary information.

B. If no beds are available, the Neuro Trauma Medical Director shall be contacted to assist with appropriate evaluation and placement of the patient or transfer of any current Neuro Trauma patient to another location.

IX. BED RESERVATION FOR ADMISSION TO MEDICINE

A. Reservations are to be made in advance directly with the Admitting Office. When beds are reserved in advance, type of accommodation will be held up to 24 hours for the patient, when possible. There must be a diagnosis, not a symptom, on the reservation card.

B. Emergencies will be admitting to the accommodation desired if that accommodation is available, and will be moved to the accommodation desired on a "first-come, first-served" basis.

X. BED RESERVATION FOR ADMISSION TO OBSTETRICS

A. Any patient in active labor who reports to the Outpatient Service, Emergency, or Admitting Office shall be immediately admitted to the Labor & Delivery.

B. A physician may make a reservation directly with the Admitting Office for obstetrical patients who are not in labor and/or have complication of pregnancy.
C. Physicians attending the patient during pregnancy should have the patient call the Admitting Pre-Registration Unit approximately two months prior to delivery and have their history pre-typed, or have the patient complete a pre-registration form and mail it to that office.

XI. BED RESERVATION FOR ADMISSION TO BEHAVIORAL MEDICINE

A. Physicians will make reservations directly with the Admitting Office for direct admissions.
B. Physicians shall make contact with the Behavioral Medicine Unit Nursing personnel to facilitate the patient's care upon arrival.
C. All admissions to the Behavioral Medicine Unit must have a signed Voluntary Admission Form.
D. If the patient or guardian refuses to sign the Voluntary Admission Form, the patient cannot be admitted. If, in the opinion of the physician, the patient should be admitted involuntarily, a Petition for Hospitalization may be completed by the physician.
E. All involuntary patients admitted to the Behavioral Medicine Unit must have:
    a. A Petition/Application for Hospitalization signed by a family member, significant other, physician, or staff who witnessed patient behavior meeting commitment criteria, **as well as;**
    b. A Physician's Certificate signed by a medical resident, physician or psychologist.

XII. BED RESERVATION FOR ADMISSION TO SURGERY AND TRAUMA

A. Bed reservations are to be made at least 24 hours in advance on preboarded surgery, through the Boarding Office, with the Boarding Clerk. There must be a diagnosis, proposed operation, and ICD-9 code on the reservation card.
B. If the patient has been injured, it must be stated how the injury was received.
C. All Class I Trauma patients must be admitted to the Trauma Service.
D. Class II Trauma patients may be admitted to the service of the primary care physician with a consultation to the Trauma Surgeon.
E. Burn patients must be admitted to the Burn Unit, unless otherwise dictated by the ED or Trauma/Burn Physician.
F. For patients with insurances that require prior approval or authorization, that number must also be submitted with the reservation.

XIII. BED RESERVATIONS FOR ADMISSION TO PEDIATRICS

A. Physicians will make reservations directly with the Admitting Office, including in the diagnosis a statement of whether or not the patient has upper

respiratory infection or requirement for any isolation or need for infectious precautions.

B. All patients admitted to Pediatrics will be placed on Teaching Service. Exclusions to this will be done at the request of the Attending Physician.
C. The Senior Resident or Chief Resident may limit teaching service patients as necessary or appropriate. This limitation shall be made known to the Admitting and/or Attending Physician on admission.

XIV. ORDERS FOR PATIENTS

A. Admitting Office personnel may accept orders signed by the admitting or attending physician. These orders may be electronically entered and transmitted through the electronic health/medical record system (see Medical Staff policy regarding computerized practitioner order entry).
B. Medication or treatment orders can be accepted only by Admitting Office personnel authorized to accept verbal orders (see Telephone/Verbal Orders Policy); otherwise only Nursing personnel may accept these orders.
C. Admitting Office personnel may accept orders (i.e. request) to place patients on Teaching Service and specific unit bed placement/reservations. The Senior Resident or Chief Resident may limit teaching service patients as necessary or appropriate. This limitation shall be made known to the Admitting and/or Attending Physician on admission.
D. A Resident Physician, Nurse Practitioner or Physician Assistant may write this order and subsequent orders defining the care of the admitted patient, on behalf of the physician, pursuant to a conversation with a/the physician ordering the admission. However, a Nurse Practitioner or Physician Assistant is not delegated the authority to admit a patient with a physician's express order or consent.

XV. TRANSFER FROM INTENSIVE CARE UNIT TO OTHER NURSING FLOORS

A. When beds are full and a transfer out of the Intensive Care Unit must be effected, the attending physician whose patient is most suitable for transfer will be contacted in an attempt to effect such a transfer. If no agreement is reached, the matter is to be referred to the director of the Intensive Care Unit. If the problem is still unresolved, it shall be referred to the Chief of Staff. When the attending physician or his/her alternate cannot be reached, the ICU resident, under the authority of the ICU Attending or Director of the ICU, may effect this transfer. Notice shall be made to the Attending physician and efforts regarding this notice and contact, or failed contact shall be documented in the medical record.

XVI. NOTIFICATION OF PHYSICIAN ON ADMISSION

A. It is the responsibility of the unit's Nursing Service to notify physicians of patient's arrival to/on the Nursing Unit.
B. If the physician cannot be reached within thirty (30) minutes, the patient may be placed on staff or Hospitalist service, or in accordance with current Medical Staff Bylaws, Medical Staff Departmental Policy approved by the Medical Executive Committee and Board of Manager, or prevailing approved hospital policy.
C. If the physician is out of town or unavailable for call, his/her alternate physician shall be called. In all instances, an inability to contact the appropriate/necessary physician shall follow the Chain of Command policy for clinical matters.
D. To expedite the above, each doctor must notify his/her alternate **and** the Medical Staff Office, if appropriate when he/she is unavailable for call. (See General Rules, Alternate Physicians") Physicians failing to provide appropriate notification of his or her absence and not provide arrangement for the care of his/her patients shall be brought to the attention of the Department Chair, Chief of Staff and/or Chief Medical Officer.

XVII. DISCHARGE OF PATIENTS

A. Discharges may occur at any time during the calendar day.
B. Discharges should be coordinated with the Nursing Staff and Case Management Staff to achieve optimal patient care and patient satisfaction.
C. Only a physician (MD/DO), physician's alternate, dentist, or podiatrist can order a patient's discharge. A Resident Physician, Nurse Practitioner or Physician Assistant may write this order and additional discharge orders defining the post hospital care of the discharged patient, on behalf of the physician, pursuant to a conversation with a/the physician ordering the discharge. Patients demanding to be released from the medical center without recommendation by the attending physician and/or alternate shall be required to sign a special form. It shall also be documented in the Progress Note that the patient left against medical advice.
D. Should a patient voluntarily leave the hospital without a discharge order, the patient is automatically discharges. The necessary notifications will be made by the Admitting Office. Should the patient return more than four (4) hours from the time he/she left the unit, he/she will be processed as a new admission.

XVIII. BLOOD TRANSFUSIONS

A. Blood transfusions for outpatients must be scheduled by the attending physician with the Procedures Clinic and Patient Registration Department.

XIX. VISITORS

A. A physician may restrict visitors for medically necessary reasons, upon notifying the patient.
B. Visitation may also be restricted upon the request of the patient or a law enforcement agent. In addition, visitors may be restricted in certain areas of the hospital by departmental policy. The Patient Directed Visitation hospital policy should also be consulted.

XX. RELEASE OF INFORMATION

A. Information regarding patients may be released by the administration to the news media only after approval by the attending physician and the patient, or his/her legal guardian.

XXI. MEDICAL-LEGAL CASES

A. Medical-legal cases in the State of Michigan include:
    1. All abortions, self-induced or otherwise, if the patient dies.
    2. All deaths in which the attending physician refuses to sign a death certificate.
    3. All cases dying suddenly without known cause in which the attending physician refuses to sign a death certificate.
    4. All cases dying by accident.
    5. All cases dying by violence.
    6. All cases dying suddenly without medical attendance during the 48 hour prior to death, unless the attending physician is able to accurately determine the cause of death.

    (This listing of case types is for information only. For details see Act 181, P.A. 1953, amended; MSA 5.953.CL '48, 52.20)
B. The Medical Examiner must be notified in all of the above cases, and a Medical-legal disposition form obtained from Admitting and filled out. More specifically, the Medical Examiner must be contacted for each of the following situations:
    a. Deaths by violence of any type or cause (death may follow immediately or be delayed.
    b. Deaths that are unexpected or unexplained.
    c. Death without medical attendance during the 48-hour period prior to death unless the attending physician is able to accurately determine the cause of death and is willing to sign the death certificate.
    d. Death occurring more than ten (10) days after the deceased was last seen by a physician, or if the physician cannot accurately determine the cause of death, or if the attending physician is unavailable.

e. Natural deaths where the attending physician in unavailable and only the on-call physician can be reached (and does not verify that the attending physician will sign the death certificate).
f. Maternal and/or infant death due to abortion, whether self-induced or otherwise.
g. Death of a prisoner in a city or county jail or penitentiary or in police custody at any place. The death of any person who is held involuntarily should be examined carefully.
h. Death of any hospice or nursing home patient when it cannot be accurately determined that the patient died of the disease and/or condition for which they were being treated.

C. The body in the above case is under the jurisdiction of the County authorities. If the Medical Examiner signs a disposition form releasing the body to the next of kin, then the family may legally grant permission for an autopsy. The family has no jurisdiction over the deceased until the Medical Examiner releases his/her rights. The Medical Center will be especially interested in securing autopsies on those cases which have been previously admitted.
D. The family may sign a permit for performance of an autopsy by the medical center pathologist; however, this permit is not valid until the Medical Examiner releases his/her rights. This signed permit has no bearing on the Medical Examiner's decision and has no directive decision making authority to the Medical Examiner. Upon the decision of the Medical Examiner to perform an autopsy, this permit for the medical center pathologist to perform an autopsy shall become null and void.
E. Where the Medical Examiner has released his/her right to the decedent and the family wishes to have an autopsy performed, consent and required documentation for Hurley Pathologists shall follow. Results of this autopsy shall not be under the purview of the Medical Examiner unless previously unknown pathologic or forensic findings or other legal proceedings so require.
F. Questions regarding whether a case is appropriate for the Medical Examiner shall be referred to the hospital pathologist or Medical Examiner.

HURLEY MEDICAL CENTER

PROFESSIONAL STAFF
POLICIES & PROCEDURES
FOR
MEDICAL RECORD COMPLETION

These Policies & Procedures are adopted in connection with the Medical Staff Bylaws, and made a part thereof. The definitions, terminologies and processes for amendment of the bylaws also apply to the Rules & Regulations and Policies & Procedures and proceedings hereunder.

SECTION 3 – MEDICAL RECORD COMPLETION GUIDELINES

I. DEFINITIONS

A. "Allied Health Professional" – a licensed or certified health care professional, other than a physician, who has been approved to render patient care in the hospital (e.g., psychologist, physician assistant, nurse practitioner, etc.)

B. "Attending physician" – primary physician providing care, or on teaching cases, the physician supervising the residents/medical students on the case

C. "Author" – the physician, resident, medical student, or allied health professional writing or dictating a report

D. "Provider" – any physician, resident or allied health professional

The masculine gender is used for purposes of convenience in this document and shall be interpreted in all cases to refer to both masculine and feminine genders.

II. LEGALLY FORMED MEDICAL PARTNERSHIPS AND PROFESSIONAL CORPORATIONS:

A. When members of legally formed medical partnerships or professional corporations (functioning as partnerships) desire to practice as a unit, the Medical Staff Office and Medical Record Department shall be notified in writing of such intentions.

Legal partners are defined as sharing equal risk and liability. Notification shall include the legal name of the group and be signed and dated by each member.

B. After proper notification, any member of the practicing unit who has seen the patient during hospitalization may complete the charts, except for operative dictation and/or delivery records. The partner who performed the operative episode, procedure or delivery is responsible for the dictation. Legal partners may not dictate operative reports/procedure reports/delivery records unless they are present during the procedure.

C. All members of the partnership are equally responsible for completion of clinical records of the partnership. If one member of a partnership should fail to complete his/her records in the time specified in the Rules and Regulations,

all members of the partnership shall be delinquent and placed on the Off-Staff List.

III. REQUIREMENTS FOR MEDICAL RECORD DOCUMENTATION:

A. A legal, accurate medical record shall be maintained for every person treated as an inpatient, outpatient, or emergency patient.

B. The medical record shall contain sufficient information to identify the patient clearly, to support the diagnosis and justify the treatment, and to document the results accurately and in a timely manner. All entries shall be dated and timed. The medical record shall also contain evidence of appropriate informed consent for any procedure or treatment for which it is appropriate.

- All caregivers providing service to the patient are authorized to document in the medical record on specific forms for their area or in the progress notes, including pastoral care.

C. Medical Records shall be confidential, current, accurate, legible, complete and secure.

D. The hospital medical record shall include at least the following:

- **Face Sheet**

  Demographic information is entered at time of patient admission as follows, if available:

  - Patient name, social security number, address, phone number, sex, race, age, birthdate, marital status, religion, church,
  - Next of kin, address, phone number, relationship.
  - Emergency Contact, address, phone number, relationship.
  - Patient employer, occupation.
  - Responsible Party, relationship, employer, address, phone number, social security number.
  - Insurance information.

- **Coded Diagnosis Sheet**

  The coded diagnosis sheet shall include:

  a. All pertinent diagnosis(es), including complications, which can be coded using ICD-9-CM

  b. All operative procedures, including invasive diagnostic procedures which can be coded using ICD-9-CM and/or CPT-4 in accordance with coding guidelines.

- **Emergency Room Report**

a. All reports shall be completed within a timely manner. *Reference specific site contract timeframes.*

   It is recommended the Emergency Room Report be completed immediately following the conclusion of treatment.

b. Note the following when completing Emergency Room Records:
   - Clinical appropriateness
   - Standard of care to support patient visit to ER

     1. *History:* including how, when and where an injury occurred or when symptoms first appeared.

     2. *Physical Findings:* including the site and approximate extent of lacerations; site, and degree and percent of body surface of burns.

     3. *Management:* treatment given including anesthetic used, if any, and number and type of sutures, injections, shots, dressing or cast application.

     4. *Diagnostic Test Ordered:* include the specific (diagnostic x-ray/lab/cardio) test ordered and results.

     5. *Diagnosis:* including specific detailed diagnosis, state medical condition or site, including right, left or bilateral; state type of trauma or injury, such as abrasion, contusion, concussion, lacerations, etc.

c. When a patient is pronounced DIE or DOA in the Emergency Room, the physical findings which established the diagnosis should be included in the record.

- **History and Physical Examination**

A clinically pertinent medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

A updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

The history and physical of each inpatient shall include, at a minimum, the following:

1) Identification data – at least two patient identifiers
2) Chief complaint or reason for admission
3) History of the present illness
4) Pertinent medical and surgical history
5) Medications with current dosages
6) Allergies / sensitivities
7) Pertinent social history and family history
8) Review of systems pertinent to reason for admission
9) Physical Exam pertinent to reason for admission
10) Results of pertinent diagnostic studies leading up to admission
11) Conclusion/impression/diagnostic considerations
12) Plan of care

Failure to complete the History and Physical as noted above may result in cancellation of the procedure unless the physician states in writing that such a delay would be detrimental to the patient. If such is stated, the History and Physical is to be completed within 24 hours of the emergency procedure as documented by the physician. *(These provisions may be waived in extreme emergency, but a preoperative diagnosis shall be recorded in the medical record and the History and Physical completed within 24 hours post-procedure).*

- **Readmission Note**

  An interval Readmission Note may be recorded as the History and Physical, if a complete history and physical has been recorded and a physical examination performed within 30 days prior to the patient's current admission to the hospital for the same or related condition.

  Readmission Note shall include:

  - pertinent additions to the history;
  - subsequent changes in physical findings;
  - statement patient was re-examined and chart reviewed; and
  - statement the History & Physical form was reviewed, signed and dated

- **Admit Note**

  Contains sufficient history, physical findings, and enough documented medical complexity to support the need for care to be rendered on either an inpatient or observational basis.
  a. For acute care admissions the documentation must also support the need for a stay that will likely span two midnights.
  b. Additionally the physician must be sure that there is an appropriate admission order, as well as, the necessary certification required for inpatient admission.
  c. The admit note may be used as the History and Physical if the History and Physical contents are present.
  d. An admitting note is required at the time of the acute hospital admission, unless the History and Physical is handwritten.

  While a complete H&P by the attending physician is preferred, if all elements of the H&P are documented elsewhere in the record in a single source, indications that the record is being used for an H&P and that the attending is in agreement must be included in the admit note for the previous documentation to be considered an H&P.

- **Consultations**

  A consultation report shall be completed within the timeframes specified for consultation. If the consultation report is dictated, a written consultation response including the consultant's impression and plan of treatment must be documented in the Consultation Record.

  a. Consultation Types

     Consultations will be two types: URGENT and ROUTINE

     - **Urgent** consults shall be expected to be done as soon as possible but not greater than 12 hours. When writing orders for urgently needed consultations on seriously ill patients, the attending physician **must** contact the consultant to ascertain his/her availability and to explain the urgent nature of the patient.

     - **Routine** consults shall be expected to be done within a 24-hour period.

  b. Consultation Categories

     The attending physician must specify on the patient chart which of three following consultation categories is applicable.

     1. Consult only (examine the patient and provide an opinion and advice);

2. Consult and assume care of the patient; or
3. Consult and assist in the management of the illness.

Note: When writing a consult or management order, identify the name of the physician to perform the service rather than the physician group to which they belong (ie. GI, Pulmonary). Notwithstanding the foregoing, a physician may specify a particular Physician or his/her designee to participate in the consultation or management of a patient, as above.

Note: If the category is not designated, the default shall be "consult and assist" in management of the illness.

e. Consultations shall be handwritten or dictated.

f. Consultations content shall include:
   - Date and time of reply
   - Notation that the patient was examined and medical record reviewed
   - Physical Examination: except in cases involving emergency surgery, consultation, when indicated, must be recorded prior to surgery.
   - Impression
   - Recommendations

g. Authentication (signature)

   The document must be signed AND dated by the author or his legal partner, or if written/dictated by a medical student or resident must also be signed by the attending/supervising physician.

   Note: When a full consultation report is dictated, a brief written consultation shall be documented on the Consultation Record immediately following examination and shall include: presumptive diagnosis(es), pertinent findings and recommendations.

f. Except in an emergency, consultation with another qualified physician is required in:

   - Amputations above the mid-metacarpal/tarsal level
   - Cases in which, according to the judgment of the physician or dentist:
     - Patient is not a good risk for operation or treatment
     - Diagnosis is obscure
     - There is doubt as to the best therapeutic measures to be utilized
     - All cases of critical illnesses or severe complications

        - Cases when services needed are outside of the attending's clinical privileges
        - All premature infants:
            - Under four (4) pounds
            - Those who fail to gain in one week

- **Record of Operation and Reports of Other Invasive Procedures**
    - Required for:
        - An operative/procedure report is required for operative or other procedures involving anesthesia or conscious sedation.
        - Reports of operative and invasive procedures must be written or dictated immediately following the procedure.
        - A post-operative progress note about the procedure(s) is entered immediately in the medical record to briefly describe the pre-operative and post-operative diagnosis(es), procedure(s) performed, findings, specimens removed, complication, if any, estimated blood loss, and name of surgeon(s)/assistant(s).
    - Contents, as applicable
        - Patient Identification
        - Date of Procedure(s)
        - Primary Surgeon/Assistant(s)
        - Pre-operative Diagnosis(es)
        - Post-operative Diagnosis(es)
        - Description of procedure(s) performed, to include:
            - Specific procedure(s) or technique(s) employed
            - Nature of specimen(s) removed and sent to Pathology
            - Estimated blood loss
            - Condition of patient upon leaving operating room
        - Authentication (signature)
            - The document must be signed AND dated by the author, or if written/dictated by a medical student or resident must also be signed by the attending/supervising physician.

- **Progress Notes**
    - Frequency
        - Daily progress notes shall be documented for all patients as evidence that the patient is under the care of a physician in an acute care setting.
    - Content
        - Pertinent chronological documentation of the patient's course in the hospital showing change in the patient's condition and the results of treatment.

- A statement of the patient status, whether improved, unchanged, regressing, etc.
- Any pertinent x-ray or laboratory data, physical findings or addendum to history of present illness.
- Current assessment
- Be legible
- Dated/timed/signed by author
- To document an omitted note the caregiver should date the note as written and indicate that his/her observations reflect the condition of the patient on the previous date.

Progress notes are required if a patient signs his/her own release prior to being seen by the attending physician, except it must be stated that the patient signed his/her own release against medical advice.

- **Paramedical Record**
  - Allied Health Professional Staff shall be allowed to write and sign progress notes in the progress record. The person making the entry shall sign each progress note, the signature to include either his/her professional initials or title.

- **Orders**
  - Orders for treatment shall be in writing or electronically entered as authored by the physician. All previous orders are canceled when patients go to surgery or enter/leave the Special Care Units. Following surgery or transfer to/from special care units, new orders need to be written' shall include any written order by authorized house staff member and those individuals who have been assigned independent practice privileges.
  - Daily orders such as laboratory, diagnostic imaging and EKGs must be renewed every three days.
  - Telephone or verbal orders may be accepted and transcribed by the following qualified individuals:
    - Registered Nurses
    - Physician Assistants
    - Pharmacists
    - Other allied health professionals within their scope of practice as delineated by the Medical Staff Credentialing Committee.
  - Telephone, verbal, standing or protocol orders are recommended to include:
    - Order (Designate TO=Telephone Order; VO=Verbal Orders; SO=Standing Orders; PO=Protocol Order)
    - Physician Name giving order (at a minimum shall include)
      - First Initial and Last Name/Credentials of Physician (MD/DO)
      - Date and time order given; and

        - Individual's name taking and recording the order (at a minimum shall include First Initial and Last Name/Title)
    - Telephone, verbal, standing or protocol orders shall be signed at the next patient encounter by the authoring, supervising or legal partner physician.
    - Standing or protocol orders are individualized for patient care specifically initiated by the Medical Staff.

- **Discharge Summary**

    - May be written or dictated

    - A discharge Summary is required for:

        - Patients who stay greater than two (2) calendar days
        - Expirations
        - Complicated Deliveries
        - Newborn with Complications
        - Transfers
    - Authentication (signature)
        - The document must be signed AND dated by the author or his legal partner, or if written/dictated by a medical student or resident must also be signed by the attending/supervising physician.
    - Contents shall include:
        - Patient identification;
        - Attending Physician;
        - Admission/Discharge Date;
        - Reason for hospitalization;
        - Significant findings including pertinent clinical/diagnostic findings;
        - Treatment Course, including procedures performed;
        - Patient's condition at discharge; and
        - Instructions to the patient and family, if any.
    - For newborns with uncomplicated deliveries, or for patients hospitalized for two (2) calendar days or less, a progress note may be substituted for the discharge summary. The progress note, which may be handwritten, documents the patient's condition at discharge, discharge instructions, and required follow-up care.

IV. OFF STAFF PROTOCOL

A. Incomplete Charts

- Any attending physician having one or more incomplete charts over 15 days post discharge shall receive a notification letter (Attachment A) requesting their completion prior to 30 days post

discharge. Any provider having one or more incomplete charts over 21 days post discharge, shall be contacted via phone, fax or email stating that he shall forfeit hospital privileges unless completed within seven (7) days regardless of prior notice. Any incomplete records that were unavailable to the physician will not cause the physician to be put off staff. Temporary forfeiture of hospital privileges shall include admitting privileges, Emergency Room participation, staff participation, consulting privileges and surgical/procedure boarding.

- When a physician has incomplete chart(s) 30 days after patient discharge, they shall receive a suspension letter (Attachment B) stating they are progressing toward Permanent Off Staff status.
- When a physician has incomplete record(s) 45 days after patient discharge, the Chief of Staff shall notify him/her of such via Certified Mail with return receipt (Attachment C).
- If the physician fails to complete the charts within 15 days of receipt of said notice, he shall be recommended to the Medical Executive Committee and the Board of Managers for termination of privileges.
- When his/her previously delinquent records are complete, he/she may apply for appointment to the Medical Staff (Attachment D).

B. In cases of anticipated absences, the absence must be reported to the Medical Records Department prior to the occurrence of the absence in order for a grace period to be applied.

C. Any physician anticipating prolonged leave of absence shall notify the Medical Records Department so that appropriate grace time may be allowed, unless that physician is already off-staff, in which case there will be no grace period.

D. Members of the resident staff and consultants may assist in the completion of the medical record for each patient. Interns and residents are to complete their records within 7 days after patient discharge unless otherwise specified by hospital contract. Their deficiencies cannot be used as an excuse by the attending physician to evade penalties set forth in these Record Completion Guidelines within the Rules and Regulations.

E. Medical Record Committee Action

- If 60 days following a patient's discharge, the attending physician is not available to complete the medical record, the Director of Medical Records shall recommend to the Medical Record Committee that appropriate action be taken after all pertinent facts have been presented.
- No professional staff member shall be permitted to complete the medical record on any patient unfamiliar to him/her, in order to retire an incomplete record which was the responsibility of another staff member who is

unavailable protractedly or permanently or for any other reasons including death.

- The Chairman of the Medical Record Committee and those other individuals charged with Medical Record Committee function shall be charged with the responsibility of declaring any record complete for purposes of filing: this would apply to any patient's record whose physician is unavailable, as above.

Delinquent Records, Physician 15-Day Letter
ATTACHMENT A

Date

Physician Name
Address
City, Sate, Postal Code

Dear Dr. _____:

In compliance with the Hurley Medical Center Medical Record Rules and Regulations, this notice is sent to remind you that your medical records have been incomplete for fifteen (15) days or more.

Although there may be a Resident or Physician Assistant responsible for completion or dictation of your medical records, Hurley Medical Center Rules and Regulations state that the Attending Physician is ultimately responsible for the completion of all medical records. Therefore, it is your responsibility to ensure that the Resident Physician(s) and/or Physician assistant working under your supervision complete his/her medical records in a timely fashion.

Failure to complete your medical records in a timely fashion will result in suspension of your admitting privileges until the delinquent records are completed. Thank you for your prompt compliance and cooperation.

Sincerely,

Name
Chief of Staff

Name
Vice President of Medical Affairs

pc: Department Chairperson
Medical Staff Office
Medical Record Department

Delinquent Records, Physician 21-Day Letter
ATTACHMENT B

Date

Physician Name
Address
City, State, Postal Code

Dear Dr. _____:

On _____, you were notified by our office that your medical records must be completed on or before _____.

In accordance with the Medical Staff Rules and Regulations, your medical records must be completed by _____, or your medical staff privileges will be suspended until the medical records are completed.

Although there may be a Resident or Physician Assistant responsible for completion or dictation of your medical records, Hurley Medical Center Rules and Regulations stated that the Attending Physician is ultimately responsible for the completion of all medical records. Therefore, it is your responsibility to ensure that the Resident Physician(s) and/or Physician Assistant working under your supervision complete his/her medical records in a timely fashion.

Thank you for your prompt compliance and cooperation.

Sincerely,

Name
Chief of Staff

Name
Vice President for Medical Affairs

pc: Department Chairperson
Medical Staff Office
Medical Record Department

Delinquent Records, Physician 30-Day Suspension Letter
ATTACHMENT C

Date

Physician Name
Address
City, State, Postal Code

Dear Dr. _____:

On _____, you were notified by our office that your medical records must be completed on or before _____.

As fined in the Bylaws, you will be suspended until your medical records are completed. Inasmuch as your medical records remain incomplete, **you may not admit, board, or perform procedures, or accept referrals.** In fact, the only clinical activity you are permitted is to care for any patients who are currently hospitalized. Additionally, your **parking pass privileges** will be deactivated if your medical records are not completed by the above due date.

An incomplete medical record suspension for any physician will become a permanent suspension following the recommendation by the Executive Committee and ratification by the Board of Hospital Managers thirty days after the temporary suspension indicated above.

The timely completion of the medical record, the legibility of the medical record and the clinical pertinence of the information included in the medical record is

most certainly a quality issue. It is for this reason that the Chairperson of your Department will be informed as to your medical record activities.

Sincerely,

Name
Chief of Staff

Name
Vice President for Medical Affairs

pc: Department Chairperson
Medical Staff Office
Medical Record Department
Nursing Administration
Surgical Boarding
Patient Registration

Delinquent Records, Physician Off Staff Letter
ATTACHMENT D

Date

Physician Name
Address
City, State, Postal Code

Dear Dr. _____:

The Medical Staff Bylaws, Rules and Regulations state that when a physician has any incomplete medical records past thirty (30) days from the date of discharge, he shall be temporarily suspended.

Any incomplete medical record suspension for any physician will become a permanent suspension following the recommendation by the Executive Committee and ratification by the Board of Hospital Managers.

As of this date, our records indicate that you continue to have delinquent medical records, as stated in the suspension letter which was sent to you two (2) weeks ago; therefore, you have not fulfilled your obligation, as required.

This letter is to inform you that you will be recommended for permanent dismissal from Hurley Medical Center Medical Staff at the next Medical Executive

Committee meeting on _____. If approved and ratified by the Board of Hospital Managers, you will be required to reapply for privileges at Hurley Medical Center.

Sincerely,

Name,
Chief of Staff

Name
Vice President for Medical Affairs

pc: Department Chairperson
Medical Staff Office
Medical Record Department